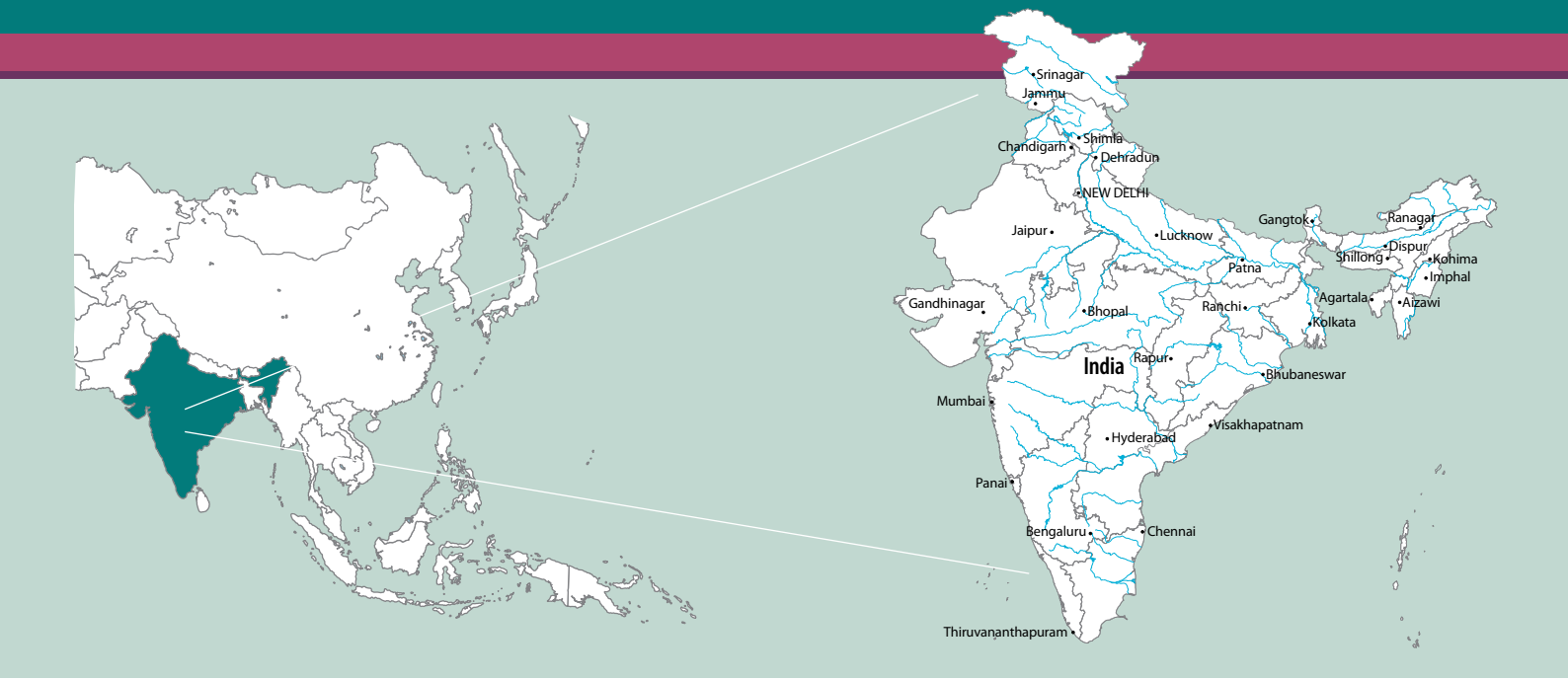
Indian food and cultural profile: dietetic consultation guide



This resource is a guide for dietitian/nutritionists to provide culturally appropriate and effective services to Indian community members. It follows the ADIME format and provides information about the food and food practices of people from the Republic of India who have settled in Brisbane (Australia).

The profile follows the chronological steps in individual case management.

These include:

1. ***Booking a client appointment***
2. ***Preparation for the consultation***
3. ***Assessment***
4. ***Diagnosis***
5. ***Intervention***
6. ***Monitoring and evaluation***

1. Booking a client appointment

Key considerations

- Ask if a Hindi-speaking interpreter is required. This is unlikely but may be more commonly required for people coming from Northern India.
- Finding out the religion of the client and the region of India from which they originate would be helpful in preparing for the appointment.
- As young adults often live with their family until they are married and often do not shop for or cook food, it would be useful to tell the client that their mother (or any other person in charge of the shopping and cooking at home) is welcome to attend the appointment. For the same reason, men should be invited to bring their wives.

2. Preparation for the consultation

Working with an interpreter

It is important that a trained and registered interpreter be used when required. The use of children, other family members or friends is not advisable. Health services must consider the potential legal consequences of adverse outcomes when using unaccredited people to 'interpret' if an accredited interpreter is available.

If you have limited experience working with an interpreter, it is recommended that you improve these skills prior to the appointment. There are many online orientation courses available, and Queensland Health has produced guidelines for working with interpreters, which can be accessed here.

Traditional greetings and etiquette

- It is generally more appropriate to greet clients in English.
- Ask permission before using a client's first name.
- Don't shake hands with women, especially if you are a man.
- Stand to welcome older clients as a sign of respect.
- Be friendly and smile throughout the interview.
- At the outset of the appointment, tell clients what the consultation is for and why the information they provide needs to be accurate so that the advice they are provided can be an effective part of their treatment.
- If you are on a home visit and are offered food, it is polite to eat it.

Background

Ethnicity	The Indian community is mostly Indo-Aryan and Dravidian in origin. Cultural practices vary in India with geographical region and religion. India can be broadly divided into four major regions (North, South, East and West), each with its own distinctive language, customs and food practices.
Religion	Hinduism is the predominant religion practiced in India (80%), followed by Islam (13.4%), Christianity (2.3%), Sikhism (1.9%), Buddhism (0.8%) and Jainism (0.4%).[1] The followers of these religions observe different dietary laws for fasting and feasting.
Language	Over 400 official languages have been recorded in India[2], but 41% of the population speaks Hindi[3] (the official language in government documents), while English is the secondary official language. Most states have their own language, e.g. Tamil, Bengali, Malayalam and Telegu.
Migration history	Indian migrants, as well as migrating from India, also migrate from Pakistan, Bangladesh and Sri Lanka. There are large Indian communities in Fiji, Malaysia, Singapore and the United Kingdom. Migration often separates family members. In the past, older parents were sponsored to join their children in migrating to Australia; however, recent changes to migration laws have made this practice prohibitively expensive.
Gender roles	Both marriage partners are expected to work; however, in the home women are responsible for a number of household duties.
Household size	The size of households in India varies from three to five and may include extended family.[4] In Australia in 2011, 78% of Indian migrants lived in households of two to four persons, with very few living in households of six of more persons (4%).[5]
Population in Australia	All states and territories are home to the Indian-born population in Australia. The largest numbers live in New South Wales and Victoria. There are approximately 30,300 Indian-born people in Queensland, with largest numbers in the greater Brisbane area.[6]

Health profile in Australia

Life expectancy	In Australia, the Indian-born population has higher rates of mortality and hospitalisation from diabetes and related complications.[7] This is partly due to changes in food habits associated with migration and a more sedentary lifestyle.
New arrivals	• Most migrants from India are healthy on arrival. It is important to stress the susceptibility to central obesity and the need to maintain a healthy weight. • Vitamin D deficiency may be an issue because traditionally Indian women avoid the sun, use umbrellas for shade and wear clothes that cover most of the body. This is done for socio-cultural and religious purposes.[8] • Iron-deficiency anaemia is endemic for children, female adolescents and pregnant women in India. Poverty and strict vegetarianism, defined as a diet without any meat, fish or eggs, as well as minimal and inconsistent iron fortification of foods in India, are considered major causes.[9]

This information is to be used as a guide and is not intended to describe all members of the community. There will be cultural differences between people belonging to different regions, religions and social groups, as well as between individuals within any culture.

Health profile in Australia – *continued*

Chronic disease	Some of the important health problems faced by Indian immigrants include chronic diseases such as diabetes, hypertension, cardiovascular disease and complications arising from any of these conditions. There is evidence from countries with a long history of migration from India (the UK, US and Canada) that the prevalence of type 2 diabetes and heart disease is much higher among South Asians (including Indians) than the general population.[10-14] This could partly be due to childhood malnutrition as well as genetic risk factors.[15] Other studies have shown that this risk continues over generations.[16]
Oral health	Alert new arrivals of the need for regular checkups. In general, preventative health is not seen as a priority in India, so people tend to wait until they have an issue before seeing a dentist.
Social determinants of health and other influences	Indian migrants have entered Australia via a number of different non-humanitarian schemes. Government policies have encouraged many people to move to Australia from lower socio-economic backgrounds to receive training and subsequent employment in specific employment areas (e.g. aged care, cooking and hairdressing). This is not applicable to all migrants. There is a high proportion of highly qualified Indian migrants living in Australia. Most families place a high value on education, resulting in upward social mobility in Australia.

Traditional food and food practices

Traditional food choices usually depend on regional preferences. About 30% of Indians are vegetarian.[9]

- ***North:*** Punjabi cuisine typically represents foods of all the states north and west of Maharashtra. This is the most popular food in restaurants and is synonymous with Indian food globally: predominantly wheat-based breads (*roti* and *naan*), basmati rice for special *pulaos* (rice-based dishes that include vegetables and/or meat), and legumes such as chickpeas and kidney beans. Dairy products such as *paneer* and yoghurt, butter and ghee are used extensively.
- ***South:*** This is primarily a rice-eating region. A variety of *dhals* (thick soup made from lentils or other legumes) and vegetables are popular. Both rice and *dhals* are served in a number of ways: pounded, ground, fermented, boiled and steamed. Coconut is used in cooking. Dairy is mainly in the form of plain, unsweetened yoghurt.

Common aspects

- Chicken and goat meat are popular all over India, depending on affordability. Beef is consumed only by Christians and Muslims, and pork by Christians only. Meat is not usually eaten every day of the week. Fish is popular in coastal areas.
- Fruits are usually consumed fresh.
- Desserts made from milk, sugar, rice or *dhals*, using ghee, nuts and spices such as cardamom, are common only on special occasions.
- Ghee may be served with rice as a flavour enhancer. Sesame, peanut and other vegetable oils are generally used in cooking. Pickles and pappadams (crispy wafers) are often used as accompaniments.
- Water is served with meals. 'Milky' coffee and tea with sugar are also consumed.
- Spices used include coriander seeds, *asafoetida*, cumin seeds, fenugreek, ginger, pepper, chilli, garlic, turmeric, saffron and cardamom.

Religion and religious festivals in all groups in India play a major role in food avoidances or inclusions.

Traditional meals and snacks

Breakfast	Cereal, toast, rice-based traditional dishes, *roti* and juice are consumed for breakfast.
Main and other meals	Rice or *roti* (dry, pan-fried flat bread) with *dhals*, chicken or fish curry (or vegetarian meals for some communities) are eaten most days.
Fruit and vegetables	Vegetables include *okra*, a variety of gourds, eggplant, snake beans, various leaves (similar to spinach), chocos, tapioca/cassava, drumsticks (long beans and leaves from a tree grown in the South of India), green adzuki beans in the pod and herbs (e.g. curry leaves). A comprehensive list of vegetables can be found **here**. Fruits include mangoes, tamarinds, bananas, papayas, sapodillas and imported temperate fruits such as apples and grapes.

Traditional meals and snacks – continued

Snacks

In India, people are likely to have a savoury fried snack, such as a *samosa*, with a hot drink. Peanuts, cashews and corn chips are also popular. Other common snacks are listed below:

Chips	Banana, tapioca, jackfruit and potato (thin slices, deep fried)
Sev, Chewda, Bhujia	All deep-fried snacks (chickpea flour base with spices; different shapes and thicknesses)
Murukku	Deep-fried savoury snack made from rice, lentils and spices
Vada	Deep-fried savoury snack made from lentils and spices
Mixture	Deep-fried chickpea flour with nuts
Samosas	Deep-fried pastry filled with potatoes, or other vegetables or meat
Bonda	Deep-fried potatoes in chickpea batter
Pakoda	Deep-fried onions or cashew nuts with chickpea batter

Takeaways

These are uncommon. Families occasionally eat out at fast food outlets, usually catering to children's requests, or at Indian restaurants.

Beverages

Water, coffee, tea and juice.

Celebration foods and religious food practices

Cakes and sweets are generally not eaten regularly. When eaten, they are usually purchased unless made at home especially for a festival. Many sweets are milk/milk powder based. For an exhaustive list with pictures and ingredients, click here.

Practices vary according to region and occasion. *Biryani* (made from meat or vegetables and rice) is a popular festive food eaten by all. Most Hindus will avoid any non-vegetarian food at festivals. Meat and fish are also avoided on certain days of the week as part of religious observances.

Fasting is important to almost all religious traditions. For Hindus, there are differences in how often this is practiced by individuals and how fasting is defined (e.g. it may just entail avoiding solid foods). In the Hindu tradition, people choose to fast as part of their worship of many different deities for various purposes, e.g. for married people to ensure a happy married life, and for unmarried girls to find an ideal husband.

Common traditional foods

Indian breads

Roti/chapatti, made from whole wheat flour (*atta*) and water

Roti are cooked on a dry griddle. They are commonly eaten at breakfast and main meals. Wheat flour is often purchased in 5 or 10 kg bags.

Puri, made from wheat flour, water, ghee and oil

Puri are deep fried and served with potato *masala* (curry made with potatoes) or *chole* (chickpea curry) and/or chutney.

Common traditional foods – continued

Paratha, made from whole wheat flour (*atta*), oil, butter/oil for frying and salt		*Paratha* are made from layers of dough brushed with ghee or cooking oil and cooked on a griddle.
Dosa, made from rice, lentils, salt and a small amount of oil		*Dosa* is crepe-like bread that is dry fried and served with a variety of items (curry, *dhal*, chutney, etc.)
Naan, made from white flour, yeast, milk, egg, yoghurt, oil and salt		Dough is baked onto the side of a hot, dome-shaped clay oven referred to as a *tandoor*.

Indian rices

		Rice types vary greatly in their glycaemic indices and amounts of fibre; e.g. red rice is eaten by people from Southern India and is higher in fibre and protein than white rice. In Australia, basmati rice is used quite extensively. Jasmine rice is seldom consumed. Rice is often purchased in bulk from specialty Indian food stores.

Food habits in Australia

Food practices	**Meal patterns:** Three meals a day are eaten, with lunch and dinner being similar in composition. **Eating style:** Food is usually eaten with the fingers of the right hand; cutlery is rarely used except to serve food. Stainless steel plates and tumblers may be used. In traditional households, elderly family members and men are served before the rest of the family. In more modern households, the family eats together.
Adaptations to diet in Australia	**Substitute foods:** New Indian migrants may be reluctant to adopt new vegetables. Many grow their own traditional vegetables and fruit in Australia. Because of the wide range of Indian products (including frozen Indian meals) now available in Australia, there is no need to substitute traditional food items. Previous migrants relied on basmati rice as a staple, but now other traditional rice types are being purchased, including red rice. This is a type of wholegrain rice with a low GI, which takes longer to cook than basmati rice. **Additions to diet:** Young people may consume convenience breakfast foods such as cereal, sandwiches for lunch, chicken nuggets and other convenience (frozen, ready-to-bake) food on occasion. Meat, especially chicken, is eaten more frequently, and often people eat larger serve sizes in Australia than in India. Processed meats such as ham and sausages are also eaten. Barbecuing is popular. Men may drink beer and/or spirits. Women may drink sweet white wine. **Other changes:** People are not likely to snack between meals, but if they do, they tend to prefer savoury snacks.
Cooking methods	Most of the cooking is done on the stovetop by steaming, boiling, sautéing, braising, or frying. Ovens are used less frequently.

Food habits in Australia – *continued*

Shopping/meal preparation	Shopping is usually a shared responsibility, with men and women each purchasing different items. Fish and meat are usually purchased by men, because butchers and fishmongers tend very often to be men in many parts of India. Women tend to do most of the cooking. Daughters are generally taught to cook when they are young.
Food in pregnancy	In India, pregnant women observe dietary restrictions and taboos, including the avoidance of certain foods that may be termed 'hot' and 'cold', either in the belief that miscarriages can be avoided or the perception that these foods may be good or bad for mother and/or baby. For example, pawpaw is thought to cause miscarriages. Some women believe that excessive eating during pregnancy may result in a large foetus and difficult labour. In Australia, women rely on medical information provided by the mainstream health system but also may be influenced by traditional advice from relatives, especially their mothers. Traditionally, there are a large number of foods eaten or avoided post partum.[15] More information on traditional health-related beliefs and nutrition practices relating to pregnancy and childbirth can be found here.
Breastfeeding and first foods	**Breastfeeding:** In India, 46.4% of all babies are exclusively breastfed from birth to 6 months and may be breastfed for over 2 years.[17] Traditionally, breastfeeding is initiated when the colostrum is fully expressed, and infants may be given other fluids (including honey) prelactation.[18] **Complementary foods:** The majority of infants are given complementary foods within the first six months.[18] More information on infant care and feeding can be found here.

During the consultation

3. Assessment

Key considerations

- **Anthropometry:** Female clients may be uncomfortable with a male practitioner taking measurements that involve body contact; however, this is not a concern for female clinicians when measuring either male or female clients.
- **Meal patterns:** Three meals per day. Traditionally, breakfast is an important meal, though that is changing now with more modern lifestyles. Lunch or dinner is the main meal, depending on the household composition. For working families, dinner tends to be the biggest meal of the day.
- **Snacks:** People may not admit to eating snacks between meals.

When taking a diet history, be sure to check the following:

Prompt	Why?
☐ Region of origin, i.e. coastal or inland	India can be broadly divided into four major regions: North, South, East and West, each with its own distinctive language, customs and food practices. This may impact dietary habits, especially seafood vs meat consumption.
☐ Religion	The followers of different religions observe different dietary laws and codes for fasting and feasting, and these influence their eating patterns. Vegetarianism is common for Hindus.
☐ Fasting	Fasting can influence overall oral intake. Check the frequency, duration and how fasting is defined by the individual.

Prompt	Why?
☐ Accurate portion sizes (especially for rice)	Large quantities of rice or Indian breads may be consumed at each meal.
☐ Type of rice	Rice types vary greatly in their glycaemic indices and in their amounts of fibre, micronutrients and protein.
☐ Amount of milk and sugar in tea and coffee	Clients may consume large amounts of very milky, sweet tea and coffee.
☐ Amount of fat used for frying foods	Amounts of oil in cooking can be excessive, with bulk vegetable oil purchased at Indian food stores. Check the use of ghee and butter; however, because of their expense, use may be minimal.
☐ Amount of salt added in cooking and at the table	Consumption may be especially high, especially for older people.
☐ Intake of food sources of vitamin D for women	This is due to limited skin exposure to the sun.
☐ If takeaways are consumed and how often	For older people, takeaway consumption is likely to be low; however, younger people eat considerable amounts of fast food.

4. Diagnosis

The following examples may be used as a guide for common PESS* statements. 'Problems' are taken from the *Nutritional Diagnosis Terminology eNCPT 2014*, which is available free in the members' section of the Dietitians Association of Australia website.

	Examples of common Problems (P) for PESS* statements	Common (A)Etiologies (E) for PESS* statements
Overweight and obesity	• Excessive energy intake (NI-1.3) • Excessive oral intake (NI-2.2) • Excessive fat intake (NI-5.6.2) • Unintended weight gain (NC-3.4) • Overweight/obesity (NC-3.3)	• High use of vegetable oil in cooking, traditional cakes and sweets, and some traditional breads (e.g. *paratha* and *puri*) (NI-5.6.2) • Consumption of large portion sizes of high carbohydrate foods (e.g. rice and Indian breads) (NI-5.8.2) • Large amounts of high GI rice consumed (NI-5.8.3) • Fasting (e.g. for inconsistent carbohydrate intake) (NI-5.8.4) • Unfamiliarity with purchasing, preparing or eating fish (for Northern Indians) (NI-5.6.3) • Preference for highly seasoned foods and large amounts of salt added during cooking and at the table (NI-5.10.2) • High oral vitamin D requirements due to low exposure to sunlight (NI-5.9.1) • Traditional vegetarian diet with low intake of high iron foods and no supplementation (NI-5.10.1) • Short duration of stay in Australia and unfamiliarity with government-generated dietary guidelines and health promotion campaigns (NB-1.1)
Type 2 diabetes	• Inconsistent carbohydrate intake (NI-5.8.4) • Excessive carbohydrate intake (NI-5.8.2) • Intake of types of carbohydrate inconsistent with needs (specify e.g. low consumption of low-GI rices) (NI-5.8.3)	
Cardiovascular disease	• Excessive fat intake (NI-5.6.2) • Intake of types of fat inconsistent with needs (specify e.g. omega 3 fatty acids) (NI-5.6.3) • Excessive mineral intake (sodium) (NI-5.10.2)	

	Examples of common Problems (P) for PESS* statements	Common (A)Etiologies (E) for PESS* statements
General	• Food- and nutrition-related knowledge deficit (NB-1.1) • Inadequate vitamin intake (vitamin D) (NI-5.9.1) • Inadequate mineral intake (iron) (NI-5.10.1) • Impaired ability to prepare foods/meals (NI-2.4)	• For single men living alone, lack of food literacy because traditionally spouse and/or daughter/s are sole preparers of meals (NB-1.1, NI-2.4) • High consumption of takeaway foods for young people (NI-1.3, NI-5.6.2, NI-5.10.2) • Reliance on traditional knowledge and little access to government-generated dietary information or campaigns (NB-1.1) **Note:** It is important to identify the underlying cause/s of eating behaviours.

* PESS: Problem, (A)Etiology, Signs and Symptoms

For the Signs and Symptoms (SS) for PESS statements, use standard clinical measurements. Make sure the Signs and Symptoms relate to the identified Problems and not their (A)Etiologies.

5. Intervention

Nutrition education

Motivating factors for a healthy lifestyle	Older Indian clients may see weight gain as an inevitable consequence of ageing; however, younger people may be very sensitive to being overweight, especially to central obesity. Almost all women are keen to lose weight for aesthetic reasons. Being thrifty is a common value, so dietary advice that is consistent with saving money is more likely to be adopted, e.g. advice to reduce the intake of ghee, which is expensive in Australia, and to eat more legumes, which are inexpensive compared to meat. For parents, motivating factors include being a good role model and avoiding sickness, because they often do not have family or social support in Australia.
Preferred education methods	**Interpretation:** It is uncommon for an interpreter to be necessary, but check with the client about what they would be most comfortable with. **Types of resources:** The need for translated educational materials depends on age and education. Many Indian migrants under 40 years of age rely heavily on the internet for health information. Recipe books are generally not used much, although recipe books that show alternative methods of cooking familiar traditional dishes may be well received. **Counselling style:** Indian clients tend to prefer more prescriptive advice, not a series of options from which to choose. They generally want clinicians to act decisively and take a leadership role in their treatment. Use probing to get more information or to confirm the information provided. Be aware that Indian clients may say yes to questions or proposed diet plans to be polite rather than to agree.
Literacy levels	English and native language literacy levels among Indian Australians are generally high.
Health beliefs	Beliefs are characterised by medical pluralism. Western biomedical practice is widely accepted. Traditional preventive measures, guided by Ayurvedic principles, may be used. Indian families place a high value on considering the needs of others, and are reluctant to seek health care for what they see as minor health issues. For this reason, they may present late for treatment.
Other considerations	Note that access to free health care in Australia may be limited. Skilled non-permanent residents don't have access to Medicare. It is polite to eat food that is offered to visitors. For clients who need to follow a strict diet, this cultural obligation can be avoided by telling their hosts that they are fasting or have a medical problem such as diabetes.

6. Monitoring and evaluation

Methods for monitoring

- Health is assessed in practical terms, so this may be a useful way of measuring change and reinforcing the benefits of continued dietary compliance. Examples include being able to work and appropriately care for one's family.
- Check if the client has access to transport (especially if referring to an outpatient clinic); otherwise phone follow-up may be more appropriate. Some women don't drive outside their local area or use public transport, so this may be an issue in attending appointments.
- If appropriate, confirm the client's preference for having an interpreter present at their next appointment. For short follow-up consultations, phone interpreting services may be more appropriate. Encourage men to bring their wives to attend follow-up appointments so they can prepare appropriate food and support dietary change.
- Be aware that clients may provide positive answers on compliance to be polite. For this reason, explain the purpose of the review and ask probing questions on behavioural changes.

Additional resources

- Indian Foods: AAPI's Guide to Nutrition, Health and Diabetes has been published by the American Association of Physicians of Indian Origin. This includes culturally appropriate nutrition information in English and regional languages. This can be found at http://aapiusa.org/Resources/Resources/ArticleID/97/Indian-Foods-AAPIs-Guide-to-Nutrition-Health-and-Diabetes-2nd-Edition
- Queensland Health's Indian Community Profile can be found at http://www.health.qld.gov.au/multicultural/health_workers/cultdiver_guide.asp
- Queensland Health *Working with Interpreters: Guidelines* (http://www.health.qld.gov.au/multicultural/interpreters/guidelines_int.pdf)
- To find out more about multicultural health, Queensland Health's Multicultural Health page has information for the public and for health workers, including the *Multicultural health framework*. Go to http://www.health.qld.gov.au/multicultural/default.asp

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Please note: The web links in this document were current as at March 2015. Use of search engines is recommended if the page is not found.

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