South Asian cultural concepts in diabetes

Diabetes is a particular problem in the South Asian community, as people from this ethnic origin are four times more likely to develop the condition than other groups (Dreyer et al, 2009). South Asian people with type 2 diabetes also have a greater risk of developing cardiovascular disease and renal problems (Chowdhury and Lasker, 2002), and a higher diabetes-related mortality rate is seen among this group than in the general population (Mainious et al, 2007; Lanting et al, 2005).

Nurses in acute and community settings regularly care for people of South Asian origin with type 2 diabetes. It is important for them to understand the effect of cultural beliefs as some people from this group believe their diabetes is due to fate (Macaden and Clarke, 2010).

This brief literature review examines several key research papers and extracts the messages for nurses to they can improve management of this group and improve support for self-management.

South Asian people originate from the Indian subcontinent, that is, India, Pakistan, Bangladesh and Sri Lanka (Bhopal et al, 2002). However, this review discusses papers reporting results only about Indian, Pakistani or Bangladeshi people, as few studies include people from Sri Lanka (Fig 1).

Culture-specific care

Five randomised controlled trials (RCTs) were identified for review; each looked at the provision of culturally sensitive care in
a range of South Asian communities. The studies were carried out mainly in primary care and mostly in inner cities (Greenhalgh et al, 2011; Bellary et al, 2008; Baradaran et al, 2006; O’Hare et al, 2004; Vyas et al, 2003).

Both Bellary et al (2008) and O’Hare et al (2004) conducted cluster randomisation trials to investigate the effectiveness of a culturally sensitive approach to alleviate risk factors in diabetes. Both used an enhanced care model with extra time from practice nurses/diabetes specialist nurses and support from link workers to provide culturally sensitive care, and compared this with standard care.

Bellary et al (2008) found significant differences between groups in diastolic blood pressure and mean arterial pressure, after adjusting for confounders and clustering. Combining the results from both groups showed systolic blood pressure, diastolic blood pressure and cholesterol decreased significantly. The authors concluded that the culturally tailored care had produced additional, though small, benefits.

O’Hare et al (2004) used similar measurements; after adjusting for baseline measurements and age, the only significant difference between the groups was in systolic and diastolic blood pressure.

Baradaran et al (2006) conducted an RCT in daycare centres with people of South Asian origin with type 2 diabetes, to investigate a culturally appropriate intervention programme to identify aspects of care that could be improved. Questionnaires were developed to measure knowledge, attitudes and practices of diabetes self-management before and after the intervention.

Participants in the educational intervention group showed improvements from baseline knowledge. They also showed more positive attitudes towards seriousness and value of control of diabetes, with increases of 13.5% and 8.1% respectively. Participants’ practices about caring for their diabetes increased in this group (20% increase from baseline). However, there were also changes in the scores in the ethnic control group; overall, there was no significant difference between the two groups in the amount of change.

Vyas et al (2003) investigated whether an acute-primary care partnership education package could improve understanding among South Asian patients. Shared care between primary and acute care is thought to produce better care processes for people with diabetes (David and Kendrick, 2004). Unfortunately, despite amending the questions used based on preliminary testing as well as using open-ended questions, the final results showed no significant differences in knowledge, awareness or self-management scores in the intervention group after a year. This demonstrates some of the challenges in attempting to modify care processes to be more culturally sensitive.

A more recent study explored the use of storytelling to develop a model to support self-management within individual minority groups including South Asians. The study concluded that self-management should have structured educational programmes and allow storytelling so participants share knowledge and ideas to manage their own diabetes (Greenhalgh et al, 2011).

**Attitudes and beliefs about diabetes**

When different South Asian communities have been compared, the Bangladeshi community has been found to experience poorer healthcare than other groups (Rhodes and Nocon, 2003). There is a need to better understand some of the cultural aspects that affect members of the Bangladeshi community with type 2 diabetes.

Three studies were found that explored lay understanding, beliefs and attitudes towards diabetes in this group (Choudhury et al, 2009; Grace et al, 2008; Greenhalgh et al, 1998). Grace et al (2008) also looked at religious teaching and professional perceptions in their 2008 study and in a follow-up report (Grace, 2011), whereas Greenhalgh et al (1998) explored diabetes belief systems that drove behaviour.

Participants were mainly people of Bangladeshi origin with a diagnosis of diabetes, although in Grace et al (2008) they were Bangladeshi people without diabetes, religious leaders/Islamic scholars and health professionals.

The sample in Grace et al (2008) was divided into 17 focus groups, which were purposively run in three phases. This study had a wider view as feelings could be analysed from different groups, enhancing the development of future health promotion initiatives.


Four themes emerged from the studies and appeared to have conceptual overlaps:

- Lay understanding;
- Lifestyle;
- Culture;
- Education.

The first three themes are concerned with how Bangladeshi people with diabetes interpret and negotiate management of their condition in the context of their own culture and cultural beliefs. The fourth highlights how they perceive health professionals, information/advice given and educational programmes.

**Lay understanding**

Lay understanding was more prominent as a theme in Choudhury et al (2009) and Greenhalgh et al (1998), where most Bangladeshi participants did not know much about the cause, prevention or management of diabetes.

They often said they had acquired the condition during a visit to Bangladesh (Choudhury et al, 2009). In contrast to this, some Bangladeshi participants in Grace et al’s (2008) study had greater knowledge gleaned from the experience of having diabetes. Therefore, the experiences of people with the condition might shape their perceptions and enhance management (Bean et al, 2007).
Bangladeshi participants were often seen to be particularly fearful of diabetes; these participants thought this fear would motivate people across the community to take action such as changing lifestyle behaviours and also to become more aware of the risk of diabetes in their group. Islamic scholars framed prevention more positively and in a less dramatic way, as part of a healthy lifestyle that all Bangladeshi people should follow (Grace, 2011; 2008).

Some Bangladeshi participants believed sugar and a Western diet were the cause of their diabetes. Often they cited physical or psychological stress as causes (Greenhalgh et al, 1998).

Lawton et al (2007) argued that South Asian people often blame external factors as the cause of their diabetes, whereas Macaden and Clarke (2006) emphasised that disease perception is influenced more by their lack of understanding and perception of the severity of the disease, especially among older people.

**Lifestyle**

Although many Bangladeshi participants had similar assumptions about the cause of diabetes, they had different views of how to live a healthy lifestyle in terms of diet and physical activity. Health professionals often quoted the beliefs of Bangladeshi people about management of diet, exercise and medication.

Choudhury et al (2009) reported that some Bangladeshi participants did not know what healthy eating entailed, which meant the link between healthy eating and diabetes was unfamiliar.

Most Bangladeshi participants shared strong beliefs about food, believing that body components may be linked to certain foods because of physical similarity. For example, they saw links between sugar, bone marrow and semen together as causes of diabetes (Choudhury et al, 2009).

Although Bangladeshi participants showed some awareness about healthy eating, most shared a cultural concept of body weight. They associated medium or large body sizes with good health and saw thinness as less healthy (Grace, 2011; Choudhury et al, 2009; Grace et al, 2008; Greenhalgh et al, 1998). Physical activity was seen as important and some religious practices, such as namaz (praying five times a day) were also seen as an activity. However, religious leaders did not share this view (Grace, 2011; 2008).

One challenge for health professionals is that one study found physical activity had little cultural meaning in this community and there is no expression in the Sylheti language, spoken by many Bangladeshis, for physical activity (Greenhalgh et al, 1998). Even though participants recalled health promotion advice, it was unclear exactly how much of this they put into practice. Cultural barriers to exercise were a theme, particularly the social roles of women that prevented them from engaging in activities outside the home (Grace et al, 2008) and many thought physical activity would exacerbate illness (Greenhalgh et al, 1998).

**Culture**

Bangladeshi participants held deeply embedded cultural beliefs. The absence of sweating and hard labour were perceived as a cause of diabetes as well as immigration to the UK (Greenhalgh et al, 1998); likewise, eating bitter gourd was believed to achieve better control of diabetes (Choudhury et al, 2009). Chacko (2003) said that “biomedicine” (Western medication) was perceived to have side-effects because of these cultural beliefs. These misconceptions may prevent people from accessing treatment or delay starting it (Choudhury et al, 2009).

Meetoo and Meetoo (2005) and Stone et al (2005) reported that South Asian participants incorporated belief in supernatural forces and fatalism into their self-management of diabetes. Although many health professionals perceived Bangladeshi people as fatalistic and therefore resistant to education, few lay participants expressed fatalism, and religious leaders saw fatalism as misinterpretation of Islamic teaching (Grace et al, 2008).

**Education**

Most Bangladeshi participants could recall information provided by health professionals, although effectiveness was not mentioned in the studies. Language barriers were identified because few Bangladeshi participants attended educational programmes.

The majority agreed that education classes should teach them whatever health professionals felt was important; health professionals were often referred to as doctors because Bangladesh participants strongly believed in doctors’ advice (Choudhury et al, 2009; Greenhalgh et al, 1998). Consequently, this can have an impact on nurses’ role in health promotion with Bangladeshi people.

Language barriers were identified, with family members acting as interpreters during healthcare consultations. This has the potential for errors to occur in translation, for example when teenage children are interpreting for older relatives (Rhodes et al, 2003).

**Discussion**

All the studies attempted to explore the impact of various culture-specific interventions but did not discuss how participants experienced culture. This could well have provided greater meaning in terms of how to create culturally sensitive care to support diabetes self-management.

Hill (2006) expressed concern that people of South Asian origin are being portrayed as a group whose culture overrides and influences their diabetes management. However, these studies reveal the variety of cultures and cultural beliefs about diabetes and self-management across South Asian communities in the UK.

It is important not to make assumptions about understanding among South Asian people with type 2 diabetes; these studies showed differences in lay understanding.

Nurses working with these communities should assess patients’ present knowledge of diabetes and its management, identify any barriers that determine their behaviour and work with existing beliefs.

Some Bangladeshi participants claimed to understand everything, either because they spoke English or had a Bengali doctor. Information and advice was often recalled from healthcare providers about healthy lifestyles, although it is not clear whether this information had been understood or acted on.

Nurses should consider beliefs that may prevent South Asian people from developing healthier lifestyles, and give advice according to cultural needs. For example, strong dietary beliefs that influence diabetes management might be overcome by dietary education tools. Promoting physical activity while understanding cultural barriers and perceptions can allow nurses to tailor advice to individual needs and allow patients to access services.

Fatalism and strongly held cultural beliefs should not be seen as resistance to health education. Religious leaders might be useful in transferring health education and highlighting misinterpretation of cultural beliefs that does not support positive diabetes management. Rozario (2005)

www.nursingtimes.net / Vol 108 No 10 / Nursing Times 06.03.12 31
Nursing Practice

Research

Members of the public attend a free health check to screen for diabetes in Yorkshire. It is important for nurses to identify and understand other cultures and how people individually relate to their own culture. This would enhance understanding and communication with people from different cultures. Culture is not necessarily a barrier to health education; it is dynamic and people are able to develop their own understanding.

It is important to consider how health information given has been understood and interpreted in a cultural context. Moreover, barriers to self-management should be identified; that is, nurses should identify each person's perception of their shared culture, their own individual beliefs and how that affects their behaviour. Individuals should not be seen as a uniform product of culture (Csordas, 2002).

Nurses should not make assumptions about cultural beliefs; rather, those working with the knowledge that culture is subjective and dynamic can create individualised care plans according to each patient's cultural needs (Fleming and Gillibrand, 2003). It is important to consider how health information given has been understood and interpreted in a cultural context. Moreover, barriers to self-management should be identified; that is, nurses should identify each person’s perception of their shared culture, their own individual beliefs and how that affects their behaviour. Individuals should not be seen as a uniform product of culture (Csordas, 2002).

Conclusion

It is important for nurses to identify and understand other cultures and how people individually relate to their own culture. This would enhance understanding and communication with people from different cultures. Culture is not necessarily a barrier to health education; it is dynamic and people are able to develop their own understanding.

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References


