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Experience of dietary advice among Pakistani-born persons with type 2 diabetes in Oslo

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Abstract

Experience and implementation of dietary advice are influenced by various factors including ethnic, cultural and religious background. The aim is to explore how ethnic minority persons with diabetes experience dietary advice given by Norwegian health-workers, which strategies they have in response to the advice and how they explain their actions. In-depth interviews were performed with 15 Pakistani-born persons with type 2 diabetes living in Oslo. The analyses are based on the principles of Giorgi's interpretation of phenomenology. The participants expressed great concern to follow the advice. However, narratives about constraints were numerous. These concerned different life-situational factors, but more importantly they were related to communication problems arising from discontinuities between universalising medical knowledge and lay knowledge, as well as between different types of culturally defined lay knowledge. As a consequence, advice was generally experienced as inadequately based on the participant's food-cultural background, leaving the person with diabetes to do the translation between different levels of knowledge. In general health-workers would benefit from expanding their knowledge of the many positive aspects of their patients' cultural background, and apply their knowledge thereafter, whether it concerns (food)-culture or the impact of religion in everyday life.

Keywords: Dietary advice; Type 2 diabetes; Inter-cultural encounter; Ethnic minority patient; Doctor-patient relationship; Communication

Introduction

Diabetes-management requires daily decisions in relation to issues as wide-ranging as medication, diet, physical activity and symptom monitoring. These decisions are inevitably influenced by psychological, ethnic, religious and cultural as well as structural and socio-economic factors (Kleinman, Elisenberg & Good, 1978; Helman, 1997) that in turn influence the understanding of dietary advice, and the degree to which advice is followed. Internationally there is a long tradition of research on diabetes counselling. However, studies that have explored the problems people from ethnic minorities experience when it comes to diabetes-management are not abundant (Bissell et al., 2004; Kelleher & Islam, 1996; Greenhalgh et al., 1998; Rhodes et al., 2003). The existing health literature on ethnic minorities typically discuss problems in diabetes-management as being explained by various combinations of material, cultural, social and religious factors. However, the specific, and important aspects of diet in a cultural context are only rarely discussed in any depth (Chowdhury et al., 2000; Greenhalgh et al., 1998; Kelleher et al., 1996).

People from South-Asia (Pakistan, India and Bangladesh) have higher prevalence of type 2 diabetes (Mather & Keen, 1985) and coronary heart disease (McKeigue et al., 1989) than ethnic Europeans. This is the case also in Norway (Grøtvedt 2002; Jenum et al., 2005). Persons with Pakistani background constitute the largest immigrant group from outside Europe in Norway. The majority come from rural areas of Punjab, and many have low level of education and low-income occupations (Lie, 2004). In some districts of Oslo they account for up to 11% of the total population (Statistics Norway, 2005; City of Oslo, 2005), whereas the majority of health-workers, even in multicultural city-areas, are of ethnic Norwegian origin (Norwegian Medical Association, 2005; Havelin, 2001) and have been trained

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within a Western medical system. In such contexts, differences related to both class, ethnicity and medical expertise characterise the medical encounter.

As in other Western countries, the ageing immigrant population is perceived to represent an increasing challenge to the health-system (Grøtvedt, 2002). Results from another part of the present study showed that health-workers experienced that patients with Pakistani background very often took a passive attitude and expected the health-worker to take full responsibility for diabetes-management, yet the health-workers were often reluctant to do so (Fagerli et al., in press). In light of these findings, one might assume that the ethnic minority patients *themselves* also encounter considerable challenges when faced with health-systems of Western countries. First of all, lay knowledge of diabetes and diabetes-management may be difficult to combine with the advice of the health-worker. While the former is culturally specific, the latter is embedded in allopathic medicine and may be referred to as 'universalising knowledge'. Successful communication across these two spheres of knowledge requires some process of translation.

In line with the Ottawa Charter for Health Promotion (Ottawa Charter for Health Promotion, 1986), health-workers in Norway have increasingly taken responsibility for such processes of translation, through professional ideals of empowerment, and in agreement with the norm that health-workers approach their patients in a patient-centred manner (Norwegian Diabetes Association, 2004; Fagerli et al., in press). In doing so, health-workers draw upon cultural knowledge of food they possess as ethnic Norwegians, and that they most often share with the recipients of their advice. This includes, for instance knowledge of a typically Norwegian meal pattern consisting of one hot meal and up to three bread based meals a day, the structure of these meals and its typical combinations of dishes and foods (Bugge & Døving, 2000; Kjærnes, 2001). In inter-ethnic encounters, it can no longer be assumed that this shared knowledge-base exists. This could imply that the ethnic minority person must take greater responsibility for the processes of translation, or - if not - that the advice is not easily adopted in daily life. Whether and to what extent such translation-processes take place, and what consequences they have for the person with diabetes, relate on the one hand to the traditional religious and cultural heritage, and the lifestyle and worldview that might follow from that. On the other hand, and this is the focus of this article; such processes of translation are also influenced by the situational factor *of being in a minority situation* in a country where the health system is dominated by the *majority* ethnic group, and where health-workers' multicultural knowledge is often limited. International research indicates that even in countries with the same focus on empowerment in health-care as in Norway, and with a longer tradition for multi-ethnic health care, like for instance the UK, communication problems are abundant between ethnic majority health-workers and ethnic minority patients (Gerrish, 2001; Bissell et al., 2004; Rhodes et al., 2003; Vydelingum, 2000). Moreover, the challenges that the need to '*translate*' dietary and other lifestyle advice into culturally acceptable practices might pose on the individual person with diabetes is hardly discussed in the research literature.

Based on the research needs identified above, and acknowledging that self-management of a chronic disease involves a continuous attention to a health challenge within the complexities of everyday life (Thorne, Paterson, & Russell, 2003), the following research questions were asked: How do Pakistani-born persons with type 2 diabetes experience *dietary advice* from the health-workers? Which *strategies* do they use in response to the advice, and what are the *explanations* they provide for their actions? More broadly we also asked: How do their experiences relate to the special context of the encounter between *minority patient* and *majority health-worker*?

In this research project the medical encounter between ethnic Norwegian health-workers and Pakistani-born immigrants is used as a case. We consider, however, that our findings may be useful for providing care for ethnic minority persons more generally and beyond the Norwegian context.

Methods

Setting and participants

The overall study encompasses qualitative interviews with 26 Pakistani-born persons living in Oslo (15 with type 2 diabetes), and 12 health-workers. In this article we present and discuss experiences related to diet- and lifestyle advice emerging from the interviews with the 15 Pakistani-born persons with diabetes.

We applied a purposeful sampling-strategy covering Pakistani-born persons with type 2 diabetes living in Oslo, Norway. Participants were recruited from a) General Practices in two city-districts where a high percentage of persons with Pakistani background live, b) one of the local hospitals where persons from these districts are referred to further consultation with a dietician when deemed necessary and c) a group education programme in diabetes at two different occasions at the same hospital (in the following referred to as the 'Diabetes-course'). Participants were invited by their doctor/dietician to meet the researcher (first author) after the consultation for further information. Oral and written information about the topic of the study, anonymity, voluntary participation and about the consent from the Medical Ethic Committee and the Data Inspectorate was provided in Norwegian and Urdu with the invitation. Among the persons with whom the researcher personally met for information, 80% agreed to participate. Written informed consent was obtained from all participants.