South Asians face several barriers when it comes to promoting cardiovascular lifestyle changes

Among all ethnic groups, South Asians (people from India, Pakistan, Bangladesh, or Sri Lanka) have the highest rates of cardiovascular disease. This group faces a number of barriers to adopting lifestyle behavioral change to reduce their risk of cardiovascular disease, according to a new study. These barriers result from several beliefs South Asians hold regarding body image, cultural identity, and gender roles, among others.

Researchers conducted a literature review to identify 24 studies that addressed the relationship between the South Asian belief system and how this group approaches modifying lifestyle habits. Six categories of beliefs were identified that promote barriers to lifestyle changes: gender roles, body image, physical activity misconceptions, cultural priorities, cultural identity, and explanatory model of disease.

In the case of gender roles, the female is responsible for food preparation and raising children. However, the male or the eldest woman in the household exert influence over dietary decisions and are resistant to dietary modification. In certain communities, exercising is seen as taking time out for oneself as opposed to tending to the family’s needs, and is thus viewed as inappropriate for women. With so many responsibilities, South Asian women find it difficult to make time to exercise. Also, in this culture, a larger body size is associated with sound health, affecting motivation to participate in healthy lifestyle behaviors.

Traditionally, South Asian culture has not placed much emphasis on physical activity as many South Asians have not been brought up to exercise. This unfamiliarity has led to a misunderstanding of the physical effects of exercise (such as increased heart rate and shortness of breath) and are viewed as alarming rather than expected. There are also societal pressures that time outside of work should be spent helping or caring for relatives and children and not in leisure activities such as exercising, even for men. Food is also central to South Asians’ identity. There is a cultural reluctance to reduce the butter and milk content of foods, particularly in social gatherings, as these ingredients are seen as nurturing.

Finally, under the explanatory model of disease, South Asians believe that acquiring diseases is not under one’s own control. Many South Asians develop disease due to factors one has little control over such as psychological stress, adjusting to life in a new country, and lack of food options, as opposed to one’s own dietary and exercise habits. The study authors suggest that clinicians become aware of these barriers and employ culturally relevant interventions to promote healthy lifestyle changes in this group. The study was supported in part by AHRQ (T32 HS00066).