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'We should change ourselves, but we can't': accounts of food and eating practices amongst British Pakistanis and Indians with type 2 diabetes

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Objective(s). To look at food and eating practices from the perspectives of Pakistanis and Indians with type 2 diabetes, their perceptions of the barriers and facilitators to dietary change, and the social and cultural factors informing their accounts.

Method. Qualitative, interview study involving 23 Pakistanis and nine Indians with type 2 diabetes. Respondents were interviewed in their first language (Punjabi or English) by a bilingual researcher. Data collection and analysis took place concurrently with issues identified in early interviews being used to inform areas of investigation in later ones.

Results. Despite considerable diversity in the dietary advice received, respondents offered similar accounts of their food and eating practices following diagnosis. Most had continued to consume South Asian foods, especially in the evenings, despite their perceived concerns that these foods could be 'dangerous' and detrimental to their diabetes control. Respondents described such foods as 'strength-giving', and highlighted a cultural expectation to participate in acts of commensality with family/community members. Male respondents often reported limited input into food preparation. Many respondents attempted to balance the perceived risks of eating South Asian foodstuffs against those of alienating themselves from their culture and community by eating such foods in smaller amounts. This strategy could lead to a lack of satiation and is not recommended in current dietary guidelines.

Conclusions. Perceptions that South Asian foodstuffs necessarily comprise 'risky' options need to be tackled amongst patients and possibly their healthcare providers. To enable Indians and Pakistanis to manage their diabetes and identity simultaneously, guidelines should promote changes which work with their current food practices and preferences; specifically through lower fat recipes for commonly consumed dishes. Information and advice should be targeted at those responsible for food preparation, not just the person with diabetes. Community initiatives, emphasising the importance of healthy eating, are also needed.

Keywords: food; diet; identity; type 2 diabetes; Pakistani; Indian

Background

Pakistanis and Indians belong to the two largest ethnic minority groups in Britain, and together comprise 3.1% of the population (2001 Census). Their mass migration to Britain commenced in the 1950s. Most came from peasant farming families, and the majority migrated from the Punjab region, which straddles the border between India and Pakistan

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in the north-west (Ballard 1994). Initially, they intended only to stay temporarily, their aim being to earn money for their extended families before returning home. However, with the arrival of family and fellow villagers, the birth of children, and a growing investment in property and businesses in Britain, migrants gradually turned into settlers, their socioeconomic commitment in this country making a permanent return to the Indian subcontinent unlikely (Ballard 1994).

Pakistanis and Indians who live in Britain are 4–6 times more likely to develop type 2 diabetes than members of the general population (D'Costa *et al.* 2000). They also have a higher risk of developing diabetic complications, a 40% higher mortality and develop the disease 10 years earlier than their white counterparts (Raleigh *et al.* 1997). Changes in lifestyle following migration have been held partly responsible for this increased disease risk (Bhatnagar *et al.* 1995), which has prompted interest in looking at their food and nutrition intake. To date, studies have primarily been concerned with measuring and documenting the composition of what South Asians[1] eat (e.g., Anderson and Lean 1995, Parsons *et al.* 1999, Kassam-Khamis *et al.* 2000, Savak *et al.* 2004, Anderson *et al.* 2005), through the use of quantitative data gathering methods such as food diaries and structured questionnaires. These studies have revealed both continuities and changes in the diets of South Asians living in Britain. Whilst some dietary synthesis appears to have occurred, most notably through the incorporation of Western-style items into breakfasts and often lunches (Anderson and Lean 1995), for many, particularly first-generation migrants, the evening meal appears to have been remarkably resistant to change. While South Asian foodstuffs continue to be consumed regularly, there has been an increased incorporation of 'special menu' items such as meat, *ghee*, and traditional sweets into the 'everyday' menu, since such items become more affordable following migration and are seen as a mark of affluence and hospitality (Chowdhury *et al.* 2000). Consequently, the pre-migration diet which comprised little meat and dairy products and large amounts of staples (chapattis, rice), pulses, fruit and vegetables has evolved into one with a higher fat, sugar and calorific content (Williams *et al.* 1998). This dietary evolution, coupled with the continued use of cooking methods such as frying and deep fat frying, has been used to account for South Asians having a higher percentage of food energy derived from fat and saturated fat than the White population in Britain (Lip *et al.* 1995, Anderson *et al.* 2005).

The aforementioned studies have helped to enhance understandings of why people from the Indian subcontinent have an increased susceptibility to type 2 diabetes following migration to Britain. However, given that dietary methodology has been predominated by quantitative measurements, our understanding of the social and cultural factors which may underpin their dietary practices is, by comparison, less developed, albeit one team linked their dietary methodology with measures/changes in body image (Bush *et al.* 2001) and patterns of hospitality (Bush *et al.* 1998). When qualitative studies have been undertaken, they have tended to have relatively restricted foci, such as the meaning of marriage meals (Bradby 2002), parental and young people's perceptions (Wyke and Landman 1997), or the views of specific groups, such as Bangladeshi diabetics (Chowdhury *et al.* 2000).

Dietary management is central to effective diabetes care as it is considered vital for improving/maintaining blood glucose control and promoting weight loss in those who are overweight/obese. The diet recommended to people with type 2 diabetes is the same 'healthy', balanced diet the general public is encouraged to follow, being low in fat, sugar and salt. Specific recommendations highlight the importance of replacing fat-rich foods and other dietary sources of fat with starchy carbohydrate foods (e.g., those which are

cereal based) and fruit and vegetables. When weight management is required, people are encouraged to reduce the overall energy content, rather than the bulk, of what they consume, as it is considered important to continue to consume 'sufficient volume for satiety' (Nutrition Subcommittee of the Diabetes Care Advisory Committee of Diabetes UK 2003). Hence guidelines place emphasis upon changing the composition (e.g., increasing the proportion of fresh fruit, vegetables, boiled/grilled, that is, low fat foods consumed), and not necessarily the quantity, of what one eats.

Given the recommendation that, to be effective, nutritional advice should take 'account of the individual's personal and cultural preferences, beliefs and lifestyle' (Nutrition Subcommittee of the Diabetes Care Advisory Committee of Diabetes UK 2003), we looked at food and eating practices from the perspectives of Pakistanis and Indians with type 2 diabetes, their perceptions of the barriers and facilitators to dietary change, and the social and cultural factors informing their accounts. Our objective was to inform the delivery of dietary advice for those affected by the disease. However, given the emphasis placed on diet (and dietary change) in the management of type 2 diabetes, we also recognised that our respondents' views and experiences could be used to inform broader understandings of the dietary patterns observed within their communities. Hence, this study also aimed to complement and enhance the small, but growing, body of qualitative work which has looked at food and eating practices from the perspectives of South Asian people living in Britain.

The research was undertaken in Edinburgh which contains the second biggest South Asian population in Scotland. As is typical of South Asians in Scotland, and many of those living elsewhere in Britain, virtually all of those resident in Edinburgh originated from the West (Pakistan) and East (India) Punjab. Although there is some diversity amongst Punjabis (for instance, in terms of religion), due to their geographical proximity, they share similarities in terms of spoken language and diet.

Recruitment and sample

Both clinician and local community recruitment were utilised, as other researchers have shown that recruiting members of ethnic minority groups can be difficult and time-consuming, and several methods may be needed to access a sample with broad-ranging experiences and characteristics (McLean and Campbell 2003, Sin 2004). Following approval from Lothian Research Ethics Committee, patients were recruited from five general practices in Edinburgh which had a high proportion of Pakistani and Indian patients with type 2 diabetes. Healthcare professionals contacted patients by letter (in English, Urdu and Punjabi), inviting them to 'opt in'. All respondents were diagnosed with type 2 diabetes and were of Pakistani or Indian origin. Bangladeshis and other people of South Asian descent were excluded due to the logistical problems of including additional cultural and language groups, and the very small numbers resident in Scotland (2001 Census). To achieve a sample broadly representative of Pakistanis and Indians with type 2 diabetes, respondents were purposively sampled on the basis of their ethnic/religious group, age, sex and disease duration. In line with a grounded theory approach, recruitment continued until no new themes emerged from data analysis (Strauss and Corbin 1990). Thirty-two respondents took part – 23 Pakistanis (22 Muslims, one Christian) and nine Indians (four Hindus, five Sikhs). Fifteen were male and 17 female. Whilst their ages ranged from 33 to 71 years, most were in their 50s and 60s (an issue which is unsurprising as type 2 diabetes tends to be a late onset disease). As would be expected amongst a sample with this age profile, most respondents ($n = 26$)

were first-generation migrants, and many ($n = 19$) described their ability to speak/understand English as being very poor or limited. Almost a third of respondents described the head of household occupation as being that of a small shopkeeper. However, there was considerable occupational diversity within the rest of the group (occupations included: interpreter, car mechanic, senior civil servant, restaurant proprietor and postman).

Data collection

Interviews were conducted in 2003/2004. Respondents were interviewed in their first language (Punjabi or English) by a bilingual researcher (NA). Interviews were informed by a topic guide, which was revised in light of emerging findings. Relevant issues covered included: food and eating practices during a typical day and on special occasions (including the kinds of foods consumed, with whom, and when); changes/continuities in one's diet since migration (if relevant) and diagnosis of type 2 diabetes; perceived barriers and facilitators to dietary change; role of self and others in food purchase and preparation; perceptions of the relationship between diet and health; social and symbolic role of food in everyday life; and (in light of emerging findings) perceived impact of diet and dietary changes on self and identity.

Interviews took place in respondents' homes, averaged one hour and were tape-recorded with their consent. When necessary, interviews were translated by NA into English and all were transcribed in full. To ensure rigour and to highlight potential areas of misunderstanding, NA was assisted by two casually employed translators, one of whom was Indian and the other Pakistani. These translators checked tapes against the transcripts and were available for troubleshooting when words/concepts did not easily translate from Punjabi to English.

Data analysis

To maximise flexibility and responsiveness, data collection and analysis took place concurrently with issues identified in early interviews being used to inform areas of investigation in later ones. Transcripts were read repeatedly and cross-compared by team members using the constant comparative method (Strauss and Corbin 1990) and discussed in regular meetings to identify emergent themes. Notes were taken during these meetings and an initial analytical framework developed in light of the themes and subthemes identified. QSR NUD*IST, a qualitative data indexing package, was used to facilitate data coding and retrieval.

Findings

With few exceptions, respondents reported consuming Western food items for breakfasts, lunches and snacks; such as, toast, cereals, sandwiches, (packet) soups, fish fingers, biscuits and crisps. Many, especially first-generation migrants, contrasted these daytime meals and snacks with what they saw as the 'proper' meals they ate in the evenings. These evening meals tended to comprise what respondents described as 'our foods' or '*roti*' (the latter term being used by most respondents to describe a complete meal consisting of curries, *chapattis*, and/or rice together with side dishes such as *achar* (pickle) and *raita* (yoghurt with cucumber and mint), although its literal meaning is *chapatti*). Following diagnosis of diabetes, most claimed to have made some changes to

their diets in order to manage their disease, such as replacing sugar with artificial sweetners in tea and full fat for half fat milk (what respondents termed 'green milk'). While dietary changes such as these tended to be presented as uncontroversial and easy to orchestrate, this situation contrasted with respondents' more emotive accounts of the South Asian foodstuffs they consumed in the evenings and at family, community and religious events. Despite perceiving South Asian foods, such as *roti*, as being detrimental to their disease management, most respondents claimed only to have made remedial changes to their consumption and the methods used to cook them, such as frying. However, for reasons we shall explore, one change was almost universally reported: respondents said they had reduced the quantity of South Asian foods they ate, despite this leading to a reported state of hunger.

Information from healthcare professionals

Virtually all respondents reported a perception or awareness that dietary change/management was important for their diabetes control, and the vast majority claimed to have received some sort of advice following diagnosis. However, the type of information given appeared to be both eclectic and varied, and depended upon whom the respondent had seen, when they had seen them (one respondent, for instance, claimed she had not received any dietary advice apart from when she had been diagnosed 20 years previously), and their ability to communicate with their (mostly White) healthcare professionals in English (see Lawton *et al.* 2006). Some, like Mrs Saeed, a Pakistani Muslim in her 30s, claimed that they had received very limited information: 'they don't tell you how to eat, they just say "do diet"', others, especially veteran patients, complained that the advice proffered had been insensitive to their culture and food preferences. For instance, Mrs Akbar, a Pakistani Muslim in her 60s, described how, when she had been diagnosed 10 years previously, 'they [dietitians] would be like "stay away" if you even mentioned chapatti and curries'. Mr Ruhaul, an Indian Hindu in his 60s, likewise, recounted how, when he had attended a hospital appointment three years previously, 'they gave me some booklets about what sorts of foods are best…to a certain extent that has helped, but I don't think the sort of food that I eat, that didn't really come into it'. At the other extreme, some described receiving a complex array of instructions from dietitians and other sources (e.g., GPs, nurses, relatives with diabetes), such as, 'to diet and to eat more boiled things, not to eat oil or butter…to eat more fish, to eat more vegetables and to eat more *dahl*' (Mrs Mughal, 50s, Pakistani Muslim). Mr Narin, a second-generation Indian Sikh in his 50s, similarly recounted how, 'they told me not too many fried foods, vegetables will make you help it, brown bread and fish and things like that'.

Despite the seeming heterogeneity of the dietary advice given, and the different lengths of time they had lived with their disease, most respondents offered strikingly similar accounts of the dietary changes they had and had not gone on to make. Respondents (irrespective of age, gender, ethnicity, religion and occupation) also seemed to attach very similar social and symbolic meanings to their food and eating practices, suggesting, as we shall see below, that they had understood and enacted upon any dietary advice they had received in ways which reflected common perceptions and experiences.

Perceptions of South Asian foods: bad for health; good for self

> 'In our people there are more diseases. . .Asian people are getting a lot of diseases, like diabetes, because of what we're eating. The doctors have said "it's what you are eating that is causing you to have so many diseases"'. (Mrs Manjit, Indian Sikh, 40s)

The majority of respondents, like Mrs Manjit, described type 2 diabetes as being a disease which was particularly prevalent within their own communities, and one for which they held their own lifestyles (in particular, the consumption of *roti*, 'Asian' or 'our' foods) at least partly responsible. This disease understanding, as Mrs Manjit's quote illustrates, could arise from amalgam of experiences and sources. This included information/steers from health professionals, community hearsay, and observation of the disease's presence/absence amongst family, community members and others, including White people living in Britain (these people often being termed the *goray* by respondents) who were noted to suffer from the disease less frequently than people living within their own communities. Indeed, whereas respondents tended to describe *goray* foods as being bland and tasteless (see below), this contrasted notably with their accounts of the curries, rice and/or chapattis which tended to form the basis of their evening meals, dishes such as *zarda* (sweet rice) and sweets consumed on special occasions. While a minority of respondents described curries 'as okay' (Mr Mohan, Indian Sikh, 60s) for their diabetes control, the majority made generalised references to South Asian foodstuffs being 'dangerous' and 'damaging' as well as more specific references to their containing latent sources of fat and sugar. As Mr Ismael, a Pakistani Christian in his 60s suggested, '*roti* is dangerous you know, it turns into sugar, *ghee* is dangerous too'. This perception was echoed by Mr Munir (50s, Pakistani Muslim) who told the interviewer that, 'for your own safety, you should eat less *roti*' and Mr Maskeen, an Indian Sikh in his 70s, who described how, 'our fatty foods, we should not eat that, and the chapatti, that also has sugar. They also say that rice has sugar'.

Despite perceiving these kinds of foodstuffs as 'dangerous', and as being detrimental to their blood glucose control, many respondents, especially first-generation migrants, also presented them as being an aspect of their diet that they were either unwilling, or felt unable, to change. As Mrs Mughal, a Pakistani Muslim in her 50s put it, 'it's difficult for us to resist who have had the habit of eating sweet', a viewpoint echoed by Mrs Mir (another Pakistani Muslim in her 50s) who told the interviewer that, 'some things we cannot be disciplined about, we maybe eat too much of the wrong kinds of foods, like rice, but we cannot give that up'. Mrs Queshi, likewise described how:

> 'The thing is us Asian people we mostly eat *roti*, which is the truth, but we should not eat that much *roti*, it is not good for the sugar. But the thing is *roti* is the foundation food for us, we are used to it now It we were to eat fast food all day and not eat *roti* then we'd not be able to sleep'. (Mrs Qureshi, Pakistani Muslim, 60s)

Mrs Mughal and Mrs Qureshi (both of whom were first-generation migrants) accounted for their dependency on *roti* and other South Asian foodstuffs on the grounds of habits and routines formed over many years, an issue which was echoed by Mr Mohan, an Indian Hindu in his 60s, who described how 'we need cooked foods and spices, because we've been brought up on that'. However, Mrs Qureshi's reference to *roti* being a 'foundation food for us' is also telling, her use of the word 'foundation' suggesting that, at a deep level, she perceived the consumption of *roti* as being formative of identity; as making an 'us' or a 'we'. This notion was also evident in other accounts. Mr Yunus, a Pakistani Muslim in his 60s, for instance, described how, 'while people like us who were born in Pakistan will eat crisps or a sandwich or whatever [during the day], we will come home in

the evenings and we will have our *roti* because *without some things we cannot be*' *(emphasis added)*. Likewise, Mr Idress, a Pakistani Muslim in his 40s, highlighted a central reason for not changing his diet as being that this would, quite literally, require or lead one to change oneself: 'our food isn't right, you know, we can't control sugar with our food you know. We should learn to change ourselves, you know, but we can't'.

The dietary stasis our respondents reported was not simply confined to specific foods eaten, but also the methods used to cook them. Many respondents described a perception that they *should* be eating more foods which were boiled, grilled or baked (an understanding which sometimes came from health professionals; for others, it appeared to arise from their perception that their White counterparts ate more grilled and boiled foods than themselves, and are less likely to develop diabetes). However, most also described being reluctant to change the cooking practices with which they were familiar, and which were used on the Indian subcontinent, such as frying vegetables in oil before making them into curries. As Mr Idress (quoted above) put matters simply, 'I don't think our food was made to be boiled y'know', a sentiment echoed by Mr Maskeen who explained that, 'you know our kinds of foods, fried food is part of that and a lot of foods are fried'. Some respondents drew upon a discourse of taste to account for this stasis. They suggested that boiled and baked food foods were 'bland' as Mr Idress put it, or 'tasteless' as Mrs Yunus similarly described, and thereby 'unpalatable' (Mrs Yunus). Others, in not dissimilar ways, focused upon the perceived fortifying properties of different kinds of foods. These respondents described how the fried South Asian foods they were used to eating comprised 'strength foods' (Mrs Akbar), which provided the body with 'a lot of energy' (Mrs Navdeep). By contrast, foods which were boiled, grilled or roasted, and which the *goray* supposedly found 'very very easy to eat…because they were brought up eating the food that they eat, you know' (Mr Idress), were presented as constituting 'light-weight foods' the excessive consumption of which could have 'weakening' effects, and/or lead to a lack of satiation. For instance, Mrs Mir, a Pakistani Muslim in her 50s recounted how:

> 'If you eat something boiled or lighter, then you feel hungry after a short time…In our *salan* (curry) we add oil, and maybe because of that it becomes very rich, and maybe that's not good either. But if you eat fried foods more time will pass until you eat next, you don't feel hungry. I've tried and tested that [whereas] if you ate something boiled and lighter, then you will feel hungry after a shorter time'.

Mrs Mughal, likewise, shared her concerns that, were she to stop eating fried foods, 'your arms and legs just [wouldn't] have the same strength because you're not eating your complete food, so where do you get your energy from?'

Not only was the consumption of 'light-weight foods' seen to cause lethargy, it was also described as undermining respondents' ability to fulfil their obligations to others. Mrs Abdullah, for instance, was one of a minority of respondents who claimed to have made radical changes to her diet, although this was because she had stomach ulcers rather than for her diabetes management. Instead of eating curries 'which hurt my stomach, like its burning', she now ate 'other foods, like boiled foods. I will bring vegetables like sprouts, broccoli, carrots, just like that, and I will boil them'. Not only did Mrs Abdullah describe an overwhelming sense of lethargy because she was unable 'to eat food which provides strength', she also shared her anxieties that her family thought she was lazy because, 'I just make *handi* (curry) and get tired. I do a little work, and get tired…I have to sit a little and do a little more'.

Settlement, sharing and commensality

The importance respondents attached to the consumption of South Asian foods became further evident when they talked about family and community life in Britain. As others have documented (Ballard 1994, Shaw 2000), after the pioneer male migrants were joined by wives and children, religious practices and family and community values became central features of their everyday lives. For our respondents, this situation became particularly apparent in the introduction of regulated and routinised patterns of eating, which contrasted with those characterising the lives of first-generation males in the early, post-migration era. For instance, Mr Sheikh, a Pakistani Muslim in his 60s, described how, when he first came to Britain to work as a bus driver in the 1960s, not only did work demands make religious activities such as regular praying difficult to perform, without female kin to cook for him and his peers, regular meal times and acts of commensality were replaced by unregulated and often excessive eating: 'We used to come home and maybe go to each other's homes. There was no control over what we would eat. Whatever we got, we just ate that, we would keep eating *roti* and keep eating curry'.

In contrast to the early situation Mr Sheikh presented, many respondents described how, since family reunion, the evening meal had become a regular (usually daily) event which brought family together to eat a shared meal of curry, under the same roof, prepared and served in a *handi*, a large, communal pot from which everyone would help themselves. As Mrs Mir described, 'whatever there is, is made for everyone. If somebody wants a piece of chicken or meat, the rest of the family enjoy that'.

Acts of commensality (i.e., shared food consumption) were also described as extending to the wider community. Respondents described a culture of gift-exchange in which luxury food items, such as Pakistani and Indian sweets, were given/received on occasions such as the completion of exams or the passing of a driving test, as well as at special events, such as a marriage. Others, such as Mr Narin, highlighted the central role that the consumption of South Asian foodstuffs played at community and religious events. One such event, for him, was a weekly, Sunday meal organised and hosted by his local *Gurdwara* (Sikh temple) where, 'we have chapatti and curry and things like that, all cooked with oils'. Mr Narin described how he had continued to partake in temple meals despite his concerns that eating them could be detrimental to his blood glucose control because: 'you don't refuse, that's why you eat it, everyone does'. His explanation is powerful and telling, indicating that socially regulated patterns of eating were, in key respects, compulsory. Indeed, other respondents also highlighted the seemingly obligatory nature of acts of commensality within their families and communities. In these, declining to eat *roti*, *metai* (traditional sweets) and other foodstuffs could not only result in their being 'the odd man out' as Mr Rahul an Indian Hindu in his 60s put it, but, more crucially, could cause 'offence' as Mrs Saeed described. Indeed, Mrs Parween, a Pakistani Muslim in her 60s, told the interviewer how she always accepted and ate *metai* when it was offered by neighbours and kin because:

> 'They [would] wonder why you don't want it when they have offered it to you. Maybe they think it's because you don't like them. That's why I take it'.

Respondents' accounts thus resonate with sociological and anthropological work (e.g., Delphy 1979, Goody 1982) in which it has been observed that, across cultures and time, 'the identity and differentiation of the group is brought out in the practice of eating together or separately, as well as in the content of what is eaten' (Goody 1982, p. 38). In other words, just as the act of eating the same foods within a communal setting can

bolster and reinforce group membership, refusing foods, and/or eating different foods separately from others can lead to differentiation and loss of identity; or, as Mr Ismael suggested, to one becoming 'an unwelcome guest'. As Caplan (1997, p. 3) has, likewise, contended 'food is never just "food" and its significance can never be purely nutritional . . . it is intimately bound with social relations, including those of power, inclusions and exclusion'.

Given the social and symbolic role which food played in respondents' lives, it is understandable that many saw themselves as being in a paradoxical situation: either they could continue to eat a diet which they saw as presenting risks to their health, but as being beneficial for self-identity, or they could avoid South Asian foodstuffs and acts of hospitality and thereby risk compromising their identities as family and community members. As we shall now see, most respondents had, over time, devised strategies by which they attempted to manage their diabetes and identity at one and the same time. As their accounts suggest, however, although these strategies seemed successful insofar as they enabled them to act in ways which seemed acceptable to family and community members, they could also come with certain costs.

Strategies for passing: cutting out or cutting down

One strategy involved respondents eating what appeared to be the same foods as family and community members, when, in actuality, an 'unhealthy' ingredient (e.g., sugar) had been removed from their portion at the preparation stage, or a 'healthy' ingredient substituted in. For instance, Mrs Anwar, a Pakistani Muslim in her 60s, described how, when she cooked dishes such as *kheer* (sweet rice pudding) for guests, she would separate out a bowlful for herself before she added sugar in. In this way, it was possible to fulfil her social obligation 'to provide company' to her guests by sitting and sharing food with them (as she pointed out, 'if you completely refuse to eat with them, it looks wrong'), at the same time as avoiding consuming sugar herself. Whilst this strategy was effective for some, it was difficult for others to implement, especially males, who described having limited input into meal preparation, as this responsibility normally fell to female household members. Indeed, whereas Mr Awan (Pakistani Muslim, 40s) described how he relied upon his wife to separate out a portion of curry at the cooking phase to which she would add less salt and chilli, others, such as Mr Sheikh, accounted for his dietary stasis on the grounds that his wife and daughter-in-law 'should not be expected to do anything differently for me'. The etiquette of preparing and serving curries in communal cooking pots could also make the removal of 'unhealthy' ingredients unviable. Mrs Parween, for instance, found it easy to substitute butter for low fat spread in the sandwiches she made for herself at lunchtimes. However, when she prepared evening meals, she continued to fry vegetables and other ingredients for curries in butter because 'none of our family like the taste of food cooked in oil'.

Given the limited input some respondents had into food preparation, the importance attached to commensal acts, and their stated need to eat 'strength-giving' South Asian foods, an alternative strategy of dietary management was more commonly reported. This involved respondents continuing to consume foodstuffs as they had always done, but in much smaller amounts. For instance, Mr Narain, an Indian Sikh in his 50s, recounted how, when he was offered *metai* on occasions such as weddings, 'I will usually have one piece and half it in two, because it's a happy occasion so you can't refuse them, so I just take half of it and that's it'. In the case of meals shared with family and community members, many respondents, likewise, described how they would reduce the quantity of staples eaten (e.g.,

chapattis), and hence the amount of curry needed to go with them. Mr Yunus, for example, pointed to a change in his food consumption in the evenings in which:

> 'I've reduced the amount of *roti* I eat . . .Since childhood I've always had 2 chapattis, but now I will eat one and a half and I will take a small amount of curry that I can have one and a half chapattis with'.

Mr Akbar, likewise, recounted how at meals shared with family and events such as weddings and *Khatams* (religious events hosted at his local Mosque):

> 'I eat *roti* as I used to, the only thing is that I used to eat 2 chapattis or 3 chapattis and now I have reduced that to 2 or 1. [Interviewer: and how about fried foods?] I eat everything like that, but to a limit'.

A few respondents claimed that health professionals had advised them to reduce their portion size in this way. For others, confusion seemed to have resulted from the language and terminology used in consultations, with respondents understanding words and terms such as 'dieting' and 'diet-control' to mean that they needed to cut down, rather than change, their food consumption. As Mrs Anwar described, 'like diet control, I took this to mean not eating too much to fill the stomach in one go . . .[so] I have reduced the amount little by little, but, other than that, nothing else'. Most respondents, however, claimed to have devised the strategy of cutting down themselves (as Mr Sheikh put it, 'I am the doctor'), in some cases, in light of their experiences of fasting during religious events such as *Ramadan* (the ninth month of the Muslim calendar, in which Muslims fast between dawn and sunset) and *Karva chot* (a Hindu event requiring a wife to fast for a whole day to grant her husband a longer life). On such occasions, respondents noted improvements in their blood glucose control, leading them to deduce that cutting down their food intake could be a quick and effective means of controlling their diabetes when their blood glucose levels were high. Mr Awan, for instance, observed that his blood glucose had fallen to 'normal' levels following Ramadan. This not only promoted him to explain to his 'astounded' doctor that 'I'd been fasting this year, like I did last year', but also to suggest to the interviewer that 'I will try to continue the way I've been eating during Ramadan'.

While reducing one's portion size may appear to be a rational solution to the challenges and dilemmas described above, as already indicated, it could come with certain costs: hunger and lack of satiation. Not only did respondents talk about the need to reduce the amount of food they ate in order to achieve dietary change, many also expressed the view that hunger was a necessary and inevitable consequence of their disease; that they *had* to 'hold back' and 'go without' in order to keep their diabetes under control. As Mrs Parween put it, 'if you have a lot of sugar, you *must* stay a little hungry – you can just eat a little'. Mrs Abdullah, similarly, told the interviewer that: 'this disease is very horrible. It's not good, you cannot eat to fill the stomach. You have to kill your heart when you see others eat things you cannot eat in full measure'. A few respondents, like Mrs Akbar, described how, on occasions when their blood glucose levels went high, they would go as far as to stop eating altogether:

> 'When it's high I wouldn't eat, I had to bring it down so I would drink a cup of tea and I don't eat anything. I would get through the night, and then I'd check it in the morning, and if it was fine I'd eat a little'. (Mrs Akbar)

Similarly, Mrs Navdeep, an Indian Sikh in her 60s, told the interviewer how, when she recorded high readings in the evenings, she would 'drink a lot of water, we don't eat

anything'. Like Mrs Akbar, she would do her best to get through the night; in her case, it was impossible to sleep because she 'felt hungry'; hence, she would sit up in bed with the light on, waiting for 'when it [blood glucose level] goes down, when I can eat something'.

Conclusion

In this study, we have sought to illuminate the social and cultural processes informing the food and eating practices of Pakistanis and Indians living in Britain, by focusing on those with type 2 diabetes, for whom dietary management is a key recommendation. Despite their perceptions and concerns that South Asian foodstuffs, such as *roti*, could be detrimental to their blood glucose control, most respondents reported limited changes to their consumption of such foods following diagnosis of diabetes. Hence, while health was a consideration to them, it was one which was interwoven with other issues and concerns. A central concern for respondents, as our analysis suggests, was forging and maintaining their identity as family and community members living in Britain. As the consumption of South Asian foodstuffs played a central role in this process, respondents often attempted to manage their identity and diabetes simultaneously by reducing the quantity they ate. Rather than being a universal response, this strategy contrasts with that observed amongst White respondents in a companion, Lothian-based study. These White respondents attempted to manage their diabetes by *cutting out* what they perceived as 'unhealthy' and 'risky' foodstuffs (such as chocolate and crisps) and replacing them with 'healthy' alternatives. They also drew upon discourses of 'excess', 'gluttony' and 'guilt' in order to contextualise and account for failure to adopt and sustain a 'healthy' diet over time (Peel *et al.* 2005, see also Lawton *et al.* 2007). In contrast, Indian and Pakistani respondents tended to draw upon discourses of 'restraint', with most attempting to manage their diet by *cutting down* on (rather than replacing) what they saw as 'risky' (i.e., South Asian) foodstuffs. This contrast suggests that, for the latter, accounts of foods and eating practices are at least partly informed by concepts and experiences common to this respondent group.

Virtually all respondents, for instance, highlighted the seemingly obligatory role that the consumption of South Asian foods played within their families and communities, particularly once settlement became more permanent. Respondents, for instance, described how they could cause offence and/or risk alienation if they did not partake in the acts of commensality with family and community members. As others have observed (e.g., Werbner 1990, Shaw 2000, Bradby 2002), complex systems of gift-exchange (called *lena–dena*) – which include the giving and receiving of South Asian sweets and dinner/meal invitations – perform a vital function amongst South Asians who live in Britain. Not only do they serve as a means by which honour, status and prestige are generated and expressed (as in highly visible, and often ostentatious, events such as wedding meals – see Bradby (2002)), more crucially, as Shaw (2000) has observed, this system of gift-exchange has enabled those separated from their extended families on the Indian subcontinent to create social networks, which may include neighbours and other fictive kin as well as 'real' kin. In addition to providing a system of mutual support, these networks have enabled South Asian settlers 'to rebuild almost every aspect of their social and cultural traditions' and Britain to become 'a home from home' (Ballard 1994, p. 18).

It is notable that when respondents used terms such as 'Asian', 'our people' or 'our foods' in the course of describing their food and eating practices, they did not tend to explicate or articulate differences with other people originating from the Indian

subcontinent, such as those based on ethnicity or religion. Instead on occasions when differences were highlighted these tended to be with White people, whose foods were described as bland and tasteless. This suggests the presence of a shared or common sense of identity, one which, as Bradby (2002) cogently suggests, may have arisen from the shared experience of moving to a 'foreign' and 'racialised' society, one which, as she further contends, may have compelled South Asian people to consider similarities cutting across ethnic and religious boundaries. Such a process, as Baumann (1996) and Burdsay (2006) have, likewise, observed, may have extended, albeit in slightly different ways, to those born in Britain. As their work highlights, rather than undergoing any simple process of assimilation, members of the younger generations seem to construct specific British Asian identities for themselves, predicated on shared convictions; for instance, that all 'Asians' are subjected to racial discrimination.

We have seen that, whilst respondents perceived there to be risks associated with eating certain South Asian foodstuffs, they had to balance these against those of alienating themselves from their culture, families and communities. A central way in which respondents attempted to reconcile this paradoxical situation was by practicing dietary restraint. On one level, reducing one's food intake (and cutting out hidden ingredients from certain foodstuffs) appears to be an obvious and rational solution to the dilemmas with which respondents had to contend. It is a strategy, furthermore, which, for those belonging to the Muslim and Hindu faiths, may have been informed by the lived experience of fasting (and the associated cultural template of 'food denial'); in particular, of observing blood glucose levels fall in the aftermath of not eating. However, abstaining to the point of hunger, while commonly reported by our respondents, is not recommended in current dietary guidelines for patients with diabetes (Nutrition Subcommittee of the Diabetes Care Advisory Committee of Diabetes UK 2003). To the contrary, guidelines emphasise the importance of continuing to eat sufficient food for satiety, albeit sometimes with a lower energy yield.

In order to follow current recommendations, our findings indicate the importance of promoting dietary changes which work with the kinds of foods Indians and Pakistanis are eating already. In particular, they underscore the need for strategies for fat and energy reduction which focus on traditional cooking practices and, more specifically, through the promotion of lower fat authentic versions of recipes for commonly consumed dishes (see Kassam-Khamis *et al.* 2000). To achieve this, it is vital that education and advice tackle the potentially erroneous perception that South Asian foods are necessarily an 'unhealthy' or 'risky' options since, as indicated earlier, the pre-migration diet is considered, from a biomedical perspective, to be a healthy one – one, furthermore, which is well suited to the plentiful use of foodstuffs such as vegetables and dhal. Education should also emphasise that 'healthy' food options do not have to be bland and tasteless (in other words, spices can be used) and the consumption of what are perceived as 'strength-giving' foods is acceptable, provided, as indicated above, these are cooked in 'healthy' ways, and eaten alongside high-fibre foodstuffs, such as fruit and vegetables. When delivering this kind of dietary advice, it is important that health professionals avoid stereotyping the diets of South Asians (and, indeed, that any misconceptions and stereotypical assumptions are addressed – see below). As South Asians tend to eat a blend of Western and 'traditional' cuisines, health education materials should reflect this diversity, and not simply target South Asian foodstuffs (Wyke and Landman 1997).

Our findings also underline the importance of delivering education, advice and support to the whole family and not just the person with diabetes, since responsibility for food

purchase and preparation may be devolved to several household members. Given the broader role that the shared consumption of South Asian foods plays in community life, and respondents' concerns about causing offence if they did not participate in commensal acts, it may be prudent to invest energy and resources in raising general awareness about healthy eating through group and community-based initiatives. As part of this education, it would be helpful to recommend that, when offering hospitality, people serve 'traditional' food items, such as slices of fresh fruit and nuts, instead of sweets.

Limitations and future research

The scope of this study has been limited by the focus on patients' perspectives. As Lutfey (2005) has persuasively argued, such a focus may occlude consideration of the ways in which healthcare professionals' assessments of patient adherence, and the recommendations and advice arising from them, may also affect patients' perceptions and behaviours. Hence, future work could look at health professionals' perceptions and understandings of what South Asian patients eat (and why), how these might guide the advice they give to such patients. This kind of research may also help to clarify from where respondents derived their perceptions that South Asian foods are 'risky', and to establish if health professionals, themselves, hold erroneous or stereotypical perceptions which may need to be addressed. It may also be useful to observe communication and information exchange in diabetes consultations where dietary issues are discussed in order to develop a better understanding of whether, and for what reasons, South Asian patients (particularly non-English speakers) are misinterpreting or misunderstanding health professionals' advice regarding 'diet' and 'dieting'.

In considering our findings, it is also important to be mindful of the limitations which may arise from using in-depth interviews. As described elsewhere (Lawton 2003), interviews may invite a particular kind of account in which people may be more concerned with presenting themselves in a socially favourable light than conveying their beliefs and behaviours in literal and direct ways. Hence, ethnographic approaches (e.g., observation of family and community meals) could be usefully employed in future work to look at whether (and why) there are any discrepancies between what respondents say they eat in the context of an interview, and what they actually eat in practice.

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Note

1. The use of the term 'South Asian' is unavoidable here because it is the terminology used in the literature to which we refer. The term refers to people born on the Indian subcontinent (i.e., India, Pakistan or Bangladesh), or descended from those who were born there.

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