



CAN MEDICATION AND RELIGION CO-EXIST: RAMADAN AND DIABETES

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The **PRO**-Active **TE**lemedicine **TaCT**ical **OpeR**ation (PROTECTOR) programme was a telehealth pilot intervention to support people living with poorly controlled diabetes.



AIM

The aim of the intervention was to see whether a short telehealth-delivered intervention could help patients in the Klipfontein and Mitchells Plain region of Cape Town to optimise their diabetes condition and bring their clinical measures (such as HbA1c) within clinically normal ranges.



INTRODUCTION

The pilot intervention coincided with the period of Ramadan, a time where healthy Muslim adults are expected to fast from dawn to sunset. Ramadan is a period of heightened spirituality, sacrifice, and patience for Muslims. Muslims all yearn to reap the benefits of this auspicious month; therefore, it is not surprising that people living with diabetes want to fulfil this obligation too.

There were many Muslim participants in the pilot, and the telehealth doctor administering the intervention was herself a Muslim woman. This ability to understand her patients' context and religious requirements allowed her to pre-empt some of the challenges faced by Muslims living with diabetes during the holy month of Ramadan.



FINDINGS

Even after advice from a Muslim doctor that fasting may be difficult/ill-advised, some patients still expressed a strong desire to fast during Ramadan. Two people who were taking oral medication managed to fast well and reported feeling more energised. Two people who were on insulin, developed hypoglycaemic symptoms. For the one person, the telehealth doctor adjusted the insulin dosage and after this they were able to continue their fast safely. For the other, they had to stop fasting as the health risks were too severe.

Some who were advised that fasting may be difficult chose not to fast. However, many of the participants who had heeded the health advice and opted not to fast, developed spiking sugar levels. This could be attributed to the consumption of refined, fried, and sweet treats consumed at Iftar (the meal of breaking the fast), which participants understandably still attended. Ramadan, being a time of sharing meals and Iftar treats with non-Muslim neighbours and friends too, meant that the challenge of spiking sugar levels was not limited to Muslim patients only. **This is evidence for the role of place in understanding why or how interventions succeed or fail.**

In 2021, the period of fasting was about 12 hours. Patients on oral medication did not require any dosage adjustment. However, those patients on the long-acting medications, required close monitoring. For the fasting patients on insulin, the morning dose was reduced, and evening dose increased to reflect the change in mealtimes.



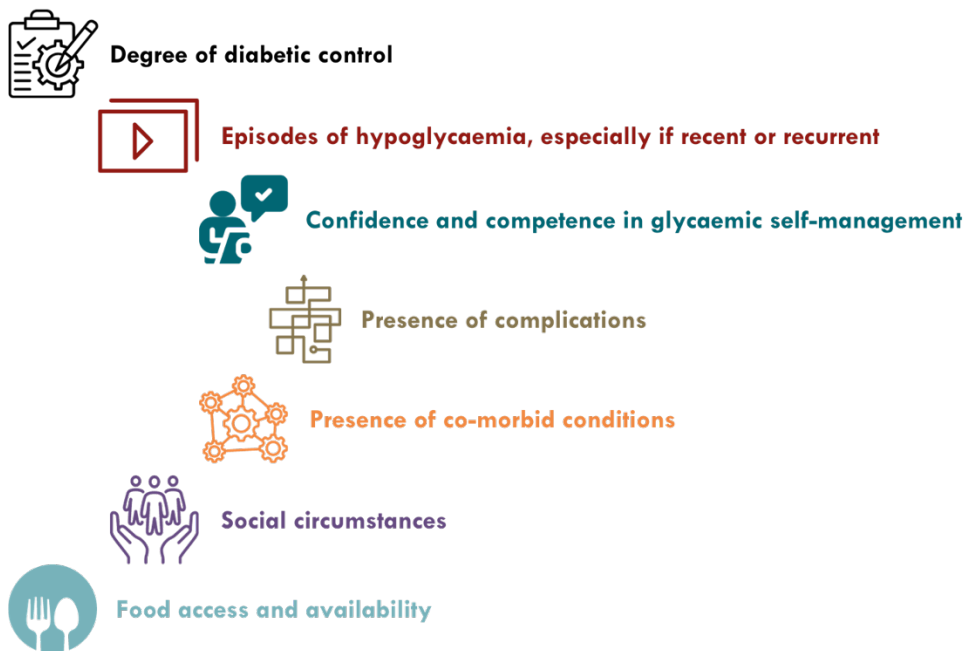


REFLECTION

Reflecting on our cohort of Muslim patients, it was found that fasting during the month of Ramadan brought on some unique challenges for the pilot participants.

While there are proven metabolic benefits of fasting, this needs to be weighed against the potential risks that may occur for people living with diabetes. These include hypoglycaemia (too little glucose in the bloodstream), hyperglycaemia (too much glucose in the blood stream), Diabetic ketoacidosis (which can cause swelling in the brain and is potentially fatal), and dehydration.

To advise patients appropriately, it is important to determine which patients would be most at risk of developing complications. Some factors that were taken into consideration to assess a patient's risk were found in our study to be:



Ramadan also presented a challenge related to the religious and community activities that take place during this auspicious time. Two participants were very busy with community activities during the month that they were unable or found it difficult to remember to take their sugar readings each day. This meant the doctor was unable to remotely monitor their health effectively.



CONCLUSION

Some diabetic patients can safely fast during the month of Ramadan, while others require guidance and support to fast without developing complications. Those at high risk of developing metabolic changes should ideally not be fasting.

When developing an intervention such as this one, it is important to consider the **place of the intervention**; ensuring that the **patient is being met where they are at**, for example with respect to dosage changes, counselling on whether to fast and supporting those who choose to fast despite the advice not to; and to **view religion as an important contextual factor in understanding what matters to patients** and not viewing it as an “optional” matter that patients should just give up. Fasting is a personal choice. Healthcare workers should be culturally sensitive and knowledgeable to best support the patient who chooses to fast during the month of Ramadan.

