



University of the West of England, Bristol

Healthy Eating Initiatives with Black and Minority Ethnic Groups in Bristol

Report Prepared for Bristol NHS

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Introduction

Project Overview

The project was developed in response to a request by Bristol NHS for assistance with qualitative research on attitudes to food and diet among Black and Minority Ethnic (BME) groups in Bristol. The overall project aim was to conduct qualitative research on attitudes to healthy eating, food and nutrition among several BME groups, namely Somalis, South Asians, and African Caribbeans, in Bristol. More specifically the project aims were to:

1. To identify beliefs, attitudes and knowledge about diet, food and health among Bristol's minority ethnic individuals, groups and communities and to explore current dietary behaviour.
2. To determine the most effective strategy/approach to reach the target audience and to induce dietary behaviour change.

The information gathered by this research will be used by Bristol NHS as a foundation for the development of a Social Marketing approach which addresses a number of key objectives from the Bristol Food & Health Strategy Action Plan. These objectives include the development of appropriate and culturally sensitive healthy eating initiatives and resources for ethnic minority individuals and communities in order to promote dietary behaviour change and reduce diet related ill health and inequalities.

Project Proposal

The proposal set out an agenda for undertaking:

1. A brief literature review was undertaken in order to identify extant gaps in the literature, and as a guide to developing an interview schedule for the focus groups.
2. A series of focus groups with members of established community groups in each of the BME communities (3 per BME group = 9 in total)
3. A series of in-depth interviews with individuals from each BME community (3 per BME group = 9 in total)

Executive Summary

- This report describes a qualitative study on the dietary patterns, attitudes and beliefs about healthy eating of three BME communities (Somalis, South Asians and African Caribbeans) in Bristol.
- Dietary research points to longstanding associations between ethnicity and health status and highlights and number of prevalent health concerns and illnesses amongst BME communities which are signposted in this study.
- Increased levels of obesity in South Asian and African Caribbean communities in the UK are now increasingly reported in the Somali community, increasing the risk and prevalence of hypertension, type 2 diabetes and cardiovascular disease amongst others. Vitamin D deficiency, well documented in South Asian and African Caribbean communities is now of increasing concern in the Somali community. Overall BME and migrant groups report less physical activity compared to other groups.
- Dietary research on BME groups gives an indication of broad dietary patterns and preferences (including the cultural significance of traditional food), while pointing to the difficulty of generalizing about BME communities given their extreme diversity.
- A review of evaluated dietary intervention studies by Stockley (2009b) points to a number of methodological flaws in these studies. Research indicates the need for qualitative research which explores the social contexts of BME dietary behaviours.
- BME communities are largely concentrated in Bristol's inner city, particularly in the Ashley, Easton, Lawrence Hill and Eastville wards. The BME population in Bristol has increased dramatically since the 2001 census, with the highest increase occurring in the Somali community.
- Focus groups and in-depth interviews were held with members of three community organizations (SEDSOB, Awaz Utaoh & PAX Productions) utilized by the BME target groups. Samples were not representative but aimed to access a wide range of people in order to capture some of the diversity of the BME communities in relation to gender, age, socioeconomic status, and religion).
- A general set of themes was identified in relation to the dietary patterns and behaviours of the three groups. These pertained to: meals and mealtimes; meat; English food; take-aways, junk food and snacks; drinks; salt; the role of children; cooking; shopping, planning and budgeting; labels; growing your own food; do you/your community eat un/healthily; sources of health information; and vitamin D.
- A set of significant themes emerging in relation to dietary attitudes and beliefs were identified, these were: the duality and ongoing importance of culture; cooking and eating as shared experience and care; eating as knowing as distinction, credibility gap; healthy food is fresh, well-cooked food.
- The identification of dietary patterns, attitudes and beliefs informed the recommendations for effective strategies and approaches to reaching the target audiences and inducing dietary behaviour change.
- Recommendations were made for a range of different practical sessions (including cookery events and vegetable/fruit growing demonstrations) taking place within and between community groups. Based on key themes in the data these should all be framed by a core emphasis on the positive aspects of traditional diets.

Literature Review

Health problems associated with dietary behaviours

Smith, Chaturvedi, Harding, Nazroo & Williams (2000) point to the longstanding associations between ethnicity and health status, while Stockley (2000a) argues that relationships between health and ethnicity have been highlighted in the UK for two decades. This literature review briefly summarises some of the main areas covered by this work, points to gaps in the literature, and highlights issues that are relevant to the aims and objectives of the research.

Dietary research on BME communities consistently highlights a number of prevalent diet-related health concerns and illnesses among these communities. A snapshot of these health concerns is presented below:

- South Asian and African Caribbean communities living in the UK experience increased levels of obesity (Kassam-Khamis, Judd & Thomas, 2000; Landman & Cruickshank, 2001).
- Morbidity as a result of obesity is linked to hypertension, type 2 diabetes, and cardiovascular disease amongst others (Landman & Cruickshank, 2001).
- South Asian and African Caribbean communities experience much higher rates of type 2 diabetes and cardiovascular disease than Caucasian populations (Wyke & Landman, 1997; Kassam-Khamis, Judd & Thomas, 2000; Lovegrove, 2007; Smith et al., 2000).
- Recent research indicates increased levels of obesity and higher incidences of the above illnesses amongst adult Somalis living in the UK (Gardner, Salah, Leavey & Porcellato, 2010).
- Vitamin D deficiency in the South Asian and African Caribbean communities is well established, however this is increasingly a matter of concern among the Somali community (Maxwell, Salah & Bunn, 2006; Mytton et al., 2007).
- Research also indicates less reported physical activity in BME groups overall compared to other groups (Landman & Cruickshank, 2001).

Traditional diets among BME groups

As a result of the diverse geographical, cultural and religious influences that shape them BME diets are considerably varied. Many components of BME diets are healthy (such as the use of vegetables, fruits and pulses), however many components are equally potentially unhealthy, particularly as it is these very components that constitute staple dietary ingredients. Given how varied BME diets are it is difficult to generalise or 'fix' them into a set of foods or ingredients, however, broad patterns and staple items are discernible. Rice and wheat are staples of the South Asian diet – wheat is particularly present in the various unleavened flatbreads (chapattis, paranthas and rotis) eaten by South Asians. Rice and/or flatbreads are often consumed with a variety of meat-based dishes (particularly lamb), and many dishes are cooked using oil or ghee. Ghee or oil may also be used to cook injera or injera – Somali pancakes (made from teff or normal flour) that are eaten with a variety of meat-based (lamb, goat, liver) stews or soups, often for breakfast. Rice accompanied by meat is often eaten at lunch. Rice is also a prevalent item in African Caribbean diets, as are lamb and goat meat, accompanied by starchy root vegetables such as yam, cassava or sweet potato (Stockley, 2009a). Additionally all three BME groups make use of high levels of salt and sugar in their food and beverages (Stockley, 2009). Research suggests that second generation migrants consume more fat than (older) first generation migrants (Chowdhury, Helman & Greenhalgh, 2000). One reason put forward for this is the increased consumption of fast food or take-aways by this generation (Lawrence et al., 2010) due to pressures on time. However it has also been suggested that the relative affordability of produce in the UK means that even the diets of first generation migrants might have gradually switched from the more modest everyday meals cooked in the home country to the everyday use of richer food and 'special' ingredients – for example, the daily eating of meat, rotis, chapattis and parathas with added ghee, and fried (pakoras, samosas) and sweet snacks (Chowdhury, Helman & Greenhalgh, 2000) in the host country.

Food, culture and identity

While the ingredients and cooking techniques used in BME diets are undoubtedly important it is also important to keep the cultural and symbolic significance of food in mind. According to Chowdhury, Helman & Greenhalgh (2000: 210):

Societies invest a range of symbolic meanings to their foods and associate particular roles and interactions to the preparation, presentation and consumption of foods These meanings and roles, adapted and interpreted by the individual, the family, and the wider social network, play a decisive part in shaping the willingness and ability of a person to change his or her food choices.

Consequently, ethnic dietary choices and patterns are “one of the most enduring aspects of a migrant culture” (Chowdhury, Helman & Greenhalgh, 2000: 210). This is borne out by a number of studies and reviews which have found that adult members of BME communities almost always express a preference for traditional food. For example, in a study by Wyke & Landman (1997) South Asian participants spoke about traditional food as something that was needed to survive, while Landman & Cruickshank (2001) found that factors such as being elderly, making a home and/or looking after a family were all part of a commitment to traditional food. A study by Lawrence et al. (2007) indicates that how members of BME groups identify themselves (for instance as African rather than Somali or vice-versa) potentially impacts on beliefs about health and diet. Furthermore, Stockley’s (2009b) review of dietary intervention models found that half of the participants from BME groups in Wales perceived their own traditional diets to be healthier than Western diets. Identifying and understanding perceptions and attitudes to healthy eating and dietary choices among BME groups is therefore crucial to the development and success of any dietary intervention. Chowdhury, Helman & Greenhalgh (2000) therefore argue that the initial focus of any research or intervention must involve gaining an understanding of how members of BME groups – individually and communally – make choices about both the foods they do and do not eat.

Diversity

Both between and within BME groups, factors such as religion, age, gender and socioeconomic status play a role in determining dietary choices. Landman & Cruickshank (2001) warn that categories such as ‘South Asian’ and ‘African Caribbean’ conceal an incredible amount of diversity, whereby black African Caribbeans may originate from the Caribbean or from West Africa (representing a marked divergence in diet); while South Asians may stem from India, Pakistan, Bangladesh, or Sri Lanka and observe Muslim, Hindu, Sikh or Christian beliefs and practices. Largely Muslim, Somalis are nevertheless also a

heterogeneous group, stemming from diverse locations (Somalia, Djibouti, Northeast Kenya, and parts of Ethiopia) and from a range of different backgrounds as academics, civil servants, shepherds etc. (Olden, 1999). A significant factor in this regard is what Smith et al. (2000) refer to as the experience of duality (of cultures) whereby members of migrant communities continue to experience both the 'current' and 'past' culture across a range of aspects, including diet, and importantly, that the experience of this duality continues amongst the descendents of migrants. Moreover it is argued that the health of migrants will have been affected both by experiences in both the country of origin and the receiving country.

Like many health-related behaviours, dietary choices are also shaped by socioeconomic status and variations in income and wealth (Smith et al., 2000). Stockley (2009a) notes the high levels of unemployment among BME groups in Wales, with high levels of self-employment (in take-away outlets, restaurants and small corner shops) perhaps indicating the difficulties of finding other paid employment. Many members of BME groups can't speak English or read or write in their own language and Stockley (2009a) found that the understanding of key terms and issues related to healthy eating varied widely across and within BME groups.

Research methods and the evaluation of interventions

Much dietary research on BME groups in the UK continues to employ quantitative measures including surveys and self-report measures. Stockley's (2009b) review of evaluated UK dietary interventions targeting BME groups characterised many of these studies as scientifically weak as a result of low participant numbers and the absence of control groups and baseline data amongst other issues.

The diversity of BME groups, discussed above, makes it very difficult to generalise about these groups. Landman & Cruickshank (2001: 653) argue for the necessity of research that "engages with the social aspects of diet to shed light on the factors that support or acts as barriers to healthy patterns of food choice, purchase, cooking and conservation". In this regard, a smaller body of qualitative research (for example: Lawrence et al., 2007; Gardner

et al., 2010) actively engages with members of BME groups using qualitative methods such as interviews and focus groups to explore the social contexts informing diet and health. Lawrence et al. (2007) conducted focus groups with young women of African and South Asian descent across the UK in order to identify factors influencing food choice, while Gardner et al. (2010) conducted focus groups with young Somali women in Liverpool to explore issues around body image and body size. While these studies are laudable in their focus on young under-researched members of BME communities, Sellen & Tedstone (2000) argue that there is gap in information about the diets of children in BME communities.

Context of the study: BME communities in Bristol

Bristol is home to a number of established as well as newer BME communities. While there is some indication that different BME groups are gradually expanding into other areas in the city, these communities are largely concentrated in the inner city areas of Bristol – in particular the Ashley, Easton, Lawrence Hill and Eastville Wards. In recent years Bristol has experienced a sizable increase in numbers of ethnic minorities. Data from the 2001 census estimated the BME population in Ashley, Easton and Lawrence Hill Wards at 25.6%, 24.9% and 31.7% respectively (White, 2010). Further breakdowns of the target BME groups are represented by the graphs and figures below:

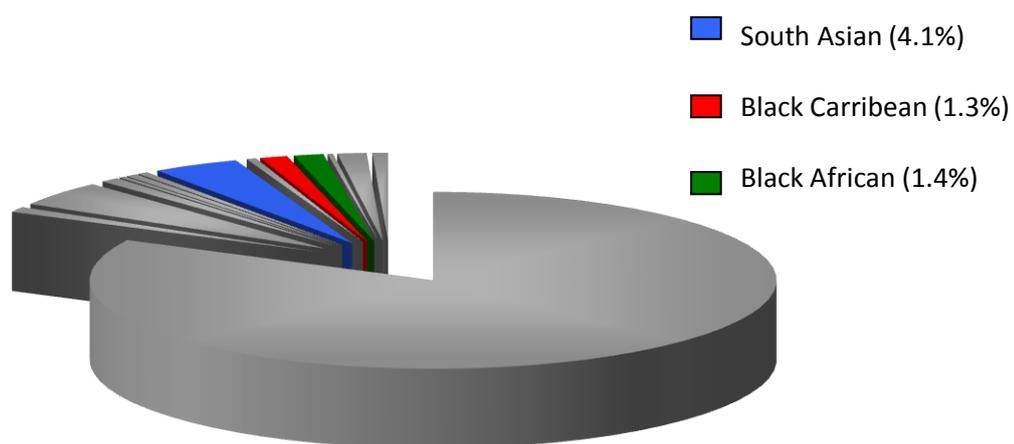


Figure 1: Population estimates for targeted BME groups Bristol (ONS, 2009)

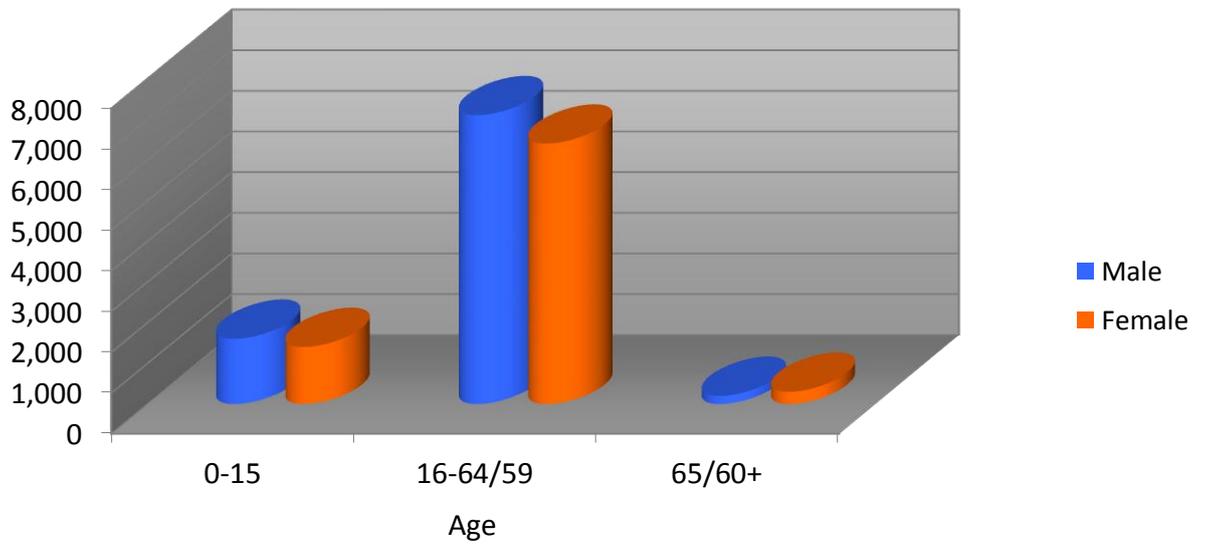


Figure 2: Age & Gender estimates for South Asian population in Bristol (ONS, 2009)

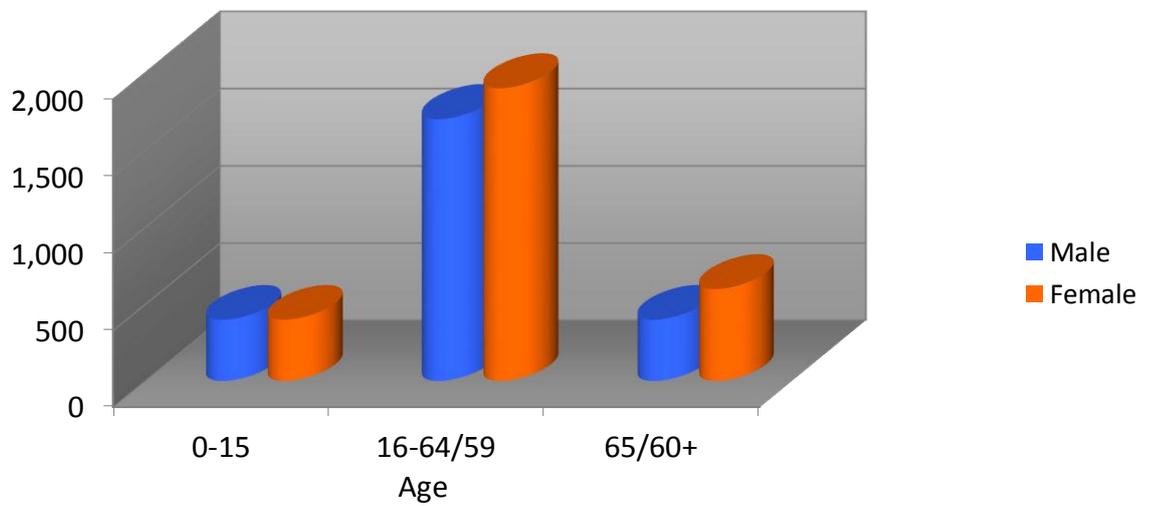


Figure 3: Age & Gender estimates for Black Caribbean population in Bristol (ONS, 2009)

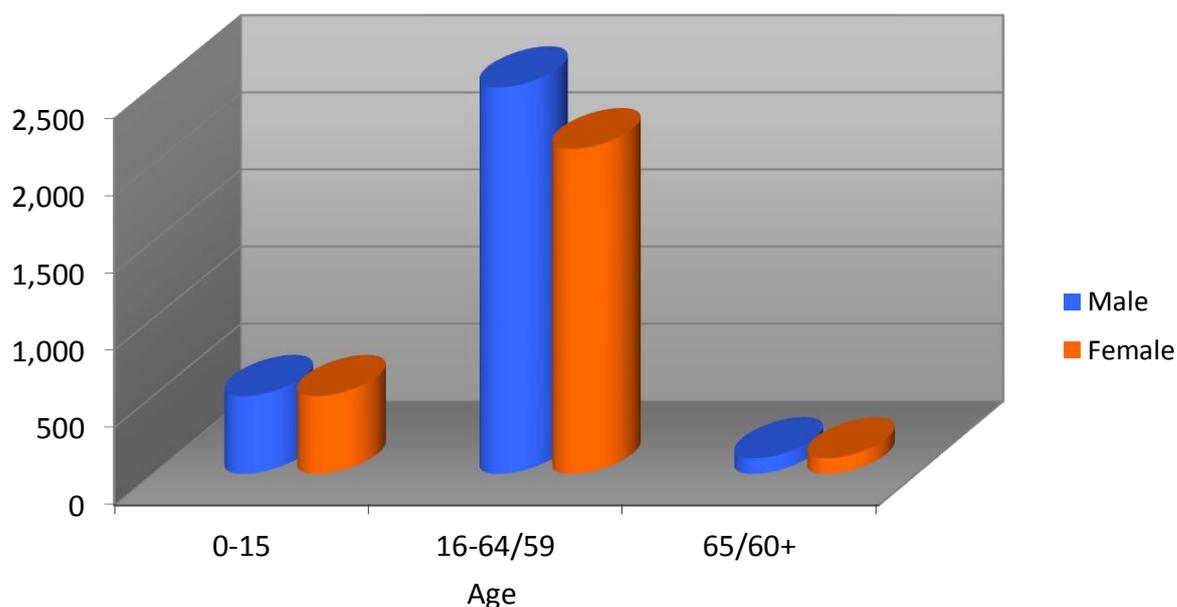


Figure 4: Age & Gender estimates for Black African population in Bristol (ONS, 2009)

However, since the 2001 census the demographics of the city have changed dramatically. According to figures from Bristol City Council’s Neighbourhood Partnership Statistical Profile for 2008 (<http://www.bristol.gov.uk/ccm/>) the BME population in Bristol increased from 8.2% in 2001 to 11.9% in 2007 (peaking just above the average of 11.7% for England). Statistics from the Pupil Level Annual School Census (PLASC) database for school intake in 2008 indicate that the abovementioned wards all have less than 50% White British pupils: Lawrence Hill (20%), Easton (31%), Ashley (34%) and Eastville (44%) (White, 2010). Somalis are one of the fastest growing communities in Bristol and have arrived in significant numbers since the late 1990s (White, 2010). Given the unreliable nature of the data held by the Office for National Statistics (ONS) which estimates a figure of 6,000 ‘Black Africans’ (in and of itself an unreliable category) in Bristol, it has been very difficult to capture an accurate picture of the size of the Somali community in Bristol. Anecdotally the population has been estimated at anything up to 30,000 individuals, however work undertaken on a Somali Community Calculator by members of Bristol City Council and Bristol’s Muslim communities (Mills, 2010) indicates a much smaller figure. Using information on numbers of children at school and numbers of children born to Somali mothers (amongst other factors)

the calculator estimates a population range of 6,600 – 10,000 Somalis (with an upper limit of roughly 13,700 individuals).

Housing in these areas consists almost equally of houses and flats, in contrast to the rest of the city where, on average, houses account for two thirds of housing (<http://www.bristol.gov.uk/ccm/>). Levels of Deprivation are very high in the central Wards - Lawrence Hill is the most deprived LSOA in Bristol and falls into the most deprived 1% of all areas nationally (<http://www.bristol.gov.uk/ccm/>). The partnership areas vary in terms of Health and Wellbeing ratings: healthy lifestyles, mortality rates and perception of health and wellbeing are all significantly worse in Lawrence Hill, while Easton and Ashley score average and average or above average ratings respectively (<http://www.bristol.gov.uk/ccm/>).

Methodology

Wyke & Landman (1997: 27-28) argue that “dietary research often makes use of highly structured, quantitative measurements of food and nutrient intake, ignoring qualitative methods which can provide insights into the ways in which people themselves talk about and make sense of food in their lives”. It was felt that the primary research aims: to identify attitudes, beliefs, and knowledge about diet, food and health among Bristol BME communities; and to determine the most effective approach for reaching out to these communities, would be best met by the use of a qualitative approach. Qualitative approaches are attentive to how people make sense of the world, their experiences, and how these are shaped by their social and cultural contexts (Willig, 2008). Glanz & Bishop (2010: 400) state that “the most successful public health programmes and initiatives are based on an understanding of health behaviours and the contexts in which they occur”.

Given the extreme diversity encompassed by the three BME groups and the aims of the project to gain in-depth insights into the different ways in which diet and food are meaningful to BME individuals and groups, no attempt was made to recruit a representative sample. Recruitment was guided by the Community Partnership Model set out in the project proposal, and by insights gathered from the extant literature. This model entails the use of

trusted gatekeepers and members of the target communities for all aspects of the data collection thereby offering a much better chance of collecting authentic and valid data. Gatekeepers from established community organisations associated with each BME group introduced the research and its aims and objectives to members of the community organisations, as well as recruiting for, and moderating, the subsequent focus groups and interviews. Given the variety of languages spoken across the three BME groups, the moderating role played by gatekeepers was therefore crucial to the success of the focus groups and interviews. Here the use of trusted community members for recruitment and data collection facilitated the kind of open and productive discussions necessary for unearthing information about attitudes and beliefs to healthy eating. A further key element of the Community Partnership Model was the incentivisation of whole community organisations, according to identified needs. Incentives for individual participants were thus organised by gatekeepers in discussion with community members. This model of incentivisation was envisaged as a way of benefitting the wider community by enriching and sustaining the group and establishing a good working relationship between NHS Bristol and the target communities.

The three community organisations involved were:

1. The Somali Education and Development Society of Bristol (SEDSOD)
2. Awaz Utaoh (South Asian group)
3. PAX Productions – affiliated with the African Voice Forum (African Caribbean group)

Three focus groups were held with members of each community organisation. Again, while samples were not representative, recruitment was guided by issues raised in the literature, as well as input from the gatekeepers. For example, an effort was made to recruit at least one group of men within each community given that:

- it is thought that gender plays a significant role in determining the kinds of meals cooked in households
- many men, particularly in the South Asian and Somali communities, work as taxi drivers or do shift work in restaurants and take-away establishments which is likely to have a significant impact on their diets.

Focus groups lasted anywhere between 45 and 90 minutes, and the follow-up interviews ranged from 45 – 60 minutes. Both focus groups and interviews were held in venues

associated with the community organisations. The following is a snapshot of the demographics for each series of focus groups:

- Somali focus groups: 2 groups of women, 1 group of men [12 in total]. Participant ages ranged from 25 – 42, all participants were Muslims and stated that they came from Somalia.
- South Asian focus groups: 1 group of women, 1 group of men, 1 mixed group [25 in total]. Ages ranged from 21 – 60, and participants came from different cities and regions in North India, Pakistan, Bangladesh and India. Participants followed Muslim, Christian, Hindu and Sikh faiths.
- African Caribbean focus groups – 1 group of Caribbean women (all from Jamaica); 1 group of African women (Sierra Leone, Ghana, Zimbabwe); and 1 group of African men (Sierra Leone, Ghana, South Africa) [20 in total]. Ages ranged from 26 – 76.

Overall 57 participants took place in the focus groups and 9 participants took place in the follow-up interviews [overall total = 66]. The literature discussed above was used to inform the production of the semi-structured Interview Schedule for the focus groups (see Appendix). The research by Lawrence et al. (2007) was particularly useful in this regard, as it complemented many of the research questions/aims and objectives of this study. However, we sought to expand the study by including a number of new areas of questioning (including questions aimed at eliciting gender patterns around shopping, cooking and eating; the impact of warning labels on food packaging; participants understanding of the role of vitamin D; and ascertaining the need for and preferred format of health information related to diet and nutrition). The follow-up depth interviews were unstructured in order to pick-up and further explore issues that arose during the focus groups. One of the authors, Yvette Morey, was present at all focus groups and interviews and, with the help of the various gatekeepers, established a good rapport with the community groups. It was usual for the groups to cook and offer food at every focus group. This was both welcoming and a good way to experience some of the foods that were being discussed first hand:



Figure 5: A meal of fried plantains, fish curry, cassava leaves and salad at focus group with African men

All focus groups and interviews were transcribed verbatim and anonymised. The data was thematically analysed with the aid of NVivo software. NVivo allows for a very thorough organization and coding of rich textual data. The complex analysis enabled by NVivo allows for the identification of potentially unnoticed themes and trends in the data. The themes that emerged from the data can be grouped into two sets. The first set of themes addresses an overall set of questions about current dietary behaviour, including general eating patterns (when and what kinds of meals are eaten); food shopping/buying/cooking; links between eating and health; and vitamin D. These themes, and the questions that prompted them were influenced by the literature; whereas the second set of themes emerged from the data and represent the beliefs and attitudes underpinning the dietary behaviour of participants (these include: duality and the ongoing importance of culture, cooking and eating as shared experience and care – the role of husbands and children, eating and knowing as distinction, credibility gap, healthy food is fresh, well-cooked food). The themes are summarised with descriptive quotes below.

Themes – Dietary Behaviours

In the excerpts below P: refers to an interview participant, while P1: etc. is used to denote different participants within a focus group. G: refers to a gatekeeper, and I: to the interviewer.

Food and diet – and in particular traditional food and diets – were very important to all three BME groups in this study: as part of a continued cultural tradition that represents the known and familiar; as an impartor of satisfaction and pleasure; as a way of demonstrating love and care within the home; and, as a way of distinguishing oneself from others (both within and outside the immediate community). However, for these groups food and diet are also part of the complexities and stresses of adjusting to, and carving out a life – often with a family – in a foreign country. For many BME individuals choices about food and diet are at the centre of changing roles, demands and expectations in relation to domestic and paid work. This often entails a delicate balancing of different priorities so that *healthy* eating may become less of a priority in the face of the numerous demands of everyday life. One participant expressed it in the following way:

P: In this society a lot of migrants are here, it is economic migration so the focus of the existence here is to better themselves. Come along that or in-between that they settle into marital life, they have children so the focus shifts and whilst they are struggling to better themselves economically, they are striving to have a better life here for themselves and their family as well as care for the family that is at home. So it is quite a complex thing **(African Caribbean interview: African female)**.

In the presentation of the data below we provide an overview of general dietary patterns and attempt to unpack some of the complexities and nuances of BME attitudes and beliefs about food and healthy eating.

Meals and Mealtimes

The three groups differ in terms of set mealtimes. While some African participants ate only one meal a day, some Somali participants (e.g. those not opting for English foods¹ at breakfast) ate three cooked meals a day – this involves a great deal of work for Somali

¹ 'English food' is a term used by participants to refer to a wide range of foods not defined as 'traditional' food.

participants, particularly Somali women who tend to do most of the cooking, many of whom prepare lunch and dinner in between taking and fetching children from school.

In general breakfast was the one meal where participants across the groups ate non-traditional foods (such as toast with jam, cereal, porridge or a banana). This was largely a result of constraints on time or, in the case of some unmarried South Asian and Somali male participants, because they did not know how to cook traditional breakfast foods such as anjera (Somali pancakes eaten with sugar – a meat and potato stew) or the South Asian parathas and chapattis. As the Caribbean women participants ate the most mixed diet (of English and Jamaican foods) they most often had non-traditional foods for breakfast. Some African participants ate rice for breakfast:

P1: I've had a bowl of cornflakes this morning and come back from church I've had a tiny portion of roast dinner, being Sunday, chicken roast dinner with veg and potatoes. The usual English roast dinner.

I: Okay. Do you usually have roast dinner on a Sunday?

P1: Not every Sunday, no. Every now and then. Cos my kids like the roast dinner, while we're really rice eaters.

(African Caribbean focus group, African women)

I: Do you have breakfast?

P2: Breakfast is rice.

(African Caribbean focus group, African men)

Lunch was the most important meal of the day for Somali participants, and the most important meal at which to eat traditional food:

I: ok so is lunch the most important meal of the day

P2: ya, lunch

G: yes it's definitely, lunch is the most important meal, you can have cornflakes or toast or whatever you like in the night and in the morning but you must have a traditional lunch **(Somali focus group, women1)**

Both lunch and dinner were significant to the South Asian women because these often represented time spent with children and husbands. Unmarried South Asian men who worked shifts often ate the same meals – prepared the night before – for lunch and dinner, or ate with extended family members. Somali and South Asian shift workers, such as taxi

drivers and men working in restaurants or take-away establishments, would most often eat junk food during the week.

For African participants rice was a staple food for lunch and dinner (accompanied by meat and cassava leaves):

P2: for us our staple is mainly rice ... most people from Sierra Leone eat rice every day. White rice **(African Caribbean focus group, African men)**.

For Somali participants rice or pasta with meat formed the staple ingredients for lunch and dinner.

P3: our main important food is rice and meat, second food is pasta **(Somali focus group, women2)**.

This was similar for South Asian participants; however, a fish, chicken or lamb curry would often be accompanied by flatbreads such as chapattis, rotis, or parathas.

Interestingly weekends were times during which both traditional breakfasts might be cooked by those who didn't have time during the week, and junk food might be eaten as a weekend treat. Non-Muslim African and South Asian participants tended to eat burgers, pizzas, chips and scampi, while Somalis tended to eat fried chicken and chips, or grilled chicken items such as shish kebabs:

P5: I think I'm generally healthy but on the weekend there's a leeway for burgers and like fried bread with a lot of fat in it **(South Asian focus group, women)**.

Meat

Meat, and in particular red meat such as lamb and goat, was heavily consumed by all groups, again with exception of the Caribbean women who ate red meat more occasionally. For the African, Somali and South Asian participants, meat was not seen as one component of a meal, but was the most important part of the meal – it was felt that a meal was not a meal without meat and this was particularly the case for men. While some participants tried to substitute red meat for chicken or fish, there was a consensus that red meat, particularly lamb, was much tastier and that chicken had no taste or flavour. In addition to this both

Somali and South Asian participants felt that eating red meat was beneficial, albeit for different reasons:

P4: We have some people as well who feel if they don't eat with the meat, each meal they feel like you know they miss that meal **(Somali focus group, men)**

P6: Yeah actually I'm a, I love my meat. For me it's like a meal it has to have meat really. That's how I grew up, as far as I understand a meal is, a meal has to be with meat. Every meal I do eat has meat but I do try to eat less red meat as possible, so I try to sort of incorporate things like seafood and a bit of, you know, fish.
(African Caribbean focus group, African men).

G: I've heard that he actually throws away the chicken if it's cooked, its lamb he loves, uh excuse me you love lamb isn't it more than chicken?

P6: Me? Ya, I love lamb

G: Which is very typical of most of us Asians we prefer red meat and we honestly believe it's the healthiest thing we are doing

P6: No no, it's not about healthy, chicken tastes nothing compared to lamb
(South Asian focus group, mixed).

P1: My generation are like meat so they eat too much meat, good food for body.

I: Do you think meat is good for you?

P1: Yeah of course. Pakistanis eat a lot of red meat. It makes you strong.

P2: Red meat keeps me warm because this country is cold **(South Asian interview, dyad)**

I: Ok and why do you feel that your food is healthy?

G: It has a lot of red meat

P3: red meat (.) steak

I: do you feel that red meat is a healthy, it's healthy to eat red meat?

P3: yeah

I: Ok and why do you feel that that is healthy?

P3: so sometimes when you're cooking a little bit we get a lot of iron that's why healthy

P2: yes you get a lot of iron (.) when I was pregnant the doctor told me
(Somali focus group, women2)

English food

As mentioned above the Caribbean women claimed to eat a mix of English and Jamaican food – and this was largely put down to time constraints and the increased cost of Jamaican foods. This is also an indication of how long the Caribbean community has been established in Bristol. The women reflected that Jamaican foodstuffs were not widely available in the UK

when they first arrived, and that they therefore had to learn to eat English food. Many participants cooked English food because their children preferred it, however, nearly all spoke about English food being bland and tasteless and not spicy enough (one participant routinely resorted to spicing up her bacon and sausages with Tabasco sauce). Taste is a very important factor in the food preferences and choices of BME groups and this is unpacked in more detail later on. For some participants chips were the only English food they enjoyed, while Somali participants stated that English foods were unfamiliar to them:

- I: Why don't you like English food?
P7: I already, I ... no like English food. I sometimes try, but no
G: Is it, you haven't got the taste for it?
P6: No spicy
G: Different taste, no spices?
P6: No spices.

(South Asian focus group, men)

- P3: Yeah the only English food that I like is chips ... when they put it in a oven, boil it and everything, I don't want it, roast anything. The only way I can eat it is chips, that's it, otherwise I don't want it **(African Caribbean focus group, African women)**

- I: So if you were gonna eat any English food, I don't mean junk food
G: We don't know any English food other than junk food
I: Ok, I mean like Shepherd's Pie or
G: We just don't know it
P3: Mashed potato that's it **(Somali focus group, women2).**

Take-aways, junk food and snacks

This has already been touched on above however there were a few other points of interest to note. African male participants viewed junk food in an interesting way. With the exception of one participant who confessed to eating junk food, most men in the group expressed a dislike for take-aways and fast food, claiming that they would only buy it because their children asked for it, and that they preferred traditional African food. One participant referred to eating junk food as false consciousness:

- I: Do you ever get take-aways?
P2: No. It's only my daughter. My daughter like take-away but we try to discourage her in this
...

- P5: Yeah, I mean I cook for myself, what I do sometimes I cook enough so then I can store half or more of what's left and then I'm not under that pressure because I'm not into take-aways. For me they're a false consciousness so.
- I: When you say that it's false consciousness can you say a bit more about this?
- P5: Yes. Well its, it looks like take-away food is cheap. You go in and it tastes ... like hamburger or whatever ... and you find like you've paid a lot of money for something that in real terms costs about 20p, a lot of the time it's all marketing and, if you do it once it's alright, but if you're doing it every day like the school kids you muck it up and then the return for them is ... obesity and god knows what. So that's enough, that's why I don't.
- P4: Normally you know with the take-aways a couple of hours later you feel you're hungry anyway it's not really good food. It's not really good for the body half of the time **(African Caribbean focus group, African men)**

South Asian and Somali participants spoke about traditional snacks – Somalis often ate Somali biscuits and cakes with their tea and coffee, or a samosa between meals, while South Asians might snack on fried pakoras or samosas.

Drinks

Participants across the groups drank mostly hot beverages during the day, and Somalis had their own versions of tea and coffee (with added ginger and spices). Many participants drank imported juices and squashes bought from local shops. With the exception of those with diabetes nearly all participants took 2 or 3 sugars in teas and coffees. The Caribbean women were less likely to take sugar, and more likely to have semi-skimmed milk and low-sugar squash. Somalis seemed to particularly like sweet drinks, often adding sugar to Ribena. One Somali participant expressed the belief that Coca-Cola aided digestion after a heavy meal:

- I: Okay. Do you have sugar in your tea and coffee?
- P1: Yes
- P2: Yes.
- I: Yes? All of you?
- G: All of you have sugar?
- P3: Yes.
(South Asian focus group, men)

P1: I always buy Coke, buy coke, comes with the shopping all the time (laugh) because that's normal thing to drink when we're at home or when you have food or you know.

P4: Basically, each time I used to have a meal. I like to drink something. I don't know maybe some people they drink even water, but for me I like something tasty with sweet

P1: Yeah when you go to Tesco you buy Ribena, doesn't have sugar but they say it does have sugar but when you come home....oh it doesn't have sugar, you go to add some.

(Somali focus group, men)

P2: I'm not a fan of Fanta or something like that, it's very fizzy. I don't like that but I always drink Coke. If I can grab something that's the only one. Rather than other drinks yes. Or orange juice.

P3: Why would you prefer the Coke? Do you think it's not going to destroy the food?

P2: That's....that's.... that's my...because when you use a big meal like rice and chicken or rice and meat or something it's a happy food. Comes with salad or banana or whatever that comes with it, so drinking coke is my favourite at that time. At that particular meal because it takes down everything, that's my understanding.

I: So you think it helps to digest the meal?

P2: Yes that's my understanding rather than having a normal drink.

(Somali focus group, men)

Salt

Salt, like spice, was one of the ingredients that made a meal tasty across all groups. There was an awareness among many participants that too much salt was unhealthy but this was ignored in favour of flavour and taste:

P4: the thing with most African dishes, most of our dishes is more to do with salt. There's a lot of salt in an African dish, like our Cassava leaf. Every dish we do have to get the salt to taste

(African Caribbean focus group, men)

Children

Among all three BME groups children played an extremely important role in determining the kinds of foods cooked and eaten (including having to cook two kinds of meals if children preferred English food, or mothers eating two main meals if they wanted to sit down to a meal with their children and husbands). All participants gave their children packed lunches for school, usually whatever children requested as well as fruit and perhaps some crisps or a

chocolate. One South Asian woman mentioned that she had not known about sandwich fillings at first, and had initially giving her daughter sandwiches containing only margarine. Most of the Somali women gave their children packed lunches with sandwiches, fish fingers or other things they'd asked for, and sometimes gave them money to buy food at school particularly as children became upset when other parents had given their children money to buy things. The role played by children in determining dietary choices is discussed in more detail below.

Cooking

Somali women learn to cook from a very young age (anywhere from 8 – 13yrs), however while some Somali men did help with cooking when necessary, it is not culturally ordained for men to cook in Somalia. Some of the South Asian men did know how to cook, but this wasn't the norm, and many African men helped their wives with cooking, stating that they enjoyed it:

P: Well I personally like cooking. I love cooking, my wife is not at home I will do the cooking, or even if she's at home I will just ask her if I do the cooking. Normally Sundays, Sundays I do my cooking. My daughter like my cooking, like today I have spinach and fish with rice, then this evening I've got goat meat and Yam.

(African Caribbean focus group, African men)

G: And you learnt from mum to cook? Yeah.

P: Yeah my mum and my friends, explaining how to cook, some ladies like my relatives, family friends, they explain me how to cook

I: Is it unusual for men to be able to cook?

P: Yeah. My friends are surprised.

(South Asian interview, dyad)

I: so why don't little boys get taught how to cook

G: uh it's the culture for girls to learn not the boys

P2: in our country it is not respectful men to cook

I: so how do men learn how to cook, from their mothers or their wives?

G: probably from their moms [asks the others] when he's little his mother and sisters do it [cook] when he's a man his wife does it so he doesn't have to learn it. Some boys do it because they don't have any sisters but if they have sisters now they won't ever do any cooking

P3: inside my country no husband is a cook, this country

G: he has to cook

(Somali focus group, women1)

Shopping, planning and budgeting

Participants shopped at a range of shops depending on the items they were buying. Somalis and South Asians did general grocery shopping at Tesco, Sainsbury's or Asda amongst others depending on what was convenient to them. Meat was bought at local Indian or Somali butchers as participants would then be assured it was Halaal. While none of the participants had a food budget – buying what and when they needed to – African and Caribbean participants were more likely to look for a bargain or for the right price. Most of the shopping was done by women who did not make lists except when men were sent out to do the shopping. The Caribbean women did all their own shopping, also shopping at a range of shops but naming more 'budget' shops like Asda, Poundland, Lidl, Morrisons.

P6: I look for more bargain. Like buy one get one free.
(African Caribbean focus group, African women)

P5: That's where the English people succeed when they go for the shopping I see the list we never make a list we pick up everything **(South Asian focus group, women)**

Labels

The most common response to questions about food labels involved checking the expiry date – freshness is a very important factor and is further discussed below. Food labels were also checked in case of allergies, if the product was a first-time purchase, or to make sure that products didn't contain gelatin (pork-derived gelatin is forbidden for Muslims). An argument repeated across all groups was that most meals were cooked from scratch, unlike pre-prepared foods which contained the unhealthy things that labels warned about:

I: Do you look at the labels on food when you buy your food, the labels on the packages?

P1: Yes

P2: Yes

P3: Yeah.

I: Okay and what do you mostly look at? What's the most important thing?

P2: Expiry date.

P3: Yes expiry date ...

I: What about you guys? Do you look at the labels?

P5: No

P6: Freshness.

(South Asian focus group, men)

- I: And do you look at any labels on food?
- P3: Well we are fortunate we haven't got any allergies to anything in the house... People sometimes will say no to some things. We don't have any of those allergies. I just look for what I want.
- (African Caribbean focus group, African women)**

Growing your own food

Caribbean women nearly all grew their own food in allotments or their own gardens (potatoes, tomatoes, cabbage, pumpkin, beans, beetroot, carrots, onions). This partly reflects the different kinds of housing between the groups. Most of the Caribbean women lived in houses, while many Somali participants lived in flats. None of the South Asian or Somali participants grew their own food, but a number of Somali women expressed interest in growing tomatoes, salad leaves, carrots etc. However, like the African women they were also keen to emphasise the difficulties of growing own food:

- I: Yes, yes. Okay. Do any of you grow your own food?
- P4: (laughs). Well not here, my family where I come from in my village, they basically grow what they eat
- P3: And the weather as well, it doesn't really
- P5: Our food doesn't grow here properly in this
- P2: Well when I was married, because I'm separated now so we just, more the wife did, I think ... what did she grow? Things like ... cabbage and lettuce and stuff but as the gentleman was saying, I wasn't really bothered because people, it's a skill. I always found it was getting little return. But you see because you've got to watch the weather and the slugs and it's a whole science (laugh). I said it's too much like hard work you know and it's all based on the seasons so I don't grow anything now.
- (African Caribbean focus group, men)**

- I: Em...and do you....do any of you grow your own food?
- P1: No.
- P2: No. Not in this country. In Africa, yes.
- P3: We do in Africa yeah not here.
- (African Caribbean focus group, African women)**

- P4: don't we need sunlight.
- G: explains to others
- P3: in the summer, worms will spoil the garden.
- P2: it is going to be hard job.
- (Somali focus group, women1)**

Do you/your community eat un/healthily?

In all of the 9 focus groups at least 2 participants were diabetic, several participants stated that they suffered from high blood pressure, some were anemic, and many were vitamin D deficient. In general participants acknowledged the problem areas in their diets – being too high in salt, fat or meat. However, this awareness did not translate into actual behaviour change. Both South Asian and Somali participants commented on not measuring their food quantities or ingredients. Use of salt and palm oil were also commented on as being unhealthy, although it was difficult to actually change this. Interestingly participants spoke about styles of cooking and taste preferences being passed down generationally. African participants spoke about only eating one meal a day as unhealthy. There was an awareness of high incidences of particular illnesses in some communities:

P6: Well I would say that the palm oil which we use a lot of probably has got an effect on our health because of the cholesterol, yeah. And the salt.

G: Yeah, okay.

P6: Because we use a lot of seasonings which are all salt base to flavour our food.

I: Okay.

P5: They're telling us about salt-free diet ... use of olive oil instead of palm oil. But then if I give my Mum olive oil, she'll say you haven't put any palm oil in this food. Cos that's what's we're used to.

P7: Salt is the main issue. I eat a lot of salt just like my father used to, so yeah my food is very salty which I think is going to take an effect in the future, but at the moment when I'm eating it I don't care cos I enjoy it with salt.

(African Caribbean focus group, African women)

P5: mostly we are not very good people at eating. The reason why I'm saying that because sometimes we do stay for the whole day and Africans is all in one meal. Maybe the person's coming work, just eat that one plate of meal for the day and that's it. **(African Caribbean focus group, African women).**

G: we tend to overeat ... we cook in huge quantities, food is always in our fridges. **(South Asian focus group, women)**

P: You never know if what you are eating is healthy unless you measure it. I use a lot of oil and stuff.

I: You think people should measure?

P: If you ask me if it is healthy, I would say of course everything is healthy but if you make me measure it, it could be the opposite. **(Somali interview, triad).**

P3: the most common disease that Somalis are now facing is diabetes. And they're the people, young people or even little babies have diabetes now. That we never had in Somalia so....it was rare even if we had diabetes in Somalia. But here it's common everyone say oh I've got diabetes. You know I've got blood pressure and I've got cholesterol and that comes with this stress. **(Somali focus group, men)**

P: There is an awareness that there is too much salt but they can't seem to associate it with themselves, that this is something they are doing. For example, I shouldn't be eating the samosa, I know it is bad for me but I am still doing it and if someone asks me if I eat healthy, blank, I blank out this. **(South Asian Interview, female).**

Health information in the community – sources and needs (also see Credible Sources)

Participants varied as to what kinds of health information they felt they could access and needed. African and Caribbean participants felt that a lot of information was contradictory or inconsistent and that they needed clarification on what foods were healthy, rather than being continually told what *not* to eat. South Asian women wanted more information on vitamin D, while Somali participants wanted information on diabetes and vitamin D. Most participants said they could access information via their GPs, although preferred sources seemed to be friends/the wider community, the internet, and other media sources (TV, radio, magazines). Interestingly several Caribbean women spoke about learning to help oneself and using one's own discretion rather than relying on GPs. Some participants – in particular the young South Asian men were fatalistic about their health:

P5: I used to live up just up the road from here, Montpelier, they've got this sort of Community thing where they have this little allotment there so what they do is, they go round giving out leaflets telling residents within that area what sort of vegetables are available you know within that month or within the next coming three months, so as well as; not just the list of the vegetables, but as well as just sort of telling you what you get out of those type of ...vegetables, what gains you get from them, eating them at that particular time
(African Caribbean focus group, African men)

I: So if you're going to get any health or diet information where do you get it from?

P3: Go to the doctors

G: You have to go to doctor?

P3: Yes.

P5: Once heart stops then we have to find out something

G: So while the heart is working they couldn't care less
(South Asian focus group, men)

Nearly all participants across groups welcomed the idea of workshops and practical sessions around different aspects of healthy eating (cooking sessions, talks). Timing would be an important issue here – while some sessions could take place during regular community meeting times, school and work-related time constraints would need to be factored in. Several members of the African groups mentioned the importance of teaching children and getting information about healthy eating to the younger generation. While members of the mixed, professional South Asian group clearly placed a great deal of value on published evidence and statistics, other groups also opted for information delivered via DVDs so that individual members could take these home to watch with their families. Somalis and South Asians watched cooking programmes on TV but said that they didn't always understand everything – they were especially interested in programmes such as Come Dine With Me and Ready, Steady, Cook.

P3: Yes, if you want to teach healthy eating you probably get the person into the kitchen or show them a video of how to cook a dish, one or two dish I think that would be fantastic and or if you go like ... the possibility of visiting farms; look at farms. Show how they get there, this is goat and lamb and all that.

(African Caribbean focus group, African men)

P4: My friend has got this boy which is like about four. And they came from school and he had packets of cake which they did from school. They said dad I did this myself and their dad was so proud for the teacher to actually tell him there how to do healthy food **(African Caribbean focus group, African men)**

P5: So if they're getting somebody to be doing the practical stuff as children for them to be aware of their own culture and to be knowledgeable I think it would be quite important **(African Caribbean focus group, African women)**.

Vitamin D

Somali and South Asian participants were aware of vitamin D deficiency (many were vitamin D deficient). Vitamin D deficiency was a very sensitive topic amongst the Somali participants – this is discussed in more detail in the credibility gap section below. African and South Asian men did not have a clear understanding of the role of vitamin D. Most of the African and Caribbean women needed supplements but few took them. Caribbean women had a good understanding of the role of vitamin D, some took supplements, but some were

skeptical about health information. Surprise was expressed in some groups about young people and African people being vitamin D deficient.

P3: Well vitamin D. Well I don't know ... I don't know ... I don't know whether it absorbs, it absorbs the, burns out the fat in our system. I suppose I'm concerned.

P4: I think er ... lack of sun also has an effect your metabolic rate I think because ... and your spirits also get dropped you know ... when there's no sunlight.
(African Caribbean focus group, men)

P6: Yeah I'm actually supposed to be taken a vitamin D tablet every morning and at night 'cos my GP is always banging about low levels of vitamin D. But I hate them, like I getting sweets all the time, so I don't take them, I forget. I only take them when I feel as though, they told me that I would end up catching cold and stuff so if I feel like a sore throat is coming I will eat one (laughs). I've got loads in my cupboard. I never take them for some reason. I know I need it

P7: I think last year, I went to my GP and I had vitamin, lack of vitamin D. So I ask my GP why are you telling an African woman like me I have a lack of vitamin D? (laughs).
(AC focus group, African women).

P6: I mean I'm a teacher and I teach at Secondary School and I was surprised, I know the older generation would have vitamin D deficiency but children and girls 12 and 11 - what's wrong, I've got vitamin D deficiency in my legs my bones. I'm a physical education teacher right, so it was, I couldn't believe it **(South Asian focus group, women)**

P: I am also lacking in vitamin D which I found out last year when I was given this pile of vitamin D and I looked at my GP and I said, are you telling me if I eat this chalk, it is going to improve and she went, maybe a little bit **(African Caribbean interview, female).**

Significant Themes – Attitudes and Beliefs

Duality and the ongoing importance of culture

The importance of traditional food was explicitly and implicitly commented on across the groups. When questioned some participants said that they preferred traditional food because it was 'more tasty' or their 'tongues were used to it' and not because it was culturally important for them to eat traditional food. However the familiarity of traditional food ('it's the way you're brought up') underscored the deeply ingrained nature of the

preference for traditional diets. Other participants more explicitly referred to the traditional food as an important part of their culture that they wanted to impart to their children. Perhaps most telling is one Somali participant's statement that the greatest barrier to adopting other kinds of foods or ways of eating is culture, 'we came here with our culture', which points to the duality of cultures that most BME participants live with:

I: Is it important to you to eat African food or is it just something that you're used to?
P2: I think it's what you're used to, I think there's nothing behind it, it's what we've grown up with and what you're used to so
(African Caribbean focus group, African women).

P2: no we think it's more tasty, I think it's the way that you're brought up
(South Asian focus group, women)

I: do you like traditional food because it tastes better or because is it important to you for other reasons

G: because of the taste, and because we're used to it, our tongues are quite used to the taste

I: ok so it's not because it's part of your culture

G: not really you could eat anything as long as it's Halaal and it's tasty
(Somali focus group, women1)

P6: No, no I was just saying that to me it is important because of when you got kids you want them to actually know our country and culture and foodwise it's not like they have to rely on Burger Kings and KFC's, so we do make it as a point of duty for them to get used to their own food all the time instead of going out and eating outside.
(African Caribbean focus group, African women)

P: My son went to the kitchen and he looked at the pot and he said can I have something else and I said, like what, he said sausages! I said what is the matter with you? Did they have sausages in the village you come out of, you better get used to this food because when you go home you will find no sausages or bacon **(African Caribbean interview, female).**

I: What do you think the biggest em.... barrier is, or the thing that stops you from eating vegetables say or including other things. Or not eating meat for one of your meals maybe?

P3: The barrier is the tradition a culture because everything based on culture. Because we came here, we came with our culture. **(Somali focus group, men).**

This duality was also strikingly expressed in environmental and physiological terms – with some participants expressing the belief that factors such as the climate (of their home countries) and hereditary ways of digesting food continued to play a role in their lives here:

P2: Like Africa we eat a lot of palm oil, with salt...and being like the weather is so hot and also with exercise over there so already the oil is not giving me no ill effect. I don't have no effect on that. I thought I just alright for me, yeah
(African Caribbean focus group, African women)

P5: we have to remember that the diet we have in India which we took was well-balanced for the country we lived in because of what we ate the different form of eating habits there was no cars you walked everywhere and the fact that (.) and the other things it's a hereditary situation you see you will find the people who have come here from generations from India you'll find historically I've found that they live longer even here because they've carried that through here
(South Asian focus group, mixed)

Cooking and eating as shared experience and care – the role of husbands and children

Most of the women across groups spoke about having to cook in a certain way in order to please their husbands and children, in particular cooking meat and English food respectively. A significant theme to emerge in relation to South Asian women was the importance of meeting the culinary demands of both their children and husbands whereby the sharing of meals with these family members equated to love and care:

P4: Yeah I get worried about the salt and all the implication with the sort of food we eat and I've got a husband who's very stubborn (laughs). Very stubborn. He's diabetic and his blood pressure is just on the border line as well, so I try my level best but it's just, he likes his African food so I haven't got a choice, I have to cook it. So I just try my best. When I buy the pre-made meal and stuff like that, you know he will just ignore that. And if I don't cook, when I cook I think it's less expensive. If I don't cook he's gonna cook and he'll finish all the meat from the freezer and put everything in so I try to make sure that there's always his African food, because he cannot do without it. **(African Caribbean focus group, African women)**

G: I used to always have a plate of mine with the children because that's the time you talk to them they used to take their uniforms come down and eat and we used to all sit together, if you wanted to eat something later on with your husband that's different but the first snack we all had you must sit with the children so we had a good time, they eating a fish finger there's no harm in you having a little bit yourself
(South Asian focus group, women).

- G: We are the queens of our kitchen. If we feel like eating chicken every day then we eat chicken and heaven help if your child asks for chicken you dare not refuse the child chicken because your husband will say what, you didn't give the chicken ... we wait for our children to say mom we want milk and we will run down ourselves no matter even how ill we are, we will go and heat the milk, we will do anything for our children **(South Asian focus group, women)**
- P4: my husband comes home about half-past eleven he brings like curry and food from outside which we have and then go to bed, every day seven days a week **(South Asian focus group, women)**.
- P6: before I do like that (.) my husband come in 2 o'clock in the night, finish taxi, bringing the food I eat it **(South Asian focus group, women)**.
- P2: sometimes my relatives say you spend most of your time in the kitchen, I said but this is my job because I love to entertain my children this is my entertainment because I love cooking, I give my children every day I don't buy frozen lasagna frozen shepherd's pie I buy everything and I make from home **(South Asian focus group, women)**.

Eating and knowing as distinction

Socioeconomic status played an important role in the kinds work held by participants, and this in turn impacted on the kinds of eating patterns adopted across the groups – whether this involved shift workers eating junk food, or South Asian women waiting up to eat with their husbands. The mixed gender, professional South Asian group took great care to show me how aware they were about different aspects of healthy eating (for example not eating ghee, using rapeseed rather than olive oil, removing the skin from chickens or the fat from meat etc.) There was a lot of talk about the unhealthy eating patterns of uneducated 'others' – uneducated Asians or Muslims or 'the Easton crowd'. However, this group also resorted to equally unhealthy measures such as skipping meals to make up for indulging in unhealthy snacks, or eating a restricted range of foodstuffs (e.g. only eating peas or drinking juice during the day). These participants placed a great deal of value on published evidence and statistics and read widely – this knowledge worked as a class signifier, distinguishing participants from other classes. However, they were just as likely to use this knowledge as a way of justifying complacency or hostility towards some ideas about healthy eating:

- P7: anything half-past eleven, twelve, maybe half-twelve but if I have breakfast then I don't have lunch you know
- I: ok you like to have one meal in the day
- P7: that's it **(South Asian focus group, mixed)**.
- P6: first of all one example doesn't make evidence, two you had a choice you could have eaten the pakoras and the samosas and missed a meal later, you did not do that. The point I'm trying to make is we can eat whatever we want as long as it's in moderation and is replacing something else **(South Asian focus group, mixed)**
- P5: one roti is equivalent to about eight slices of bread and what people don't realise one samosa is equivalent to almost a meal in calories
- P4: but we don't eat samosas every day do we?
- G: no no we he is saying is, remember there's a different class here today, you know amongst the mus- amongst the Easton crowd every evening with their tea its pakora and samosas
- P4: seriously
- P5: yes we have seen it
- G: yes you know their tea cannot be served without pakoras the Easton crowd **(South Asian focus group, mixed)**
- G: A lot of educated Asians know these things; we are trying to say how we get what you know to the people living in Easton, people living in St Paul's, who do not cook like you. See, you are among the very few Asians who know what is right what is wrong **(South Asian focus group, mixed)**

Credibility Gap

The credibility of health information sources was a very strong theme across all groups. Participants felt they received a lot of conflicting information from different sources and didn't know who to believe; they were appealed to negatively by only being told what was unhealthy rather than what was good for them to eat; they felt skeptical about the role of some health care professionals who 'had to have a job', who didn't understand their food or culture, and who came across as uncaring, uninterested and, sometimes, as hostile. The latter point was particularly expressed by Somali participants in relation to being diagnosed as vitamin D deficient. Many Somalis felt that their GPs did not listen to their complaints and that they were simply fobbed off with a diagnosis of vitamin D deficiency on account of being Somali, or on account of being black.

- P3: I read about carrots, that carrot was good for eyesight and now it's no longer good. So you don't know what to believe anymore to be honest.
(African Caribbean focus group, African women)
- P4: Well when some people say don't eat this it is bad for you and that is bad for you and nobody says what is good for you. **(African Caribbean focus group, African women)**
- P4: Dieticians?
- P6: Yeah, what they do? They got to keep themselves in a job right? ... This year they say maybe water is bad for you. Sugar or whatever is bad for you, innit? Okay, next year they say oh no, it's alright. So it's up to you to know what to eat and know what suits you or what you feel good after. It's your own common sense.
(African Caribbean focus group, Caribbean women)
- P4: I had a few problems and I was referred to a dietician in the NHS and I've been to two three of them (.) the point is when we try to explain to them what we are eating they can't comprehend which is fair enough because they can't understand what (.) if I say something in Indian they won't understand if I try to explain it's very difficult
(South Asian focus group, mixed).
- G: And you know when you go to the GP they always you know, if you say I've got kidney problems, I've got back problem, I've got headache, I've got this...they always say oh is that vitamin D ... What about someone who born and raised in this country who's just wearing jeans and t-shirt as other girls in this country, but is still when she go to the doctors says oh no, you know got a vitamin D and she says 'hello, I've been born and raised in this country, I never seen Africa what are you talking about'? Maybe it comes with the genes? **(Somali focus group, men)**

In the light of this perceived inconsistency some opted to take herbal remedies that they heard about on television:

- G: Asians believe a lot in herbal remedies and I tell you they work (.) if you have sickness and vomiting we don't take these English medicines
(South Asian focus group, women).

Healthy food is fresh, well-cooked food

All the groups mentioned the importance of looking at the expiry dates on labels. Freshness was the most important factor in deciding whether food was healthy or not. There was a great deal of fear among South Asian women about bacteria in food and food poisoning. Somali and African women spoke about food being well cooked – seeing underdone meat as harmful and repellent:

- G: if our rice gets warm and you eat warm rice you can get more bad poisoning than even salmonella poisoning **(South Asian focus group, women)**.
- P4: haven't you seen it when they (English People) make for themselves they have not well cooked the steak
- P3: when I saw the meat steak I vomited and I was shocked
(Somali focus group, women1)
- P4: To me it's important for me because really Africans will prepare our food it's well cooked and that's mostly for me. I eat African food because sometimes some of the English foods it's not well cooked. Even if you go to the restaurants, I always have to tell them I want it well-cooked. They won't do, sometimes it's not well-cooked.
- I: Well-cooked in what way?
- P5: Yeah [unclear but makes a reference to diarrhea]
(African Caribbean focus group, African women)
- I: do you ever look at the labels on the food packages before you buy them
- P5: yes the expiry
- I: ok, do you ever worry about all those other things that they put on there like fat and cholesterol and salt and
- G: not really we don't look at that
- P4: just the date, that's it
- G: and specific, sometimes when it comes to meat and stuff I like it to be the certain kind of meat that I want not expired because it gives you a tummy upset and I hate upset tummies
(Somali focus group, women1)
- P4: Because the meat that we used to use in Somalia is different from what we've got now because the one maybe killed the lamb or the goat months ago, weeks ago, you never know. You go into the butcher, you say I need lamb, and you go to the fridge and he getting you something. You going to take it, you going to put it in the fridge again. You don't know how long it going to last. You don't know what's coming out of it. So that's the main problem. But when we were in Somalia. Every morning you got to have fresh meat been killed this morning. Not even yesterday. Killed this morning that was fresh meat **(Somali focus group, men)**.

Recommendations

The following recommendations are based on barriers and potential motivators for dietary behaviour change identified in the data, as such they are written with the project aim to determine the most effective approach for reaching target audiences in mind. As is evident from the participant's talk sensory taste and cultural tastes are psychologically bound up with each other and it is unlikely that any approach or intervention would result in BME individuals simply swapping one taste for another (i.e. eating different or English food, or eating radically altered versions of traditional food). Although most participants did not heavily consume junk food, it is also unlikely that they would stop eating junk food altogether. However, several key themes in the data point to ways in which BME individuals might be persuaded to eat *healthier versions* of traditional diets. The recommendations set out a range of practical, social and engaging strategies to be undertaken within and between BME communities, and which involve members of the health promotions field or other health care professionals. As the majority of the participants expressed the desire for practical sessions or demonstrations the steps outlined below involve a number of different kinds of cooking sessions and events, as well as sessions on growing food at home. We suggest that in order for sessions to be effective they must be **framed with an emphasis on the positive aspects of traditional food** including:

- Celebrating traditional food as one important element in what makes a particular culture distinctive
- Acknowledging the pleasures of traditional food
- Emphasising the social and shared nature of traditional food
- Identify or 'brand' traditional food as food that is healthy, fresh and safe – and traditional diets as diets that can act as ambassadors for healthier ways of eating for everyone.

1. **Projects/plans to be co-created by communities and gatekeepers:**

Bristol NHS can build upon the existing relationships established with community organizations and gatekeepers during this research. Adopted strategies and approaches can be brought to gatekeepers or other identified individuals who will act as brokers and introduce the aims and objectives to community members.

Feeding the results of this research back to the community groups might be one way of keeping these communication channels open and paving the way to future collaboration. Given participants' fears that they/their cultures are not understood by some sectors of the health care system, new projects (such as any outlined below) should involve an element of co-creation by community members including a dialogue about the kinds of foods and techniques that will be involved and what will work best.

2. Develop projects that have longevity/are owned by the community/ies

Some of the research participants had experienced a practical (cooking or other) session as part of the events put on by their community organizations. However, while these were seen to be enjoyable and informative, their impact was short-lived. Practical sessions, demonstrations and workshops, such as cooking classes, competitions and food growing demonstrations, should be jointly managed and 'owned' by the communities themselves at the end of the project, should they wish to continue them.

3. Mirror preferred formats with different cooking events

Television and cooking programming were popular across the groups. A series of cooking events could be held within (and later, perhaps, between) different communities based on popular formats – programs mentioned by participants were Ready, Steady, Cook and Come Dine with Me. Sessions would be framed at the outset by a healthy eating theme (in terms of measuring quantities, using less salt or fat etc.) whilst also allowing participants to demonstrate their cooking skills and showcase their dishes. Starting with members of particular community organizations, these sessions could also be expanded beyond the immediate community, with members of different BME groups coming together for a series of meals to demonstrate the skills and pleasures associated with their cooking and food.

4. Make men Kings in their Kitchens

Many women spoke about the difficulties of having to cook in a particular way for their husbands. While some men were able to cook, the bulk of cooking was done by women. South Asian women spoke about being the 'queens of their kitchens' – a series of cookery classes involving men learning how to cook from each other, again with a healthy eating agenda – would be a good way of a) teaching young South Asian and Somali men how to cook and b) encouraging men to think about and potentially influence what goes into the food that they.

5. Children

Given how important children are within the three communities, including the link between food and love or care, BME parents might be persuaded to eat more healthily if that was framed as beneficial for their children. Participants emphasized the importance of children a) learning about their culture, and b) learning about healthy eating, food and nutrition. Cookery classes with children, which combined both these points, would reinforce the sense of pride parents felt in their culture, while children's knowledge of eating healthily could serve to prompt parents to monitor their use of salt, fat, sugar etc.

6. Use the wider community

The three community groups all have a lot to learn from each other. One example might be a trip in which Caribbean women displayed their gardens or allotments to Somali and South Asian women and demonstrated how the women could grow their own produce.

7. Celebrate the end of the project with an intra-community event

The project could culminate with an intra-community event which celebrated different traditional foods. Prizes could be awarded for the tastiest and healthiest dishes prepared on the day (including categories for children and men) or the best freshly grown produce. This would be akin to an Asian mela or festival and could be held at a venue such as The Trinity Centre which is well used by BME groups in the

city. There is a strong festival tradition in Bristol – particularly in terms of the annual St Paul’s Carnival which was mentioned by many participants – and this event could also become part of promoting any project that was adopted.

8. Vitamin D

The data points to a range of issues around vitamin D. While some participants (particularly men) did not have a clear understanding of the role of vitamin D and might therefore benefit from information, other groups had a clear understanding of the role of vitamin D and/or were diagnosed as vitamin D deficient but did not take prescribed supplements. Arguably existing strategies for dealing with vitamin D deficiency (providing information and prescribing supplements) are not wholly successful. We recommend some outreach work with community groups, via gatekeepers, to explore attitudes and beliefs around vitamin D deficiency. Talks and sessions with community groups could go a long way towards bridging perceptions about vitamin as an umbrella category for certain types of people, while highlighting the advantages of taking supplements.

References

- Chowdhury, A. M.; Helman, C. & Greenhalgh, T. (2000). Food beliefs and practices among British Bangladeshis with diabetes: Implications for health education. *Anthropology & Medicine*, 7 (2), 209-226.
- Glanz, K. & Bishop, D.P. (2010). The Role of Behavioural Science Theory in Development and Implementation of Public Health Interventions. *Annual Review of Public Health*, 31: 399 – 418.
- Fairchild, R. M. & Morgan, M. Z. (2007). Delivering multidisciplinary public health in action – the Cardiff Food Strategy case study. *Public Health Nutrition*, 10 (1), 42–48.
- Johnson M.; Seacole M.; & Owen D. (2000). Black and minority ethnic groups in England: the second health and lifestyles survey. *Health Education Authority*, London.
- Kassam-Khamis, T.; Judd, P. A. & Thomas, J. E. (2000). Frequency of consumption and nutrient composition of composite dishes commonly consumed in the UK by South Asian Muslims originating from Bangladesh, Pakistan and East Africa (Ismailis). *Journal of Human Nutrition and Dietetics*, 13, 185-196.
- Kelleher, D. & Islam, S. (1996). How should I live. In D. Kelleher & S. Hillier (eds.) *Researching Cultural Differences in Health*. London: Routledge.
- Landman, J. & Cruickshank, J. K. (2001). A review of ethnicity, health and nutrition-related diseases in relation to migration in the United Kingdom. *Public Health Nutrition*: 4 (2B), 647 – 657
- Lawrence, J. M.; Devlin, E.; Macaskill, S.; Kelly, M.; Chinouya, M. Raats, M. M.; Barton, K. L.; Wrieden W. L.; & Shepherd, R. (2007). Factors that affect the food choices made by girls and young women, from minority ethnic groups, living in the UK. *Journal of Human Nutrition and Dietetics*, 20, 311-319.
- Lovegrove, J. A. (2007). CVD risk in South Asians: the importance of defining adiposity and influence of dietary polyunsaturated fat. *Proceedings of the Nutrition Society*, 66 (2), 286 – 298.
- McMahon, S. (2008). *Joint Strategic Needs Assessment of Health and Wellbeing in Bristol. Baseline Report October 2008. Health and Wellbeing of Special Groups*. Available at: <http://www.bristol.nhs.uk/about-us/understanding-local-needs/strategic-needs-assessment.aspx> (accessed 18 May 2011).
- Maxwell, S. M.; Salah, S. M. & Bunn, J. E. G. (2006). Dietary habits of the Somali population in Liverpool, with respect to foods containing calcium and vitamin D: a cause for concern? *Journal of Human Nutrition and Dietetics*, 19, 125-127.

Mills, J. (2010). Bristol Somali Community Calculator. Consultation, Research and Intelligence. *Bristol City Council*. (<http://www.bristol.gov.uk/ccm/>) (accessed 18 May 2011).

Mytton, J.; Frater, A. P.; Oakley, G.; Murphy, E.; Barber, M.; & Jahfar, S. (2007). Vitamin D deficiency in multicultural primary care: a case series of 299 patients. *British Journal of General Practice*, 57, 577 – 579.

Neighbourhood Partnership Statistical Profile for 2010. Available at: <http://www.bristol.gov.uk/ccm/content/Council-Democracy/Statistics-Census-Information/neighbourhood-partnership-profiles/neighbourhood-partnerships-statistical-profiles-.en> (accessed 18 May 2011).

Olden, A. (1999). Somali Refugees in London: Oral Culture in a Western Information Environment. *Libri* 49, 212–224.

Sellen, D. W. & Tedstone, A. (2000). Nutritional Needs of Refugee Children in the UK. *Journal of the Royal Society of Medicine*, 93, 360-364

Smith, D.G.; Chaturvedi, N.; Harding, S.; Nazroo, J.; & Williams, R. (2000). Ethnic inequalities in health: a review of UK epidemiological evidence. *Critical Public Health*, 10 (4), 377-408.

Stockley, L. (2009). *Review of Dietary Intervention Models for Black and Minority Ethnic Groups. Prepared for the Food Standards Agency Wales*. Lynn Stockley & Associates, Food and Nutrition Consultancy. Available at <http://www.food.gov.uk/multimedia/pdfs/reviewdietethnic1may09.pdf> (accessed 18 May 2011).

White, H. (2010). The importance of culturally specific services. School for Policy Studies, University of Bristol, Bristol, UK. Available at: <http://www.social-policy.org.uk/lincoln/White.pdf> (accessed 18 May 2011).

Willig, C. (2008). *Introducing Qualitative Research in Psychology: Adventures in Theory and Method*. Maidenhead: Open University Press.

Wyke, S. & Landman, J. (1997). Healthy eating? Diet and cuisine amongst Scottish South Asian people. *British Food Journal* 99 (1), 27–34.

Appendix

Focus Groups and Interview Schedule

1. Food Choice

- What do you eat on a typical day?
- What do you drink on a typical day?
- How much of the food you eat is part of a traditional diet and how much of it is part of a Western diet?
- Is it important to eat traditional foods?
- Would you consider buying different kinds of foods?
- Do you look at the labels on food packages before you buy them?
- Do you understand any of the information on these labels?

2. Attitudes and Beliefs regarding food & health

- What does the word 'diet' mean to you?
- What effect does food and diet have on health?
- What do you think the links are between diet and health conditions such as diabetes, stroke, cholesterol etc?
- What do you know about Vitamin D? prompt: diet, where does it come from?)
- Where do you get your health and diet information from?

3. Access to and Availability of food

- Is cost an important factor in deciding what kinds of food you buy?
- What kinds of shops do you buy food from?
- Why do you use these shops for your food shopping?
- How often do you buy food?
- Do you grow any of your own foods? Would you if you could?

4. Food Preparation and Cooking

- When you cook at home, do you grill, bake or fry your food?
- What are the main ingredients that you use in preparing and cooking your meals

5. Attitudes to/choice of potential interventions

- Do you think there is a need for more knowledge about healthy eating in your community?
- What kinds of areas would you like to know more about?
- How do you want this information presented to you? [leaflets, verbally, practically?]
- What language would you like this information presented in?