Raising the issue of overweight and obesity with the South Asian community

INTRODUCTION

Despite being at higher risk for chronic disorders, the South Asian population remains largely under-represented in clinical and applied health research or service design,[1,2] and is less likely to access or be referred to relevant services compared with the white population.[3] This adds to the multiple disadvantages faced by some ethnic minority communities.[4]

Mainstream research practices that elicit the participation of the majority population can sometimes exclude minority populations because the nature of the methods used are not always culturally appropriate.[5] Given the prevalence and consequences of overweight/obesity in the South Asian population in the UK, it is important to identify strategies for raising the issue of overweight/obesity with this group, although there is little evidence on raising this sensitive issue with patients generally.

Patient and public involvement

The role of the public and patients in research and service redesign as co-producers of health has been highlighted, but descriptions and discussions of the processes are often limited.[6,7] Studies have shown that using the appropriate approaches can aid participation and involvement of different communities[8,9] in order to inform healthcare services, research, policies, and practice.

From the patient's perspective, fear of obesity-related stigma by others including healthcare professionals (HCPs) and previous experience of obesity-related discrimination[10,11] may result in people with weight problems failing to seek health care.[12] Furthermore, a mismatch between how healthcare professionals and patients make sense of the causes, consequences, and solutions of overweight and obesity[13] will lead to barriers in communication. For this reason, appropriately developed public and patient involvement (PPI) activities as a method of research are required for seldom heard groups.[14]

Therefore, it is especially important that when the issue is raised with people that societal prejudices are not reaffirmed, and that raising the issue has the desired outcome where the person is receptive and positively engaged. To address these fears, we carried out a PPI activity in Birmingham, UK to explore with representatives two key aspects with respect to the South Asian population. First, to explore who should raise the issue of overweight/obesity with South Asian people, and secondly, how it should be raised.

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PROCESS

This work was conducted as the PPI[14] element in preparation for a study to develop interventions to address overweight/obesity among the South Asian population and to develop services best suited to promote uptake. The feedback on which this article is based was obtained from a total of 24 South Asian PPI representatives, who took part in three discussion group sessions in Birmingham to identify and discuss the factors that need to be taken into account when developing strategy.

EVIDENCE COLLATED FROM PPI DISCUSSION GROUPS

GPs: responsibility, relationship, and status

While representatives acknowledged the role of family and community in raising the issue of excess weight, there was a consensus that GPs are the most appropriate HCPs to raise the issue. GPs were considered the most important first point of contact for people looking for health-related advice and were in a position to make referrals to other services that people would otherwise be unable to access. The patient–GP relationship was also perceived as significant if it was underpinned by mutual respect and cultural sensitivity, because it was more likely to lead to a productive discussion either initiated by the GP or by the patient. A strong relationship with GPs was often associated with more frequent visits and familiarity (Box 1 [a]). However, overly informal approaches were viewed with suspicion as they threatened the professional credibility of both the GP and any information conveyed.[15]

'Soft' versus 'hard' approach

PPI representatives distinguished between 'soft' (subtle or indirect approach) and 'hard' (direct) approaches. There was no consensus on which was the preferred approach. However, it was suggested that in the absence of familiarity between patient and GP, the issue ought to be raised using a 'soft' approach (Box 1 [b]).

Alternative approaches

Representatives in all three groups explored other methods of raising the issue that did not involve face-to-face interaction. Many felt that, due to the social stigma attached to overweight/obesity, some people will be 'in denial' and resistant to information on weight loss and exercise.[16] Suggestions were made for the issue to be raised holistically in relation to good health in general as well as discussing the social, economic, and psychological implications of poor health (Box 1 [c]).

"Information given by HCPs who are themselves overweight was seen to be less credible, although some representatives believed that the fact that the HCP was struggling with weight themselves might lead to a more empathetic approach."

Box 1. PPI session results: themes and comments

a) GPs	
Responsibility	• *GPs should be comfortable enough to raise it with their patients. If I don't feel comfortable enough to talk about it myself, the GP being a professional should be able to tell me about it.*
	• *Obesity can also lead to depression and other health problems so it's better if the GP is honest about it.*
	• *I think it should be the GP's responsibility in a way ... People will appreciate it in the long run.*
	• *The doctor should reach out. You expect your doctor to be friendly so if GPs were to reach out to people and express an interest in them and also because they are professionals then people would listen to them.*
Relationship	• *My personal GP is a family GP and I've known him since I was 10 and if he tells me something I wouldn't be offended by it.*
Status	• *If a friend of mine said have you seen your health recently it's really bad I wouldn't take any note of it, however if the GP said it, it's come from a professional background. It's the trust that what he is saying has got to be right.*
	• *If a nurse told me something might be wrong somewhere I would still follow that up with the GP just to get a second opinion.*
	• *You tend to have more trust in doctors because they have higher qualifications than nurses so it's OK for nurses to raise the issue but then there needs to be a doctor to follow up on that.*
b) 'Soft' versus 'hard' approach	• *Just say it in a friendly way. Then most people will appreciate it rather than be offended.*
	• *They need to have fear* [health implications].
	• *Be friendly: make the person feel comfortable about themselves and within their skins. Not to say 'you are overweight and that's why your blood pressure is high'.*
	• *I don't think he* [doctor] *should beat around the bush. If he thinks you are fat, he should be able to tell you.*
	• *He shouldn't just say you are fat, and this, that, and the other. He should say you are overweight and it may cause you trouble in life. It's all about the way people speak to you.*
	• *I suppose it's a sensitive issue so it should be put in a subtle way. Don't be blatant about it. One example is if you are going to hand them a prescription then also hand them a leaflet with that.*
c) Alternative approach	• *HCPs should start by talking about other health issues first that are related to obesity such as heart problems, diabetes.*
	• *He told me about the quit smoking scheme and when we talked about that I felt I opened up and I thought I might as well speak to him about the rest of my health also.*
	• *Leaflets shouldn't make people feel like it's targeting them specifically but something that is about someone else but then at the same time it contains information that is relevant to the person reading it also.*
	• *If there was some pre-conversation that led up to that then that would be OK otherwise if it started like that she would know exactly what you are trying to say and the barrier would go up straight away.*
d) Differences	
Sex	• *There's a stereotype which is that just because you are a woman you would be very sensitive to weight issues.*
	• *Men can be overweight but they are not as pressurised as women are.*
Cultural	• *The only stories you would hear is 'she's slimmer than you and she's prettier than you because you're fatter than her'.*
	• *Being Asian or of a Middle Eastern culture, we are not as bothered about how we look. I think that some of that mentality still exists in our culture. If someone is chubby they say he has 'jaan' meaning he's strong and healthy.*
Physical	• *Most GPs are fat themselves. They don't tell people to lose weight because they'd get told to look in the mirror.*
e) Patient empowerment	• *If there were leaflets that people can pick up with some information on who to talk to and what to do then people can decide themselves if they wanted to discuss it with their doctor. It's about empowering people rather than them being told how to live their lives by professionals.*
	• *I did speak to my GP and he referred me.*
f) Mis(use) of phrases	• *If there isn't a service then you can tell people about being healthy.*
	• *It's like you said it's better to say this would be better for your health for you rather than your weight. It's a better way of phrasing it.*

Sex, cultural, and physical differences

The patient's sex was seen as playing a role in the decision about how the topic should be introduced. Women were thought to be more sensitive to having the issue raised as opposed to men because of the societal pressures and media attention on body shape and image for women (Box 1 [d]). The sex of the GP was also considered important as it was suggested that an HCP of the opposite sex to the patient talking about weight would be a source of embarrassment and shame and likely to prevent engagement. The body size and weight of the HCP was also identified as a factor influencing the receptiveness of the patient. Information given by HCPs who are themselves overweight was seen to be less credible, although some representatives believed that the fact that the HCP was struggling with weight themselves might lead to a more empathetic approach. It was suggested that raising the issue could be couched in the HCP's own experiences, or the experiences of those close to them, so that patients do not feel as if they are being singled out.

Patient empowerment

Discussions took place about patient autonomy and choice. While representatives believed in the value of patients receiving information about risks to health and possible weight management strategies, they felt that patients needed to make their own decisions about whether or not they wanted to discuss their weight during a consultation. Given that people have some insight into body size and weight, patients should be encouraged to raise the issue proactively; however, representatives agreed that this would not be appropriate for all. The importance of a positive relationship with practice staff in general was reiterated (Box 1 [e]).

Terminology

Using appropriate terminology should also be considered when raising the issue. Many PPI representatives were in favour of the term 'healthy' as opposed to 'overweight' or 'obese' and preferred HCPs discussing health in general terms as opposed to using specific terms, which may lead their patient to feeling offended (Box 1[f]). While avoiding offence was considered easier in established relationships, initiating a dialogue opportunistically is also important, although a more indirect approach was favoured.

CONCLUSION

The responses elicited highlight the

importance of cultural sensitivity in initiating a meaningful dialogue between patients and GPs about health issues related to excess weight.

Using a PPI activity to elicit useful information and suggestions on raising the issue of overweight and obesity in the South Asian community has minimised the mistrust and power differentials that exist between researchers and research participants.[17] A PPI activity can empower representatives to participate 'with' research and other aspects of applied health without being researched 'on'. This notion of being subjects of research is what often leaves people disconnected and not wanting to take part.[18] Similarly, this form of approach where GPs work 'with' patients in understanding their needs and practicalities will also be useful in service delivery in primary care.

Engaging South Asian patients in research or service design activities is not straightforward, primarily because commonly used recruitment or educational strategies do not reflect the concerns of South Asian communities. However, if they have no voice in shaping the agenda, the allocation of resources for services and research for minority communities will not reflect their needs.

Creative strategies for involvement of under-represented groups need to be developed because these groups are not necessarily 'hard to reach'[4] or difficult to engage, but rather the approaches and methods used need to be culturally sensitive, inclusive, and appropriate. The interactions patients have with their HCPs are a crucial first step in initiating dialogue, which is especially important in relation to a sensitive health problem such as overweight/obesity.

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