VANDERBILT
Cultural Contexts of Health & Wellbeing
INITIATIVE

Race Does Not Cause Diabetes —but racial discrimination makes it worse

In the U.S., type 2 diabetes is twice as common in Black populations as among non-Hispanic Whites (and rates among Native Americans and Hispanics is also significantly higher). For that reason, "race" is commonly listed as a key risk factor for developing the disease. The implication is that being Black puts one at risk, but there is no evidence that higher rates of type 2 diabetes results from an inherent biological vulnerability based in genetic ancestry.

In fact, zip codes are better indicators of diabetes risk than race itself, with the highest rates in majority-Black neighborhoods. **This racial correlation is not about biological causation**, but rather reflects the economic, social, historical, and environmental contexts in which Black populations are concentrated.

Thus, **rather than targeting individuals because of their race or genetic heritage, interventions should look at the contexts that produce diabetes**. Blaming individuals for their genetic ancestry or their poor dietary choices distracts from addressing the underlying systemic and contextual causes, such as time poverty, stress exacerbated by racism and economic marginalization, and obesogenic environments.

The U.S. is currently experiencing an epidemic of diabetes-related amputations within the Black community. About 130,000 are performed annually, with Black people three times more likely to have their limbs removed than the national average. Physician Foluso Fakorede highlights the geographic overlap between amputation rates today and the density of enslaved population in the 1860s. In this, he sees a call for action to address the context of health, social, and financial insecurities.

Global Example: Brazil has developed one of the only successful national programs to combat diabetes by integrating nutritional guidance, education, diabetes surveillance, medication, and primary health care teams working with schools and families to increase access to medication and prevention services.

RECOMMENDATIONS:

1 Avoid assigning diabetes risk to race; rather, address the root social, economic, and environmental contexts that produce type 2 diabetes.
2 Integrate local knowledge and promote proactive, wrap-around systems that engage communities in diabetes care.
3 Shift the focus from individual blame to treat the context of diabetes through food and beverage regulation, public design, and poverty and stress reduction.