Attitudes to lifestyle risk factors for coronary heart disease amongst South Asians in Leicester: a focus group study

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Background. South Asians have a significantly higher risk of mortality from coronary heart disease (CHD) compared with the general population in the UK. There is a lack of evidence on attitudes to and knowledge of risk factors for CHD amongst South Asians. Such information is important for the provision of effective health promotion services.

Objectives. The aim of the study was to identify key issues relating to knowledge of and attitudes to lifestyle risk factors for CHD amongst South Asians aged over 40 years in Leicester, UK.

Method. A qualitative focus group analysis was carried out using randomly selected South Asians from GP lists and South Asians attending community centres. Group discussions were taped, translated and transcribed. The transcripts were analysed using qualitative methodology to identify key issues and themes.

Results. Participants expressed a range of attitudes to and different levels of knowledge of lifestyle risk factors for CHD. Barriers to improving lifestyle with respect to diet and exercise were identified; these included lack of information (e.g. of how to cook traditional Indian food more healthily) and cultural barriers, such as lack of women-only exercise facilities. Participants perceived stress as an important cause of CHD, and stress directly related to ethnic minority status was described frequently. Language was identified as a key barrier to accessing health services.

Conclusion. Health professionals need to provide individually tailored health promotion for South Asians which avoids stereotyping, but recognizes potential cultural obstacles to change. The issue of stress amongst South Asians requires more research and needs to be recognized as an important issue by health professionals. South Asians still face problems accessing health and leisure services due to language and cultural issues.

Keywords. Coronary heart disease prevention, ethnic minorities.

Introduction

Coronary heart disease (CHD) is a major cause of morbidity and mortality in the UK and is regarded as a major priority for the National Health Service. The prevalence of CHD in the UK is 3.5% in males and 2.1% in females; however, South Asians (i.e. those ethnic groups originating from the Indian subcontinent) have been shown to be at a significantly higher risk from CHD compared with the general population. The overall increased risk of mortality is up to 40%, with evidence that this is even higher in younger age groups and in women. This problem has substantial implications for the provision of health services in communities with large South Asian populations, as found in many large cities in the UK.

Given this background, prevention of CHD 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. However, for prevention to be effective, it is important for health promotion advice to be culturally sensitive and accessible and relevant for the target population. This implies that health care professionals need to be aware of the knowledge of and attitudes of patients to potential disease in order to undertake effective health promotion.

There are few previous studies which have reported on South Asians’ attitudes to and knowledge of heart disease. Beishan and Nazroo undertook a qualitative study of a limited number of patients of various ages amongst South Asian groups and found that “most subjects were well informed on the factors related to cardiovascular health”. However Lip et al. found that a questionnaire study of South Asian women attending an antenatal clinic in Birmingham revealed lower awareness of cholesterol and dietary issues with respect to heart disease. We now report on the first phase of a project aimed at identifying key issues relating to attitudes and knowledge of lifestyle risk factors for CHD amongst South Asians.

Methods

We used focus groups consisting of South Asians aged over 40 years, this age group having been selected as being at higher risk of heart disease and more likely to retain potentially relevant culturally specific attitudes and practices in comparison with younger South Asians.

Selection of participants

Six focus groups were conducted by a single female researcher (D.N.). Three of these groups were formulated from the age-sex registers of two different practices in central Leicester (an area with >50% of the population of South Asian origin). South Asians aged 40 years and over were identified from the age-sex register using recognized South Asian first and second names, an established method shown as valid for this purpose. Using an alphabetical list of this subpopulation, 12 patients were selected using random number tables and were invited to each focus group by a letter from the patient’s GP. Where possible, the letters were followed by a telephone reminder. If invited patients could not attend, further patients were invited using the random number tables until we achieved 12 acceptances. Three groups of patients were invited using this method, with patients offered the choice of a male or female group in practice A. Only a mixed group was held in practice B. The focus groups were conducted on the premises of the relevant practices. The meeting rooms were quiet and comfortable and participants were guaranteed confidentiality.

A further three single-sex focus groups were held in community centres. Participants were the attendees at an Asian Womans Group and a Sikh Community Centre (one female and one male group). The groups comprised patients aged 40 years and over attending the centre on a particular day. We found that the communities preferred these groups to be single sex for cultural and religious reasons.

The composition of participants of the focus groups is summarized in Table 1.

Focus groups

The focus groups were led by D.N. a female researcher of South Asian origin and familiar with the relevant Asian languages (Hindi, Gujarati and Punjabi), as well as English. D.N. explained the purpose of the session and
the group agreed the preferred language to be used at the outset. Each session lasted between 40 minutes and 1 hour. A number of themes (based on established key risk factors) 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 researcher.

The sessions were audiotaped and subsequently translated and transcribed. The translation process was conducted independently by two researchers (A.F. and D.N.) to check the reliability of the process. Any disagreements in the translations were identified and resolved by discussion. At least two of the tapes were transcribed independently by two secretaries to ensure that this process was also reliable.

Analysis

Each transcript was analysed independently by at least two researchers (D.N., T.E. or A.F.). Statements and responses relating to the key lifestyle risk factors for CHD (e.g. smoking, diet and exercise) were highlighted manually and grouped. Other commonly occurring themes (e.g. stress and alcohol) were also identified in this way (content analysis). The transcripts were re-read several times by each researcher until no further themes were identified. Codes were allocated for key themes following discussion and agreement between the researchers. These subsequently were applied to the transcripts by two researchers (code application).

Only data which were agreed by both the first and second researcher for each transcript were included in the final analysis. These data were then used to derive hypotheses explaining attitudes displayed by focus group participants to relevant themes.

Results

Application of codes to the transcripts resulted in >90% agreement between the researchers. Only data agreed by both researchers are presented.

### Table 2  Key themes used to lead focus group discussions

<table>
<thead>
<tr>
<th>Question</th>
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<tr>
<td>Why do people suffer from or develop heart disease?</td>
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<tr>
<td>Why do Asians develop heart disease?</td>
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<tr>
<td>What part (in developing heart disease) is played by:</td>
</tr>
<tr>
<td>Smoking</td>
</tr>
<tr>
<td>Exercise</td>
</tr>
<tr>
<td>Diet</td>
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<tr>
<td>Any other factors?</td>
</tr>
<tr>
<td>What difficulties do you find in improving your lifestyle (with respect to risk factors)?</td>
</tr>
<tr>
<td>Do you have any difficulties with the health service (as Asians)?</td>
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</table>

Diet

Participants in all groups displayed awareness of what in general terms constitutes a healthy diet. Diet was identified by many as a cause for heart disease, with Indian diets perceived as being unhealthy:

- “We eat a lot of ghee (clarified butter) and oil. This will not do us any good. In India it was all right but not here.” [Transcript code C.1.11]
- “We should eat less fried food and cut down ghee in our cooking.” [A.5.11]
- “I feel personally that foods cooked in ghee and sugary foods which are heavy are the cause of it all.” [B.65]

However, views were expressed that perhaps diet is not accepted by all Asians as an issue.

- “Our diet is in fact better than some, it is the worries in a foreign country that is the main reason for ill health.” [C.5.12]
- “The diets we have now are the same as what we had when in India, why is diet a problem?” [A.4.6]
- “I cannot blame food, our forefathers have been eating this food, the only thing that has changed is the environment and atmosphere.” [B.6.5]

Participants identified significant barriers to changing their diet.

- “Have recently changed our ways of cooking.” [A.2.15]
- “Teenage children won’t let you cook in too much ghee or oil.” [E.7.15]
- “We now grill our food rather than fry.” [B.7.11]

Exercise

Most participants agreed that exercise was beneficial; however, barriers to exercise commonly were expressed.

- “The western community centres where they have a gym and swimming, but we don’t feel comfortable...”
when it is mixed. It would be more beneficial if we had separate facilities.” [A.4.49]

“I would like to swim, but as yet have not found a place where I will be allowed to swim with my karpaan” (religious dagger). [A.4.56]

“It is our religion, somebody will see me and spread gossip about me, if I go to swimming or aerobics.” [D.7.29]

“There is no time for exercise. Home life is too busy.” [G.1.22]

Some comments suggested that exercise is interpreted as a formal activity rather than a lifestyle.

“I can’t do vigorous exercise, my muscles and joints hurt.” [B.5.4]

“We Indians don’t do that” (in response to going to formal exercise sessions). [A.7.16]

A number of comments indicated that attitudes are changing amongst younger people.

“My daughter-in-law goes with her children, she takes them swimming.” [B.5.9]

Smoking
Interestingly, a few focus groups did not mention smoking at all except when prompted by the researcher, even then the issue raised very little discussion. Smoking cigarettes seemed to be accepted as being damaging to health, although tobacco in ‘paan’ (betel nut leaves which are chewed) was not as clear cut.

“Some Asians have lots of tobacco in their paan—but I have not read that it could be the cause of heart attacks.” [F.3.4]

Alcohol
A number of participants did not seem clear on the link between alcohol and heart disease.

“Do you feel alcohol and smoking is doing harm to the heart at all?” [C.7.24]

“Is alcohol bad for the health?” [B.4.10]

“I don’t think we (the Asian community) have a drinking problem.” [F.6.12]

Accessibility of health services
Many participants identified barriers accessing health services; typical statements include “I find language is a problem, I also find Asian doctors will not speak to you in Hindi or Punjabi, why?” [F.1.21]

“Female patients want female doctors.” [F.1.3]

“We don’t know English at all, I feel they (doctors) don’t care much about us.” [D.5.22]

“I have to take one of my children to the doctors and hospital. They sometimes get annoyed and don’t explain things properly to the doctors, so yes language is a problem.” [D.5.26]

Stress
Stress as a risk factor for CHD is controversial, although it was the issue identified most commonly as a cause for heart disease amongst South Asians in all the focus groups.

“I think stress is the main cause (of heart disease) in our lives.” [B.2.18]

“Worry is a killer.” [D.6.16]

“Stress has more to do with health than diet.” [B.4.21]

“It is the worry and stress. Back in India the elderly lived till 100 years and they had no worries.” [A.4.11]

It seemed that much of stress related to living in western society and the resulting changes in family structure.

“We are leading two separate lives or cultures.” [F.6.31]

“Because of different cultures, we worry about our children and the future.” [C.6.15]

“In the past, we used to live together, share our worries but now you are on your own.” [B.2.22]

“We have lot more worries than the English.” [E.6.12]

Racial disadvantage was also quoted as a cause of stress.

“You feel there is a lot of prejudice.” [B.9.4]

“Unemployment. At the dole office when standing at the queue they look at the colour of your skin. You feel very degraded.” [B.12.4]

Many respondents felt that as immigrants there was a greater pressure to succeed.

“We try to better ourselves, hence the stress level goes up.” [D.7.2]

“Our people have a big ego problem, they are always trying to get richer and better.” [F.1.14]

“Factory owners etc. they are under so much stress they cannot sleep without taking pills.” [B.4.14]

Discussion
There are very few studies that have investigated South Asian patients’ attitudes to and knowledge of lifestyle risk factors for CHD. We therefore carried out this
Attitudes to lifestyle risk factors for CHD amongst South Asians

The issue of stress amongst the Asian community is poorly researched. Our data suggest that many South Asians feel that they are under a great deal of stress and perceive that stress is an important cause of heart disease. Although the relationship between stress and heart disease is not clear, high levels of stress may help to explain different consultation patterns and presenting symptoms reported amongst Asian patients in general practice.

The impact of stress as a consequence of immigrant status, racial disadvantage and the changing social structure of immigrant communities needs further research.

Participants in the groups emphasized that language is a key barrier to accessing health 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.

The themes and perspectives from this focus group study are to be explored in a further study using face to face interviews amongst South Asians in Leicester.

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