

# KNOWLEDGE, ATTITUDES AND PRACTICES TO LIFESTYLE RISK FACTORS FOR CORONARY HEART DISEASE (CHD) AND DIABETES AMONGST SOUTH ASIANS IN NORTH KIRKLEES, ENGLAND - A FOCUS GROUP STUDY

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## ABSTRACT

**Objective:** The aim of the study was to identify and explore main issues relating to knowledge, attitudes and practices to lifestyle risk factors for coronary heart disease (CHD) and Diabetes amongst South Asians in North Kirklees, UK.

**Design:** A comparative study.

**Place and duration of study:** The study was conducted in North Kirklees, UK from April 2001 to March 2002.

**Material and Method:** A focus group approach from qualitative research methodology was used. South Asians already attending community centers for different activities were selected randomly. Group discussions were taped and translated. Main issues were identified by analyzing these transcripts using qualitative methodology.

**Results:** A variety of attitudes and different levels of knowledge and practices to lifestyle risk factors for coronary heart disease (CHD) and Diabetes have been observed. The main issues identified were language barrier, lack of individually tailored information, cultural and religious barriers such as lack of women-only facilities. Other barriers which have been highlighted by the study were diet, lack of physical activity and stress. Stress has also been identified as an important cause of CHD leading to Diabetes especially in South Asians (SA).

**Conclusion:** The health care professionals need to be aware of knowledge, attitudes and culturally sensitive issues of South Asians to potential diseases in order to undertake effective preventive measures by avoiding being prejudice. In spite of provision of communication assistants South Asians still face problems accessing health and leisure services due to language barriers. The issue of stress amongst South Asians needs to be recognized as an important issue. Hence it is important to assess the health and social needs of SA independently in order to deliver high quality and effective health care.

**Keywords:** Life style, diabetes, CHD (coronary heart disease), focus group study, South Asians

## INTRODUCTION

Coronary heart disease (CHD), also called (CAD), ischaemic heart disease, and

atherosclerotic heart disease, is the end result of the accumulation of atheromatous plaques within the walls of the arteries that supply the myocardium

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The disease is the most common cause of sudden death and is also the most common reason for death of men and women over 20 years of age. According to present trends in

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the United States, half of healthy 40-year-old males will develop CHD in the future, and one in three healthy 40-year-old women [1].

Diabetes mellitus is a metabolic disorder characterized by hyperglycaemia and other signs, as distinct from the single illness or condition. The World Health Organisation recognises three main forms of diabetes: type 1, type 2 and gestational diabetes (occurring during pregnancy), which have similar signs, symptoms and consequences, but different causes and population distribution. Ultimately all forms are due to beta cells of the pancreas being unable to produce sufficient insulin to prevent hyperglycemia [2].

CHD and diabetes are major causes of morbidity and mortality in UK and are registered as major priorities of National Health Services (NHS) [3]. The prevalence of CHD in the UK is 3.5% in males and 2.1% in females [4]. The burden of CHD is not distributed equally in society. The death rate among men from manual classes is 40% higher than for non-manual workers. Men of working age in social class V are 50% more likely to die from CHD than men in the population as a whole. The wives of manual workers have nearly twice the risk compared to wives of non-manual workers. This social class gradient is also reflected in morbidity rates, with angina, heart attack and stroke all more common amongst those in manual social classes [5].

There are also ethnic variations. For people born in the Indian sub-continent, the death rate from heart disease is 38% higher for men and 43% higher for women than rates for the country as a whole. The overall increased risk of mortality is up to 40%, with evidence that this is even higher in younger age groups and in women [6,7]. This problem has a substantial implication for the provision of health services in communities with large South Asian populations, as found in many large cities in the UK [8].

Diabetes is a worldwide problem that currently affects 150 million people, and this

number is set to double by 2025 [9]. Diabetes does not affect everyone equally. Significant inequalities exist in the risk of developing diabetes, in access to health services and the quality of those services, and in health outcomes, particularly with regard to Type 2 diabetes. Those who are overweight or obese, physically inactive or have a family history of diabetes are at increased risk of developing diabetes. People of South Asian, African, African-Caribbean and Middle Eastern descent have a higher than average risk of Type 2 diabetes, as do less affluent people [9].

Although people of South Asian origin contribute to only 3 per cent of the United Kingdom (UK) population [10], they form a higher proportion of the diabetic population. The incidence of type 2 diabetes is six times higher in South Asian people and up to three times more common in those of African and African-Caribbean descent, than in the white British population [11]. Diabetes occurs at an earlier age and complications resulting from the condition are more likely in this population, for example, coronary heart disease. The management of diabetes is a challenge for most patients, but is even more so for South Asian patients, especially if English is not their first language. The prevalence of diabetes rises steeply with age: 1 in 20 people over the age of 65 in the UK has diabetes and in people over the age of 85 years this rises to one in five [11].

Given this background, prevention of CHD and Diabetes must be seen as an important issue for a high risk group such as South Asians. There is good evidence that both primary and secondary prevention can be effective in reducing mortality and morbidity from CHD and Diabetes. However for prevention to be effective, it is important that health promotion advice is evidence based, culturally sensitive, accessible and tailored for the targeted population.

This study was conducted as a part of a project called - peer health education on CHD & diabetes for South Asian communities in North Kirklees, England, aimed at improving the knowledge, attitudes and lifestyles factors

by raising awareness, promoting already existing services and providing health promotion advice and activities in a culturally sensitive ways. At the same time providing feedback to the health care professionals about the barriers and difficulties faced by the SA communities in accessing health care facilities and providing cultural training to the health care professionals.

## **MATERIAL AND METHODS**

This study was conducted in North Kirklees, England from March 2001 to April 2002. The methodology used in this study was qualitative focus group. As qualitative research involves an interpretive naturalistic and holistic approach to its subject matter and helps in understanding social phenomena in natural setting giving due emphasis to the meanings, experiences and view of all participants.

Qualitative research provides 'cultural specific maps that can help to improve the fit of programmes to people, it shows the presence of beliefs and behaviors in the population.

In focus group people can express the patterns of their attitudes, perceptions, motivations, and trends of behaviors and feelings. This is what this study has done exploring the different life style risk factors related to CHD and Diabetes and identifying the main issues in order to comprehend a variety of attitudes and different levels of knowledge and practices to CHD and Diabetes.

### **Selection of Participants:**

The total population of North Kirklees is 172,556, out of which, Asian or Asian British: Pakistani 15,256, (8.8%), Asian or Asian British: Indian 11,986 (6.9%), Asian or Asian British: Other Asian 772 (0.4%).

Eight focus groups were conducted both for males and females, comprised of mainly 10 participants only in one focus group there were 12 participants so the total number of participants were 82.

Some assistance has been taken by community centre managers while

conducting male focus groups. These focus groups were conducted in Dewsbury, Batley, Heckmondwike and Ravensthorpe. All these areas were in the catchments of North Kirklees Primary Care Trust, UK. These are the areas with high ethnic population of South Asian origin, majority Muslims. Two focus groups were conducted in each of above mentioned areas separate for male and female by keeping the religious and cultural values. For this purpose we used the premises of different community centers in which the participants were coming regularly for different activities on a particular day (convenient sampling technique). We found the communities preferred to come in these centers and felt more comfortable and trustworthy. The group members were with either heart related problems, diabetes or both. Each focus group consisted of 10-12 participants. The meeting rooms were quiet and comfortable and participants were assured of confidentiality. The composition of participants of the focus groups is summarized in the Table 1.

### **Focus Groups:**

Focus groups were led by project coordinator of South Asian origin and familiar with the relevant Asian languages (Urdu, Gujarati and Punjabi), as well as English. (Some assistance has been taken in Gujarati session). Purpose of the session has been explained and the group agreed the preferred language to be used at the outset. Each session was of almost an hour.

A number of key themes were identified to help direct the discussions (Table 2), although the groups were allowed to develop their views and opinions, with minimal intervention from the coordinator.

These sessions were audio taped and translated. The translation process was conducted independently by two researchers to check the reliability of the process.

## **DATA ANALYSIS**

The basic aim of analyzing data is to code the data so that categories can be recognized,

analysed and explored a sensible and comprehensive idea or practice of the participants. Statements and responses relating to the key lifestyle risk factors for CHD and Diabetes e.g. diet, stress, smoking and physical activity were highlighted and grouped. Other commonly occurring themes e.g. anxiety, cultural/religious issues were also identified in this way (content analysis). Initial analysis revealed 18 themes or categories which were reduced to six key themes. Codes were then allocated for these key themes (code application).

## RESULTS

### Diet:

Diet was pointed out by the participants as a potential risk factor for heart disease and diabetes, with perception of Indian/Pakistani diets as being unhealthy but many of them were not convinced that Asian diet is a problem.

"Still we cook our food in ghee and butter which is not good for health. We should use oil instead"

"I think we eat too much fried food and sugar in our meals"

"We are having same diet as in our own country (India / Pakistan), why it is a problem here?"

"We eat too heavy food and much sweet on our weddings, religious and cultural festivals."

"I love my Indian mithayi (sweets) I can't stop eating it I know that's why I got diabetes"

"Our Pakistani diet is healthy; our forefathers didn't have any problems. It is the weather and stress in a foreign country that is the main reason for ill health."

"There is nothing wrong with our food it the way we cook it"

"My mother, father and all other relatives back home used ghee/butter in cooking but they did not suffer from heart disease"

"It is something in the air and water of Batley which is causing heart problems"

"If our food is causing heart problems and Diabetes then why it is getting so much popular in Gora (White) community, personally I think it's not our diet it is combination of so many other factors like, stress, anxiety, cultural differences"

"Now I am using cooking oil instead of butter because my son didn't like food cooked in butter he says it's not healthy"

### Physical Activity (PA):

"In Pakistan we used to do a lot of walk but here it's too cold I can't do it"

"I know exercise is good for health but it's not my age to do it"

"I feel shy in going exercise classes"

"I want to go in aerobics or swimming classes but there in no women only facility available near by"

"Too much work load it's difficult to get time for gym"

"We never heard of our fore-fathers were going gym even then they were healthy and fit why it is necessary for us"

"I am not allowed to go in exercise classes because of music and dance"

"I heard going gym is too expensive can't afford it"

"Once I went in aerobic class but the instructor was speaking English and I couldn't understand so left it"

"Why should I do exercise I am not fat"

### Smoking / Tobacco:

"Back home, in gaoon (village), my father used to have huqa regularly with his friends but he didn't develop heart problem"

"Yes, I know smoking cigarettes is not good for heart and I am seeking help to quit"

"How can smoking linked with diabetes?"

"Smoking is getting in our community especially in our young generation"

"When I get depress I smoke"

"I know it's bad but too difficult to quit"

"Well, it is harmful for health but if I don't smoke I get headache"

"Does eating pan cause heart problems or diabetes?"

**Alcohol:**

"It is haram (prohibited) to drink alcohol in Islam"

"I don't think we (the Asian Muslim community) have a drinking problem."

"though it is haram but it is getting in, in our community especially in young generation"

"we don't talk about it openly but it is something we need to think about"

**Stress:**

But here no one to share with. "I think majority of us are depressed and worried here because of many reasons may be this cause heart problem"

"Stress has more to do with ill health than diet."

"We live in a different culture and society we are different from them our worries are different our happiness differs from them it causes more stress"

"Back in India we all live together shares our worries and happiness

"We are piling up our worries in our heart so obviously will get heart diseases."

"We are losing our moral values, our kids don't listen to us this causes more stress."

"You know there is a lot of discrimination because of your color."

"I eat less of fried food and sugary things but I have so many worries may be this caused me diabetes."

**Different Barriers Faced by Participants as an Asian:**

- Frequently highlighted issues were
- Cultural/religious issues and beliefs like
- Communication barrier
- Female only provision

Access to health care facilities

Lack of awareness to already existing services

"Language is a big problem."

"We don't know English at all; and doctors don't understand us"

"I can not speak English so I have to miss my hospital appointments"

"I have to take someone with me to the doctors and hospital and I feel I can't explain things properly to them."

I don't know English very well, so what the doctor tells me and what I understand are two very different things"

"There are so many activities going on in our community centre but I can not enjoy them because of language"

"I am not allowed to go in exercise classes"

"Female patients want female doctors."

"I don't feel good in seeing a male doctor"

"I keep postponing my appointments till I get it with female doctor and it causes trouble"

"I am not aware of any female only exercise session available in our area"

"Oh, really I didn't know dietician's help is available in the surgery"

"I know there are so many activities going on in different community centres but my husband doesn't allow me because there is no provision of purda and our relatives will say your wife is getting modern"

**DISCUSSION**

The South Asian population in the UK is at greater risk of developing CHD and diabetes mainly type 2 diabetes. The prevalence of Type 2 diabetes in the UK is known to be much higher in South Asians compared to Caucasians, with an associated increase in coronary heart disease [12]. Health professionals working in multi-cultural populations need to be aware of the cultural

**Table-1: The composition of participants of the focus groups.**

Locality	Community centre	Composition of group
Dewsbury	Taleem centre	All muslim male/female
Batley	Milan Day Centre	10 Muslims + 2 Sikh
Heckmondwike	Banadoos	All muslim male/female
Ravensthorpe	Salfia centre	All muslim male/female

**Table-2: Key themes leading focus group discussion.**

How people develop heart diseases & diabetes?
Why these diseases are more prevalent in our Asian community?
Is there any relationship between following and CHD & Diabetes?
<ul style="list-style-type: none"> <li>• Diet</li> <li>• Physical activity</li> <li>• Smoking/Tobacco</li> <li>• Alcohol</li> <li>• Stress</li> <li>• Any other factor</li> </ul>
Any difficulties you face in accessing different health care and leisure facilities as an Asian?

**Table-3: Frequencies of different attitudes / beliefs.**

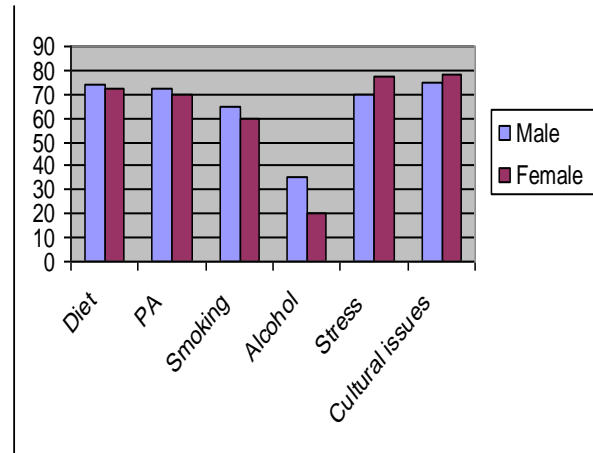
	Diet	PA	Smoking	Alcohol	Stress	Cultural issues
M	74	72	65	35	70	75
F	72	70	60	20	77	78

**Table-4: Percentages of different attitudes / beliefs.**

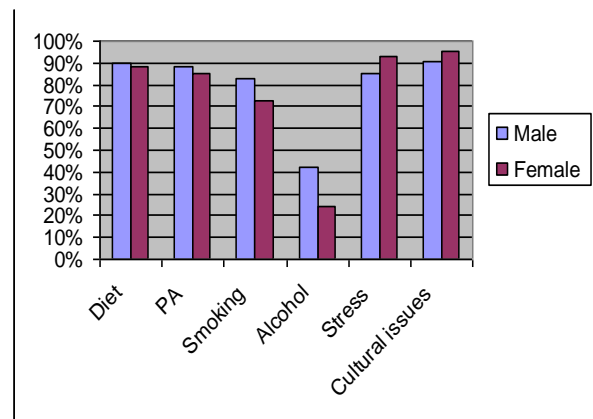
	Diet	PA	Smoking	Alcohol	Stress	Cultural issues
M	90%	88%	83%	42%	85%	91%
F	88%	85%	73%	24%	93%	95%

experiences and needs of their patients, but research, particularly recent work, in this field has been limited. There are very few studies that have investigated South Asians attitudes to and knowledge of lifestyle risk factors for CHD and Diabetes. We therefore carried out this qualitative study to explore the attitudes of South Asians. The use of appropriate information & educators with Asian language skills & an understanding of the local population's culture are important to improve attitudes, practices & lifestyle factors.

Food is an important part of social life, and the associated cultural significance of food for South Asian people can make dietary



**Fig.1: Frequencies of different attitudes / beliefs.**



**Fig.2: Percentages of different attitudes / beliefs.**

changes difficult to sustain. Patients may only tell close relatives that they have diabetes and may be reluctant to refuse inappropriate foods at other people's homes. Traditional foods are part of the South Asian identity, so a 'diabetes diet' may mean isolation from the social group, particularly in older South Asian patients. This is likely to become less of an issue with subsequent generations being born in the UK and assimilating the values of UK society [13]. Other aspects of following a healthy lifestyle may be difficult for South Asian patients. They may have poorer health generally [14], and may be more likely to live in a socially deprived area with high Townsend scores, an assessment tool for measuring levels of material deprivation [15]. South Asians living in the UK are less likely to eat fruit and vegetables than other ethnic groups, and are less likely to participate in exercise. The importance of dietary management to minimize obesity and

cardiovascular risk in South Asian patients is no different from that of white patients [16]. However, it is important to ensure that advice and information are culturally sensitive and to recognize the importance of food in the social context

It has been found that South Asians in general have lower physical activity levels; this study suggests that in order to address this, interventions need to be both individual and community based. South Asians need personal advice on exercise addressing generic barriers such as time and motivation; however, health professionals need to be aware of and society needs to overcome cultural barriers to exercise that apply to certain groups of South Asians. Examples of this include lack of provision of women-only facilities and special provision for the elderly. Older South Asians seem to have a perception that it is too late for them to change their lifestyle, indicating a specific educational need for these patients. Sporting activities are not likely to be delivered in languages other than English which also limits exercise participation in this group [17,18].

In this study during focus group discussions smoking/alcohol was not identified as a major risk factor. Whilst it seems that Asians are aware of the risk of smoking, it may be that the relative importance of this risk factor is not appreciated. This is particularly important as smoking is common amongst many South Asian groups though South Asian women tend to have low smoking rates compared with white British women.

This study identifies that many South Asians feel that they are undergoing through great stress because of living in a different country with different culture and religion and perceive that stress is an important factor of heart disease which may lead to diabetes.

Participants in the groups emphasized that language is a key barrier to accessing health and leisure services; this suggests that more resources need to be devoted to identifying effective methods to overcome

this. Poor communication with health care professionals, for example, may be responsible for the disadvantage Asians seem to have in accessing secondary care for CHD and Diabetes [19].

## CONCLUSION

This study highlighted some of the specific challenges related to CHD and Diabetic patients of South Asian origin.

Health professionals working in primary care play an important role in the management of patients with CHD and diabetes, particularly those with Type 2 diabetes. Those working in multi-cultural populations need to be aware of the cultural experiences and needs of their patients. Communicating information that considers cultural, religious and language differences is important to promote effective health care services.

Access to education for South Asian patients does not necessarily mean that it will be effective. In the author's experience, some patients who do not speak English may have poor literacy skills in their own mother language. Patients who do not speak English may find it difficult to access adequate health care information. Many healthcare professionals advising patients of South Asian origin are often not aware of relevant aspects of associated cultures, and therefore may not be able to offer appropriate information.

The use of healthcare workers who speak Asian languages and understand associated cultural norms is useful. The availability of literature, videos and well presented information contribute to improving knowledge, attitudes and behaviors towards life style risk factors of CHD and Diabetes.

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