Understanding health care professionals' barriers and facilitators to supporting the management of food allergy in British South Asian adults: Qualitative results from the FAIR Study

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Background: The burden of food allergy (FA) is greater among South Asian (SA) individuals in high-income countries.
Objective: We sought to investigate facilitators/barriers for health care professionals (HCPs) in FA management in SA patients.
Methods: HCPs involved in the management of SA adults with FA were recruited for online, semistructured interviews. Interviews were analyzed using thematic analysis.
Results: Interviews were conducted with 30 HCPs (46% White, 34% Indian, 7% Pakistani, 10% Sri Lankan, 3% ethnicity not disclosed). Allergists, immunologists, and general practitioners (77%); nurses (13%); dietitians (7%); and 1 pharmacist (3%) were interviewed. Three major themes were generated: (1) cultural and social influences on health—patient reliance on traditional medicine, scepticism toward conventional therapies, and strong family influence in decision making; (2) patient characteristics and behavior—presence of unique allergens in SA diets adding complexity to diagnosis and management; (3) health care communication and support—language barriers, interpreter limitations, and cultural misunderstandings hindering care. Younger patients were regarded as more proactive, whereas older patients relied on family members for translation and decision making. HCPs highlighted a need for multidisciplinary teams, culturally tailored dietary guidance, and training in cultural competency. They felt constrained by limited consultation times and long waiting times.
Conclusion: A multipronged and multidisciplinary strategic approach is needed to address inequalities in FA management among SA patients targeting some key areas including development of culturally tailored multimodality resources for patients and their families, education and training for HCPs in SA cuisine/allergens and cultural competency, and adaptive changes in the health service framework. (J Allergy Clin Immunol Global 2026;5:100613.)

Key words: *British, South Asian, food allergy, disparity, culturally tailored interventions*

Ethnicity-based disparities in allergic conditions, including allergic rhinitis, asthma, atopic dermatitis, and food allergy (FA), have attracted major interest in recent years. Published evidence has highlighted health inequalities and poor clinical outcomes among patients living in high-income countries such as the United Kingdom (UK), the United States, and Australia.[1-4] Studies from the United States and Australia showed a higher risk of FA and food-induced anaphylaxis among immigrant Asian populations.[5,6] A study involving emergency department admissions in Birmingham, UK, showed a higher incident risk of anaphylaxis among British South Asian (SA) patients and that severity of anaphylaxis was greater among girls younger than age 16 years.[7] Beyond the UK, large survey datasets from the United States show that Asian, Black, and Hispanic individuals report lower rates of FA than White individuals, highlighting ethnic disparities that extend across high-income countries.[8]

Ethnicity-based disparities are underpinned by multiple factors, including socioeconomic status, health literacy, cultural and religious factors, beliefs, and human behavior.[1] This is particularly relevant for allergic conditions such as FA and asthma, as clinical outcomes are dependent on patient education, acceptance of medical advice, and implementation of self-management plans including allergen avoidance measures.[9,10] Legumes/pulses commonly consumed in SA cuisines (eg, chickpea/gram flour [besan], lentils/dal, peas) are recognized causes of IgE-mediated reactions among SA individuals. Although population prevalence estimates for nonpriority legumes are generally ≤0.5%, clinical series and UK charity data highlight reactions to lentils, chickpeas and peas, and non–top 14 legume allergies can be underrecognized due to labeling gaps.[11]

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Abbreviations used
FA: Food allergy
HCP: Health care professional
NHS: National Health Service
SA: South Asian
UK: United Kingdom

Spices and seeds integral to SA cooking will be allergenic. Fenugreek (methi) has documented IgE-mediated reactions and cross-reactivity with other legumes (eg, peanut, soy, green bean) in case series. Mustard seed (sarson/rai) is a regulated major allergen in the UK and Europe and has been implicated as a hidden allergen in composite foods.[12,13] Current supportive resources for patients and carers are largely targeted toward patients with proficiency in English and Western-centric diets; they do not factor in cultural, religious, and social elements that are particularly relevant for patients from ethnic minority groups. Furthermore, little is known about the views and perspectives of health care professionals (HCPs) delivering care for ethnic minority groups with FA. The main aim of this study was to explore facilitators and barriers to the management of FA among SA patients from an HCP perspective.

METHODS

Study design

This study used a qualitative design, consisting of in-depth, semistructured interviews to explore HCPs' views and perspectives on resources that would improve the management of FA among SA patients. The study was approved by the Westminster National Health Service (NHS) Research Ethics Committee (reference 23/PR/0830).

Participants and recruitment

HCPs (eg, consultants, allergy/immunology trainees, general practitioners, nurses, dietitians) providing care for SA patients with FA were eligible for participation. HCPs were recruited via professional networks and organizations (eg, British Society for Allergy and Clinical Immunology, West Midlands Allergy and Immunology network, Travellers Immunology Group). HCPs who responded to recruitment advertisements were e-mailed with participant information sheets and consent forms before arranging a convenient time for a one-on-one semistructured interview.

The target sample size was 30 HCPs. This was determined *a priori* based on guidance for qualitative research suggesting that between 20 and 30 interviews are typically sufficient to reach thematic saturation in heterogeneous professional groups, while allowing diversity of views across clinical roles to be captured. Efforts were made to recruit participants working with patients from diverse SA backgrounds, particularly SA patients in hard-to-reach communities, but inclusion was not restricted by the ethnic background of the HCPs themselves. Instead, the emphasis was on ensuring that interviewees had relevant clinical experience with ethnically diverse patient populations.

Interviews

Interviews were conducted online via Microsoft Teams (Microsoft Corp, Redmond, Wash). The interviewer (C.S.) used a semistructured topic guide that explored barriers and facilitators to management among SA patients with FA while allowing participants to discuss issues of importance to them. Recruitment continued until theoretical saturation was achieved.[14] A preliminary codebook was generated by C.S. during initial rounds of transcript review, drawing directly from participants' language and meanings. This codebook was iteratively refined through discussion among the research team.

Data analysis

Interviews were recorded and transcribed verbatim. Transcripts were inductively analyzed using reflexive thematic analysis,[15] with the process of identifying themes derived from the data rather than deductively by the researchers. The transcripts were thematically analyzed following 6 steps, which included becoming familiar with data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing a report. There was flexibility regarding the progression through the steps, with further refinement and re-refinement of themes; the researcher's assumptions and influences were also considered. NVivo software was used in creating the code book and analyzing the interviews.

The analysis was undertaken by researchers with a professional background in qualitative health research and clinical allergy, providing complementary perspectives on both methodological rigor and subject matter expertise. Reflexivity was maintained throughout, with researchers reflecting on their assumptions and professional experiences to minimize undue influence on theme generation.

RESULTS

Interviews were conducted with 30 HCPs, including 23 physicians (comprising allergists, immunologists, and general practitioners), 4 nurses, 2 dietitians, and 1 pharmacist. The majority of HCPs practiced in secondary care (n = 25) with the remaining working in primary care (n = 5). In terms of their own nationality, HCPs identified as British Indian (n = 10), British White (n = 7), White other (n = 7), British Sri Lankan (n = 3), and British Pakistani (n = 2); 1 individual preferred not to disclose their nationality. HCPs had been practicing in their specialty for 3 months to 25 years. Several HCPs were also fluent in their native languages such as Punjabi and Urdu, alongside English; a few discussed talking in native languages with patients during consultations. Three overarching themes were identified through thematic analysis: cultural and social influences on health, participant characteristics and behaviors, and health care communication and support. Demographic details are listed in Table I.

Theme 1: Cultural and social influences on health

Role of cultural and traditional beliefs. HCPs described feeling frustrated toward patient reliance on traditional medicine, including the use of natural remedies such as "garlic, turmeric, and ginger" (HCP 8) to manage their FA. HCPs also recognized cultural beliefs surrounding food such as dishes being labeled "hot" or "cold" (HCP 3) due to their beliefs in Ayurveda (eg, nuts would be considered a hot food due to their inherent qualities and effects on the body). HCPs also reported patients frequently turning to traditional healers or family members for advice and

TABLE I. Participant sociodemographic characteristics

Characteristic	Value
Gender, no. (%)	
Male	15 (50)
Female	15 (50)
Age (y), mean (median) [range]	49 (48) [36 to 60]
Ethnicity, no. (%)	
Indian	10 (34)
Sri Lankan	3 (10)
Pakistani	2 (7)
White British	7 (23)
White other	7 (23)
Prefer not to say	1 (3)
Professional title	
Allergy and immunology consultant	14 (47)
Pediatrician	3 (10)
Registrar*	2 (7)
General practitioner (family physician)	4 (13)
Pharmacist	1 (3)
Dietitian	2 (7)
Nurse	4 (13)
Experience, range	3 mo to 25 y
Location, no. (%)	
Midlands	15 (50)
North	6 (20)
South East England/London	5 (17)
Wales	3 (10)
Scotland	1 (3)

*Equivalent to fellows-in-training in the United States.

treatment of their FA and often discounted medical advice in favor of community-based knowledge. There was also uncertainty surrounding patient acceptance of preventive strategies; HCPs discussed the cultural expectations for curative treatments for FA rather than dietary exclusions. They also believed that SA patients are more sceptical surrounding their diagnoses and approaches of HCPs to managing their allergy; aversion to the use of steroids and antihistamines (HCP 2, HCP 9) was cited, as these medicines were thought to contradict traditional practices. SA patients were also fearful about the long-term effects of using medication; they believed that medication would cause them more harm than benefit. It appeared that there was an influence of family in enhancing the reliance on traditional medicine and alternative remedies.

Culturally tailored approach. HCPs expressed the importance of understanding cultural contexts in SA patients and the need for a culturally tailored approach to allergy management rather than defaulting to a Western diet–centric approach. HCPs also discussed the need for culturally relevant food substitutions, such as addressing the use of specific nuts or halal dietary requirements, increasing the relevance and acceptability of advice. Written and visual resources, such as leaflets, videos, and apps in multiple SA languages were deemed crucial to cater to diverse literacy and linguistic needs (HCP 11, HCP 12, HCP 14, HCP 19, HCP 20, HCP 22). For certain groups, particularly older generations, personalized, face-to-face discussions combined with online and written resources were discussed as the most effective approach. Many HCPs also discussed the need for culturally inclusive laboratory tests and dietary assessments to include allergens common in SA diets, such as chickpeas, lentils, and specific spices. In addition to understanding SA-specific allergens, HCPs acknowledged religious beliefs (eg, the importance of providing advice tailored to patients who consumed only halal foods and patients with strict vegetarian diets). Patient information also needed to be written at a layperson's level, avoiding technical jargon to ensure clarity and understanding.

Role of family and friends/generational influences. HCPs acknowledged the importance of family acceptance and knowledge when managing FA. They discussed the reliance of SA patients on their family members in making important decisions surrounding their health; for example, HCP 17 talked about the significance of milk in certain cultures and that having a milk allergy was a "family issue" as family members needed to be accepting and vigilant of it. Many decisions were made after discussion with extended family members, particularly when these members also acted as caregivers and/or translators for the patient. Older generations, particularly grandparents, appeared to play a particularly influential role in health decisions (HCP 2, HCP 3, HCP 11, HCP 27) and were not in favor of medication such as steroids as they had heard about negative long-term effects. HCPs were worried that this aversion to medical treatments might influence patients' adherence to medical advice. Older SA patients were more sceptical and dismissed FA as a modern phenomenon, believing that allergies did not exist in their time; they viewed them as trivial or a means to get attention. Given the influence that family had on patients, HCPs were conscious of misinformation and incorrect advice affecting allergy management. HCPs also discussed the close-knit dynamic of SA families and the importance of providing emotional and logistical support to both families and patients; educating families was seen as a key strategy to improving management of allergy, given their strong influence on patient decisions and care.

Anxiety surrounding social and festive situations. HCPs discussed the importance of food in social, religious, and festive functions and the central role of food in SA culture, often tied to celebrations, hospitality, and social gatherings. Patients expressed anxiety surrounding these social situations, as rejecting or avoiding food could be perceived as disrespectful or rude. HCPs were also concerned about accidental exposure to allergens through cross-contamination during SA gatherings; a few discussed the presence of unlabeled buffet-style foods at cultural gatherings. The complexity and number of ingredients in SA foods made it difficult to identify allergens in social settings. HCPs also thought that patients may be uncomfortable about others knowing of their FA in social settings. The need for extra vigilance in large social situations was emphasized by several HCPs.

Theme 2: Patient characteristics and behaviors

Unique nature of allergens in SA patients. HCPs discussed the wide variation in diets within different SA populations and how this diversity often complicated allergen identification and dietary assessments. SA diets often encompass ingredients such as legumes, chapatis, curries with multiple spices, tilapia fish, and others (HCP 5, HCP 11, HCP 15, HCP 17, HCP 23, HCP 24, HCP 27, HCP 28, HCP 29), often making it difficult to pinpoint specific allergens and understand potential cross-reactivity. Certain allergens such as legumes and fish were also acknowledged as far more common among SA patients, but there was a lack of understanding in dietary management of these allergens. This lack of understanding was compounded by SA

individuals being allergic to rarer or lesser-known allergens; assumptions about management were often discussed in relation to Western diet–focused allergens. HCPs who were familiar with SA cuisines, often owing to being of SA heritage themselves, acknowledged the difficulty an HCP of another ethnicity might face when managing an SA patient. Also, patients were often not aware of the name of the allergen in English as it was an allergen largely incorporated in SA diets only. HCPs thought that there was a need for training and knowledge of SA diets to enable proper management of FA.

Older versus younger patients. HCPs discussed several differences between ages in managing FA in SA patients. Older patients were more likely and willing to take a physician-led, paternalistic approach to managing their allergies, whereas younger patients were more likely to ask questions and use online resources. Younger patients were also more proactive in managing their condition, often blending traditional and Western dietary practices. They were more likely to use digital resources, such as apps and web-based tools, for managing allergies, whereas older patients prefer traditional methods such as reading or listening to audio materials. Several HCPs also discussed older patients' reliance on younger family members to translate information in clinic settings; there was concern that this translation and form of communication may not be entirely accurate.

Risk taking. HCPs were concerned that SA patients took more risks in managing their FA than White patients. SA patients had issues adhering to their treatment plans, waiting longer before seeking professional help and introducing known allergens into their diet without medical supervision, despite being aware of their allergies. Several HCPs discussed this as more of an issue with older SA women with the introduction of common allergens early in a child's life and more food challenges at home. HCPs were uncertain about whether this was due to a lack of knowledge or a lack of acceptance of potential risks that exposure could cause; they felt frustrated about parents and elders introducing allergens into children's diets despite being aware of the adverse consequences.

Theme 3: Health care communication and support

Communication between HCP and patient. HCPs discussed the comfort and ease that SA patients felt when they were fluent in the patient's native language or wore clothing typical seen in SA cultures, with a preference for some patients to seek help from an HCP of a similar ethnic background (HCP 13, HCP 14, HCP 17, HCP 18, HCP 19, HCP 28). This was accompanied by uncertainty surrounding HCPs' ability and remit in speaking to patients in their native languages, as there were often differences in dialect. HCPs also thought that patients with limited English proficiency may feel intimidated, less confident, or anxious when communicating with an HCP and may not adequately express their concerns. HCPs who were aware of SA-specific food items, such as chapati, found that there was a sense of relief when they showed knowledge of such food items native to SA culture. Most HCPs recognized the importance of understanding the SA diet, but were also conscious that they needed knowledge and training to attain this understanding. There was also a patient assumption that if an HCP is of SA heritage, they must be able to speak the patient's native language. However, White HCPs were more concerned about their cultural awareness of the needs of SA patients during consultations. HCPs also found differences in using the correct idioms between English and native languages; for example, HCP 4 discussed patient fear when they had a negative allergy test with the misconception that this had a negative consequence on their health. Several HCPs also discussed patients feeling a level of intimidation when they did not receive treatment from an HCP of the same ethnicity; they acknowledged that this is not a feasible approach to patient care.

Confidence in interpreters and translators. HCPs acknowledged the importance of having interpreters present in clinics where patients did not speak English fluently; however, many expressed concerns over the quality and accuracy of the translation. They believed that interpreters do not often translate wholly and leave out pertinent information in their translations (HCP 14, HCP 21, HCP 23, HCP 26, HCP 29, HCP 30). This was particularly frustrating for HCPs who were able to comprehend a patient's native language and could understand the interpretation. HCPs also discussed the lack of knowledge that interpreters have of the wider context surrounding the patient's diagnosis. Working with interpreters also affected HCPs' confidence; they often felt uncertain about whether patients had fully understood what was being conveyed to them. HCP 21 discussed this affecting the level and depth of information provided to the patient. There were also similar concerns with family members interpreting on behalf of patients, as they can often distort information conveyed to the patient. HCPs also noted the importance of interpreters understanding SA-specific idioms, food practices, and specific dietary terminology. Despite all these concerns, HCPs thought that it was appropriate to have interpreters present for SA patients who did not speak English; however, this availability was found to be sporadic and unpredictable, delaying consultations.

Importance of multidisciplinary teams. HCPs discussed the need for dietitians in providing tailored dietary advice (HCP 10, HCP 11, HCP 13, HCP 24, HCP 29), particularly important for SA patients whose diets are often diverse and entail a variety of lesser-known ingredients. They emphasized the importance of current dietetic services being trained to cater to the needs of SA patients. The importance of appropriate psychological support was also discussed (HCP 18, HCP 23, HCP 29), particularly in patients whose families were less accepting of their allergies and patients who had more severe FA. HCPs acknowledged the importance of working together with other teams to provide a more culturally tailored and complete service.

Feelings of helplessness. HCPs discussed that despite the knowledge of gaps in current health care for SA patients, they were in position to improve this provision. The complexity of SA allergies compounded by language barriers needed to be addressed by longer consultation times; however, HCPs felt frustrated owing to the "20 minutes per consultation" (HCP 13) that they were afforded with patients. They also appreciated that general practitioners had "5 to 7 minutes" (HCP 4) to assess an SA patient who may not be able to communicate properly, and waiting times for secondary referral were "8 to 10 months" (HCP 18). They often conducted consultations via telephone and believed this impeded the quality of care and information provided for patients with limited proficiency in English. HCPs also thought that SA patients need to voice their problems and opinions more to receive proper treatment. Similarly, they felt discouraged by patients often not trusting their clinical judgment and seeking second opinions from different clinicians—often abroad.

TABLE II. Participant quotes corresponding to themes

Theme	Subtheme	Participant quotes
Cultural and social influences on health	Role of cultural and traditional beliefs	"What I don't know as well is the influence of religious groups and things like that and alternative medicines as well, whether people use herbal remedies." (HCP 2)
		"If people were raised in South Asia where allergy was less common and their awareness of allergy is probably less … they don't really let anyone feed their child, they don't understand the allergist's approach." (HCP 6)
		"I feel like they get loads of wrong information from families and friends, and they believe it." (HCP 13)
	Culturally tailored approach	"We should have leaflets in multiple languages, we should have videos in the waiting area in multiple languages, we should have [an] interpreter present, not over the phone, because it's not easy sometimes, also that applies in primary care. We don't really make the effort to make their life a bit easier." (HCP 6)
		"If you find anyone who's already doing a kind of … cinnamon, cardamom, chickpea, and lentil panel, please send it." (HCP 17)
		"For us it was probably just knowing that the food you're recommending are halal and all the treatment options are halal as well, and it also gives confidence to the patient that you made sure it was halal for you. For them to know that you've thought about it goes so far, people are so happy that you've considered their background." (HCP 28)
	Role of family and friends/generational influences	"I feel like they get loads of wrong information from families and friends, and they believe it. So really, we need to spend time to explain, because they have had that impression for a long time, if they are allergic to one thing, they believe they are allergic to nuts as well, back home in the area I grew up they don't believe doctors a lot." (HCP 13)
		"SA families are close-knit, and very rarely you will find someone who isn't comfortable with English come alone to clinic." (HCP 18)
		"Extended families often influence decisions, but family members might filter the information they translate." (HCP 27)
	Anxiety surrounding social and festive situations	"If you go to someone's house, you take some food, it doesn't matter if you've been doing the rounds and visiting relatives, it's a little uncomfortable or can be perceived as rude if you don't have something to eat. It's getting the other party to understand that you have an allergy, or you can't have this or you've brought your own food that can have some cultural negative tones linked in with it." (HCP 3)
		"The other thing that worries me about the Asian population is when they have a, they do tend to have a large gathering for various events and it's not predominantly displayed about the allergies and things." (HCP 10)
		"Some patients feel obliged to eat food prepared as a gesture of hospitality." (HCP 27)
Patient characteristics and behaviors	Unique nature of allergens in SA patients	"I see Bangladesh patients they report an allergy to Bangladeshi fish, here in the UK we know and understand cross-reactivity between common fish here, salmon and its effects, but if they tell me that Bangladeshi fish, we sometimes make an assumption that their allergy is common, for example, all white fish share the common allergens." (HCP 5)
		"The food contains lots of ingredients. It's not like fish and chips—it's like lots of ingredients, like spices, and the nuts can be in it or not in it." (HCP 11)

(Continued)

TABLE II. *(Continued)*

Theme	Subtheme	Participant quotes
		"Not understanding the ingredients that go into common SA foods … can make it difficult to provide advice." (HCP 20)
	Older vs younger patients	"There probably is more influence from the grandparents in the family, often more so I would say living with the family." (HCP 2)
		"For grannies, for example, for the elderly population, for their grandchildren, it's not easy to get to know this concept of allergy. So, it's a new concept and for them the food is a festive thing, it's not a dangerous thing." (HCP 11)
		"With older sort of North Indian and Pakistani, there's often family involved in history taking … a lot of older patients tend to be sort of fairly happy to be doctor-led." (HCP 27)
	Risk taking	"This lady went home and did her own challenges and did her own thing, and took the risk and thought 'I'll just get on with it,' and then wrote a letter to say, 'I don't need to come back to clinic, I'm fine with this, and I know what's going on,' a bit less caution with their own health feeling they are less important, and thinking 'I'll just do this and get on with it' and taking that self-risk type of thing." (HCP 8)
		"That culture may be a bit more inclined to just say, 'You just eat this,' or, 'You can't be allergic to that.'" (HCP 20)
		"My aunty and mum say, 'No go on, you can eat shellfish, you'll be fine,' and there's not that fear or awareness." (HCP 23 reflecting on a patient)
Health care communication and support	Communication between HCP and patient	"When you see they aren't able to converse or there are certain things, like you say chapati or Madura or whatever, and then you, if you start speaking to them in Hindi or Urdu, then there is such a relief that someone is able to understand and they are not then having to second guess in English." (HCP 14)
		"In the beginning as a new consultant, I used to think, 'Shouldn't they be able to converse in English?' but I've matured with age. If you slip into mother tongue, there is a degree of comfort, they relax." (HCP 18)
		"I'm not necessarily saying that every person of ethnic minority needs to see an ethnic minority doctor, obviously that's neither feasible nor ethical in some ways, but then there are some people who feel intimidated when you don't speak the language very well, then you don't feel like you have the confidence to negotiate the pathway." (HCP 19)
	Confidence in interpreters and translators	"I do find working through a translator really challenging because you give less information, and you're not sure if the patient is understanding." (HCP 21)
		"Some people have expressed that when you get an external interpreter in, you then lose some of the context because they are just literally translating your words, but they know nothing about the family and the context." (HCP 26)
		"My heart sinks whenever I see I have an interpreter because it just delays the consultation horrendously, but also I have found when I have used an interpreter for languages I only speak a bit of, not fluently, and it confirms my suspicion that the interpreter doesn't do the job they should do, you will say quite a lot and it translates to 2 words." (HCP 29)
	Importance of multidisciplinary teams	"Our dietitian is excellent … with ethnic patients who were incredibly anxious, I found [the dietitian] very useful." (HCP 13)
		"What I would really like is psychological support and counseling, that is a postcode lottery." (HCP 18)
	Feelings of helplessness	"I just feel really guilty … an 18-year-old … diagnosed with a nut allergy … followed up for 18 years and then they come to the adult service and get discharged." (HCP 12)

(Continued)

TABLE II. *(Continued)*

Theme	Subtheme	Participant quotes
		"If they have a language barrier, telephone appointments are useless. If they have severe FA, telephone appointments are absolutely useless, so many of them once coming face to face, didn't have a clue what happened in the last appointment. Definitely if there is a language barrier, face to face is really important." (HCP 13)
		"You need to put a little pressure on the GP because of resource scarcity, and if you're from a minority ethnic group you may be at somewhat of a disadvantage." (HCP 20)

GP, General practitioner.

Participant quotes pertinent to all themes discussed here are presented in Table II.

DISCUSSION

This is the first study to our knowledge to explore the views and perspectives of HCPs regarding management of FA among British SA patients. Our data highlight the challenges and complexities faced by HCPs in the management of FA in British SA patients. HCPs expressed concern regarding reliance on complementary or alternative therapies among SA patients, and this was further compounded by poor awareness of FA among older family members and the wider SA community leading to misinformation, given the close-knit family dynamics and social network within the SA community. The cultural expectation of a "cure" for FA has also been reported in the context of native South Indian patients with asthma, leading to a search for alternative therapies and poor acceptance of medical advice.[16] Similarly, reluctance to use antihistamines and corticosteroids reported by HCPs in this study can be related to poor use of inhaled corticosteroids among native Indian patients with asthma, resulting in a very high proportion having uncontrolled disease and poor clinical outcomes.[16,17]

Poor awareness of FA among the SA community is particularly relevant during social events and visits to temples and mosques where cross-contamination and accidental exposure to allergens could potentially occur, increasing risk of anaphylaxis. Unacceptance of offerings in faith institutes is deemed disrespectful and causes anxiety among patients. This strengthens the case for raising community awareness via education. Raising awareness of asthma among parents and caregivers via community-based education has proven beneficial.[18] However, this education needs to be culturally tailored and targeted toward patients from the lowest socioeconomic strata with poor health literacy to maximize reach and impact. Culturally tailored interventions have been shown to be clinically effective in the context of diabetes in African American and Mexican American patients and might be worth considering in British SA patients with FA.[19,20]

Some unique allergens[21] are implicated in FA among SA patients, such as lentils, chickpeas, sesame, aubergine, jackfruit, certain types of fish, and spices, among other allergens. A sound knowledge of SA cuisine and names of the food allergens in English and the ability to communicate with patients with limited or no proficiency in English are critical to the clinical assessment process and counseling regarding allergen avoidance measures. HCPs highlighted the importance of training in these areas and in cultural competency, as well as provision of multimodal culturally tailored resources for patients and access to an extended food allergen panel for laboratory testing. Some changes in NHS service framework were also suggested as ways to improve clinical management, including conducting face-to-face consultations as opposed to remote consultations, availability of interpreters who could provide more accurate translations, and extended outpatient consultation times.

The barriers to delivery of clinical care for FA in this study share commonalities with those reported in the study of a multifaceted intervention program for the management of asthma involving HCPs managing asthma in British SA children.[22] This study identified similar barriers, including limited consultation times; English language proficiency; issues surrounding quality of language interpretations, particularly when family members are involved; HCPs focusing more on pharmacotherapy and less so on provision of holistic care; challenges in the provision of linguistically and culturally suitable information; expectations from parents for HCPs to fix the child's problem rather than understanding the concept of chronic inflammatory airways disease management; and the need to engage with the NHS in the long-term care, thereby causing dissatisfaction and a search for alternative therapies.[22] Ahmed et al[23] explored the views and perspectives of HCPs from a diverse ethnic background regarding self-management of asthma in British Pakistani and British Bangladeshi patients. Despite organizational barriers with respect to resources and language, participants in their study attempted to provide culturally tailored and adapted management plans based on their own views regarding the patient's ability to self-manage.[23] They recognized the need for training of HCPs and patients via education, group discussions, and culturally relevant action plans.[23]

Our study involved a diverse group of HCPs with respect to age, sex, ethnicity, experience, and professional roles from primary and secondary care across the UK NHS, contributing to generalizability of the dataset. It is plausible that some of the lessons learned from the current study could also apply to British patients from other ethnic minority groups, although further research is needed to gain a deeper insight into nuances. This study recruited Indian, Pakistani, and Sri Lankan HCPs; HCPs from other SA ethnicities such as Bangladeshi and Nepali and Southeast Asians were not specifically represented. This restricts the transferability of findings across the full range of Asian ethnic minority populations. Further, although English-proficient SA HCPs were included as participants, interpreters or translators of SA ethnicity could also have been systematically used. This might have enhanced culturally relevant interpretation and more nuanced

understanding of dietary practices, food naming, and cultural contexts, as has been recommended in cross-cultural qualitative work. Finally, although most interviews were conducted online due to feasibility constraints, in-person face-to-face interviews may have enabled richer insights into participants' nonverbal cues and more detailed understanding of their responses.

In conclusion, the perspectives of HCPs suggest that disparities in the management of FA in British SA patients are multifactorial. Addressing inequalities and inequities requires a concerted, strategic, multipronged, and multidisciplinary approach with a focus on raising awareness of FA among patients, their families, and the SA community through multimodal education channels; developing culturally tailored supportive interventions for patients; enhancing cultural and professional competency among HCPs; and making appropriate adjustments in the current health service framework to suit the needs of SA patients.

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Key messages

- **Cultural and social factors strongly influence FA management in British SA patients, including reliance on traditional remedies, family decision making, and the stigma of refusing food in social or religious contexts.**
- **Unique allergens in SA diets (eg, lentils, chickpeas, spices, certain fish) are underrecognized, creating diagnostic and management challenges that require culturally tailored resources and training for HCPs.**
- **Language barriers, limited consultation time, and lack of cultural competency hinder effective care, highlighting the need for multidisciplinary teams, culturally adapted education, and systemic changes in the NHS to reduce health inequalities.**

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