Living with Diabetes

Diabetes (T2) Among Bengali Women: Camden Snapshot 2025

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Contents

**Diabetes (T2)
Among Bengali Women:
Camden Snapshot 2025 Draft**

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PLEASE NOTE: For the purpose of this report, the term 'Woman' is used throughout to refer to anyone assigned female at birth (AFAB).

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1. Background

1.1. Why We Did This Project

Diabetes is the second most common long-term condition in Camden with a prevalence rate of 4.04%[1]. It is especially problematic among Asian ethnic groups who have a higher prevalence of diabetes at 6.2% compared to the Camden average (3.6%)[2]. People from South Asian backgrounds have an increased risk of type 2 diabetes as they are more likely to experience insulin resistance at a younger age. 4.3% of Camden residents are Bangladeshi, making them the largest single minority ethnic group in Camden[1]. Our focus on Bengali women with diabetes reflects growing concern among this population group. While epidemiological data highlights the disparity, understanding the lived experience is crucial for developing effective, equitable services. Diabetes represents a significant challenge for patients, their families, society and the system. With access and engagement with care limited, looking at current barriers provides opportunities to address health inequalities.

1.2. What We Did

We reached out to community partners to conduct qualitative surveys with their female Bengali service users. A total of 61 women shared their views on living with type 2 diabetes/pre-diabetes. For some responders, English was not their first language, so the survey was translated into Bengali and our community partner colleagues also supported with live interpretation of the survey questions and responses during their coffee morning sessions.
See Appendix for demographics.

1.3. What We Found

Through our surveys, Bengali women living with type 2 diabetes spoke of its impact on their emotional and physical well-being, compounded by cultural and structural barriers. A central conflict emerges between the medical necessity of managing diabetes and the women's roles as primary caregivers and their cultural food traditions. While women demonstrate proactivity in making lifestyle changes, they feel underserved by current healthcare advice and express a strong demand for more culturally and linguistically tailored support, particularly around diet, physical activity, and community-based, female-only services.

2. Findings

2. Findings

The survey questions focused on their daily challenges, interactions with healthcare services, and the cultural factors that influence their ability to prevent or manage type 2 diabetes.

2.1. Profound Psychosocial and Familial Impact: "A Disease of the Family, Not the Individual"

In the context of Bengali families, where collectivism often outweighs individualism, a diabetes diagnosis is a source of significant emotional and social disruption to the entire family ecosystem. For many of the women, the diagnosis had a ripple effect, necessitating lifestyle changes that impacted the entire household. Women reported becoming the focal point of dietary change, which created additional emotional and practical labour. While some families are supportive, others create tension by maintaining unhealthy food practices.

It meant that I need to have avoid sugary stuff where sometimes it caused anxiety and stress level.

It has meant that I have to be cautious of what I am eating and what I have make at home for the family.

I have had to change my diet and lifestyle - my husband has been very supportive in helping me to change the things I eat.

"It has impacted my daily life and the way I feel and do things."

"I feel physically and mentally drained."

Women describe feeling "tired," "dizzy," "weak," and experiencing mood swings, and low self-esteem, which affect their ability to perform daily tasks and socialise.

Fear Rooted in lived Experience:

A diabetes or pre-diabetes diagnosis was often met with fear, worry, and a sense of foreboding, frequently linked to family history. As one respondent noted, "yes my mother got blind at the end of her life."

This creates a unique psychological burden. Many respondents reported feeling "scared," "worried," and "shocked". “Feeling scared” is the overwhelming emotion in relation to this condition and this fear is not abstract. Many women have been primary caregivers for parents or partners who likely suffered severe complications of diabetes like blindness, amputation, or kidney failure. This personal history transforms the diagnosis from a clinical condition into an inevitable and scary future they have already witnessed first-hand.

> When I first I had diabetes, it made me depressed. I felt lonely because I didn’t want to hear that I have diabetes because I felt scared.

However, there is still a lack of understanding of the long-term consequences of diabetes, and the high prevalence in this community risks it being seen as a norm, reducing its perceived severity. This is underscored by the majority of the respondents replying, “More Motivated”, when asked,

> Would you be more motivated to prevent or manage your diabetes, if you were given more information about the seriousness of further health complications of diabetes (e.g., CKD, Retinopathy)?

This fear is a primary motivator for behavioural change.

Stigma and Misunderstanding:

Stigma often arises from cultural misconceptions that diabetes is solely a result of "indulgence" or being "greedy." This leads to "fat-shaming" and embarrassment during social gatherings, where refusing sugary treats can be seen as insulting or antisocial. One respondent highlighted, “You cannot eat anything when you go to a party or with friends." This conflates a metabolic condition with a moral failing.

> Lack of understanding. Everyone is embarrassed to say they have diabetes, it’s like you have a cult. I think it needs to be made less taboo and more the norm.

When people say I need to cut down on what I eat.

People often think that it’s eating too much sugar or fatty foods. I get upset as I know stress and lack of sleep also contribute to diabetes and more education should be given to people instead of people judging and making assumptions.

> Some people think you get diabetes only from indulging.

The "Selfless Caregiver" Identity:

Culturally, a Bengali woman pays great attention to their role as a nurturer, often expressed through food. Managing diabetes, which frequently requires refusing her own cooking or preparing separate meals, can feel like a betrayal of this core identity. The request, “I would like for my family to help me more with work in the house and understand my stress and anxiety...,” is a direct call for a more equitable distribution of domestic labour and emotional support. It positions diabetes management as a family responsibility, not an individual one.

> I have to cook for the family so it would be difficult to make food that’s good for managing diabetes when I have to make two separate dishes.

> For my family I cook food that are no good for me.

> Having to cook for family members. Always cooking and eating.

> Having to cook big portions and not eating at the correct times.

> Not being able to keep times of eating so when hungry you eat more.

2.2. Cultural Culinary Practices as a Central Challenge

Dietary management can be identified as the single greatest challenge, deeply entangled with cultural identity. When asked ‘What type of information would be useful for a Bengali woman with diabetes/pre-diabetes’, participants overwhelmingly spoke of the need for advice around food to be made available in their local language, as seen in the word cloud below.

Staple Foods as a Problem:

Rice is overwhelmingly cited as the biggest dietary challenge. It is a symbol of sustenance and Bengali identity, eaten at almost every meal. Therefore, advice to "reduce rice" is not a simple dietary tweak; it demands change of a fundamental cultural practice.

> RICE!
> And pretty much all the foods we eat is starch based...

> We eat a lot of rice and meat which can make diabetes worse.

Traditional cooking methods involving generous use of oil, deep-frying, and sugar-laden desserts are consistently seen as exacerbating the condition. As one respondent poignantly explained, "We are finding it hard to give up sugary stuff," but the challenge with rice is even more profound. Women expressed a desire for practical alternatives, not wholesale rejection of their cuisine.

Using the same food but use less oil. Don't deep fry. Sometimes you don't need to use oil after you marinate the food with your spices.

Bengali instructions of what to do in diabetes, what to eat, what got more sugar in it and less carbohydrates.

What foods to eat but fitting the usual Bengali foods. What we can change in what we are already used to eating rather than to change your whole palate.

❝ There should be approachable Bangladesh eating habits that can be seen and that has been done by someone who has stuck to it. Where what we eat can still be seasoned with the spice but eaten with vegetables instead of rice. ❞

The Economics of Food:

Respondents noted that "eating healthy is more expensive." Feeding a large family on a budget often prioritises cheap, calorie-dense staples like rice and potatoes, making healthier alternatives financially out of reach. Another recurring theme is the burden of cooking separate meals – one for themselves and another for a family unwilling to adapt. This doubles a woman's labour, emotional and financial strain. There is a need for dietary advice that addresses this specific disparity.

❝ Cooking healthy. Family food training because most times women have to cook what the family want and not what she needs to eat, so the whole family should attend a class. ❞

❝ Healthy Asian food options that can be mass cooked for whole family. ❞

Social and Religious Obligations:

Festive occasions (Eid, weddings) and frequent family gatherings are centred around rich, sweet, and fried foods (e.g., biryani, misti, puri). The cultural script dictates that you show hospitality through abundant, rich, food which is culturally significant but often unhealthy. Not partaking is seen as a rejection and disrespect to the host. Guests are typically serviced six to seven dishes for each meal, and it is seen as shameful to serve curries with reduced oil and spice content[3].

One woman described the difficulty of managing portions "in Eid or special events is hard because that's when you are cooking the fried and sweet food and there is a lot of it." This makes adherence to a diabetic diet socially isolating.

> When there are get together or weddings it becomes very limited and having the right food becomes hard as the food and drink provided are mostly carbs.

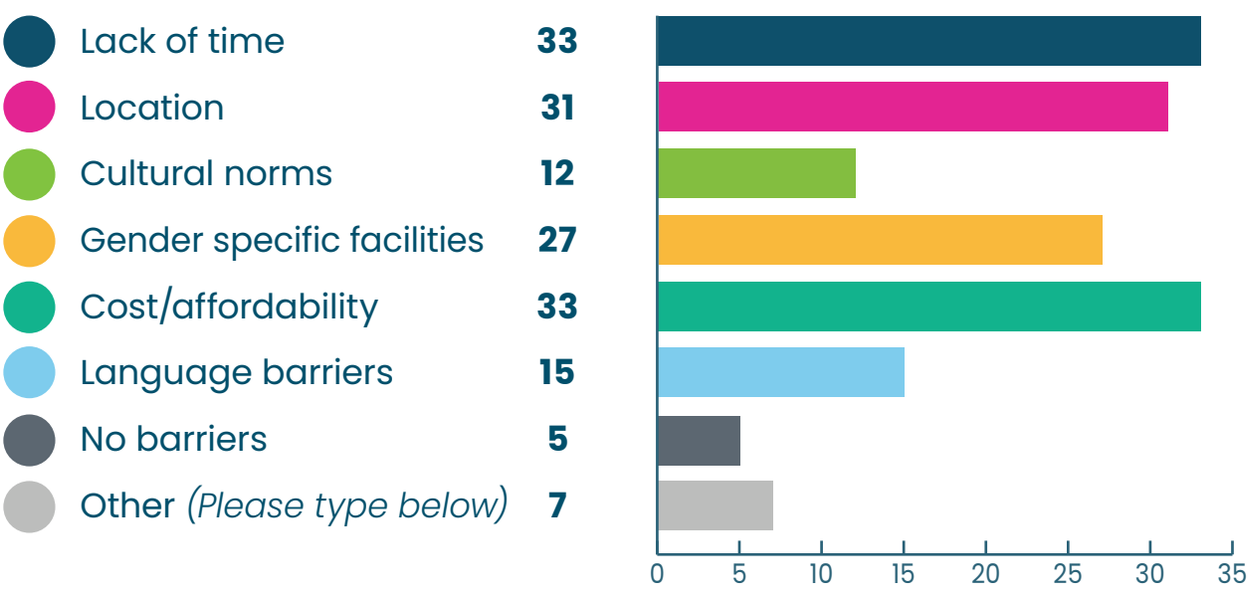
> We have frequent family gatherings and there is always a lot of rich food which is rude not to eat. You also have to cook the same when you host.

> You are born into Bangladeshi culture and heritage, you can't change what you eat, but I made sure I stuck to my personal choices regardless of the comments made. I didn't allow others to change me back.

2.3. Significant Barriers to Physical Activity

The barriers to exercise are not merely about motivation but are structural and deeply embedded in their social roles and economic reality. The citing of cost/affordability (e.g., gym fees) and inconvenient location highlights that even if time and cultural barriers were overcome, financial constraints and the practical difficulty of travelling to a facility can be prohibitive.

Do you face any of these barriers to engaging in physical activity?



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Another significant obstacle is physical health issues (e.g., arthritis, back pain), directly preventing them from engaging in any physical activity.

I have backpain and knee pain so struggle with walking and I cannot afford to go to the gym.

She used to go swimming but now she suffers from dizzy spells and has other physical disabilities - arthritis in her hands and knees.

My mom does not do any physical activity because she is over 80 years old.

The "Purdah" (Privacy) Factor:

The need for gender-specific facilities is not a preference but a non-negotiable requirement for many of the women. The absence of women-only swimming sessions or female-led exercise classes is seen as a complete barrier to participation, not an inconvenience. “Gender specific facilities” was a frequently selected barrier.

There should be more female activities only run by the female.

Only women facilities are hard to find or the time they give is not possible to attend.

There should be female people carrying out female activities.

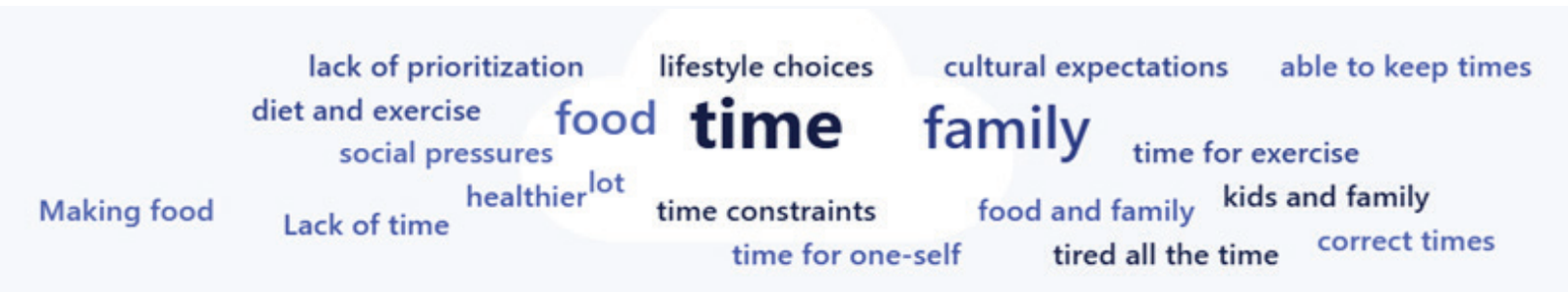
The lack of gender specific facilities is a major issue.

Time Poverty as a Gendered Issue:

"Lack of time" is paramount and directly linked to the expectation that women are the primary managers of the household. As one respondent summarised, "I am too busy looking after my kids and family and cannot always make time for exercise...". This "time poverty" is a consequence of culturally assigned gender roles. Cultural norms that prioritise household duties and family care over self-care, and for some, a lack of a companion to exercise with, further limit participation.

“We are expected to manage the household and other chore on our own which in turn leaves us less time to look after ourselves.”

“When I was diagnosed as pre-diabetes, I was shocked. I didn't want it to define my lifestyle and choices; I did lots of diets and exercise as both my parents have type 2 diabetes. Both me and my husband had been diagnosed. But in the lockdown, we took a very different approach to our eating habits and exercise and now have been given the all clear.”



Cultural Norms of Femininity:

In some traditional contexts, older people or women exercising in public view, or engaging in strenuous activity, can be frowned upon. It can be seen as inappropriate, and something that opens the door for gossip[3].
This is compounded by a lack of safe, accessible green spaces for walking.

Embarrassment from others watching me exercise

“No park close to my house”

Appropriate and culturally specific programs

Obesity and being overweight are risk factors throughout the life course increasing the risk of developing or exacerbating chronic conditions like diabetes. When asked “What types of physical activities or exercise do you feel comfortable doing?”, most women said they would prefer walking.

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2.4. Awareness, Accessibility, and Gaps in Healthcare Support:

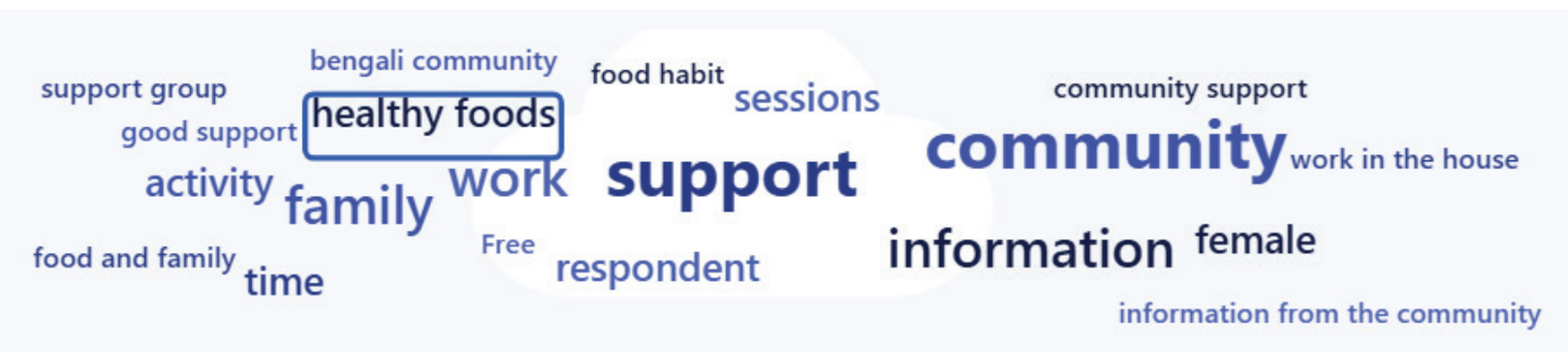
The healthcare system often provides advice in a cultural vacuum. There is a gap between the support needed, what is currently being provided, and women's access to those services.

The "Brown Rice and Salad" Fallacy:

The common advice to switch to brown rice and eat more salad fails to acknowledge that these are not direct substitutes for the sensory and cultural experience of eating traditional Bengali food like white rice with a meat curry. The advice feels alien and unsustainable. There is a need for culturally specific dietary guidance which is not just "eat healthily," but practical advice on modifying specific Bengali dishes (e.g., using less oil, substitutes for sugary sweets, baking instead of deep frying, balancing protein and carbs during different times of the day).

Linguistic and Cultural Barriers:

Language barriers prevent a deep understanding of the condition as well as the support around it. Misconceptions about carbohydrates and "hidden sugars" are common. There is a strong desire for more services in Bengali, visual aids (e.g., pictures of portion sizes), cooking classes on healthy Bengali cuisine, and for female-only spaces. Furthermore, as one respondent requested, there is a need for "female practitioners" for physical examinations, as modesty is a key concern.



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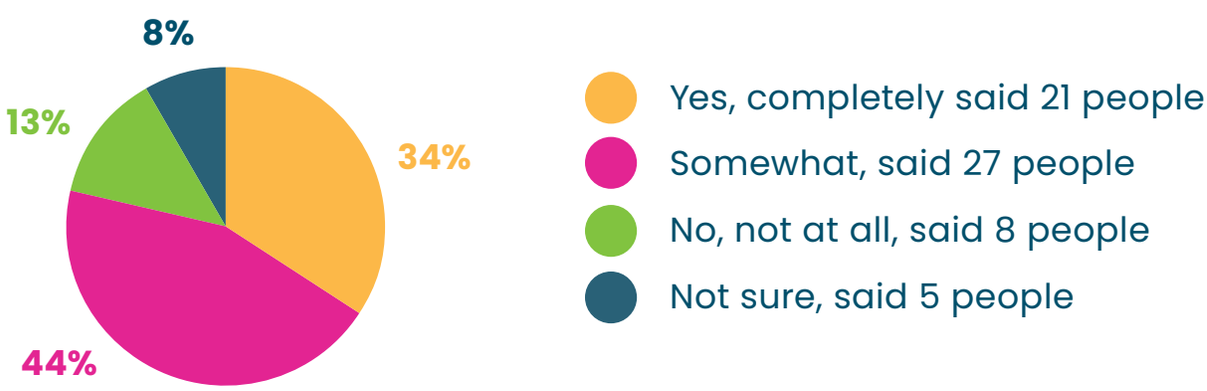
Seeking Culturally Resonant Information:

The quote, “I also followed a very well-known doctor in Bangladesh who shared lots of valuable information... I found it very helpful, and it was easier for my husband to follow with me,” is highly significant. It shows that when UK-based services are perceived as lacking cultural relevance, women will seek information from trusted sources in their country of origin. In one study, it was found that while British Bengalis recognised a medium sized body as healthy, health professionals had incorrectly believed that Bengalis associate obesity with being healthy and with fertility. Many health professionals were hesitant to discuss lifestyle changes with Bangladeshis – they had a poor understanding of their religious beliefs and culture. They also believed that Bengalis were resistant to education on prevention, because they were incorrectly viewed as fatalistic. However, religious leaders saw fatalism as a misunderstanding of Islam[3]. This underscores a need for increased awareness among healthcare professionals in order to provide culturally competent care within the NHS. Services that were known and valued were those that were local, culturally attuned, and accessible. The Camden Community Diabetes Service was mentioned positively by several participants.

Information Deficit:

A significant number of women are simply unaware of the support available to them. Participants consistently reported that the information received from healthcare professionals was "somewhat" adequate. There is a stark divide in awareness and engagement with formal diabetes services available in Camden and beyond. Many respondents reported being unaware of programs like the NHS Diabetes Prevention Programme, DESMOND, or The Healthier You NHS Diabetes Prevention Programme indicating a need for improved communication and referral from primary care to connect patients with culturally appropriate resources.

Do you feel you received enough information about managing or preventing diabetes from healthcare professionals?



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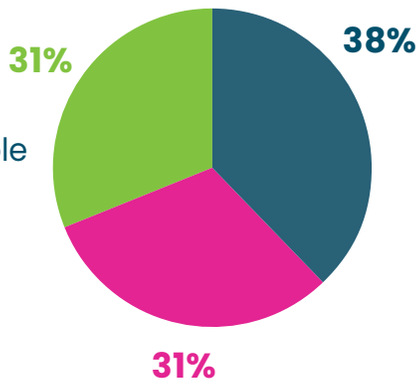
Have you ever participated in any of the programs/services in Camden?

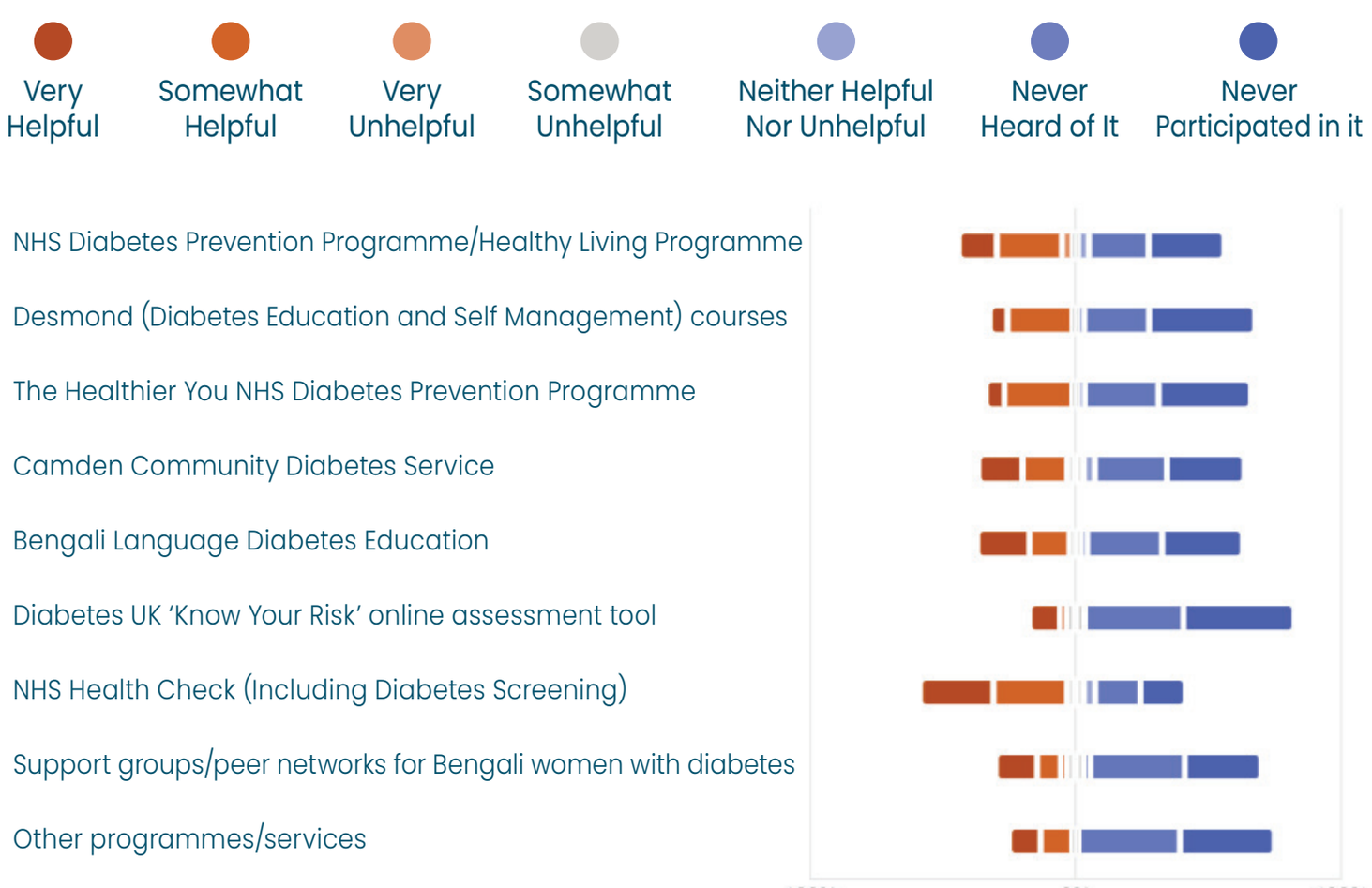
- Yes, I have participated in one before, said 19 people
- No, I have not participated but I am aware of them, said 19 people
- No, I am not aware of these program/services, said 23 people



Comfort with Coaches:

For those who had participated in programs like the NHS Diabetes Prevention Programme, comfort levels in expressing cultural or religious needs were mixed, ranging from "very comfortable" to "somewhat comfortable."

Please rank the programs/services in Camden, from the most helpful in helping you manage your diabetes.



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2.5. The Critical Role of Family and Community:

The level of support from family and community is a key determinant of a woman's confidence and ability to manage her condition. It is a crucial but complex factor. While some women felt supported, for many, family obligations were a primary barrier to self-care.

> We are expected to manage the household and other chore on our own which in turn leaves us less time to look after ourselves.

> I am too busy looking after my kids and family...

On a scale of 1-5, family support ratings varied widely, thus reflecting diverse home environments. The quantitative score for family support (Mean ~3.4) masks a stark qualitative divide. This means that on average, women described the level of family support to be approximately at a level 3, out of a scale of 1-5.

High Support Scenarios:

Some women reported husbands and children being actively supportive, adapting their own diets in solidarity. This was linked to much higher confidence scores.

Low Support Scenarios:

Women who feel unsupported describe a relentless cycle of cooking for others with little regard for their own health needs. One respondent captured the essence of the plea: "I wish they would see the side effects and harm this is causing." This highlights that the problem is not always a lack of caring, but a lack of culturally fluent health literacy within the family. They don't need nagging; they need educated allies. Participants expressed a desire for their families to be more involved and understanding of their journey with diabetes.

Community support averaged at ~3 on a scale of 1-5. This means that on average, women described the level of community support to be approximately at a level of 3, out of a scale of 1-5. The most requested solution was community-based, peer-led support groups, which would address isolation, stigma, and the information gap simultaneously.

> Lack of understanding, and negative stereotypes associated with certain conditions or groups of people

> Not a lot of people understand about diabetes there is still lack of education

> Because they feel scared frightened lack of education around diabetes

2.6. Religious Practices and Management Challenges:

This theme highlights how diabetes management must be integrated with, not separated from, spiritual life.

Ramadan and Medication Routines:

The clear statement, “Ramadan - difficult to manage medication at optimum times,” identifies a concrete clinical challenge. Managing long-acting insulin or metformin around a fasting schedule requires specific, proactive advice from healthcare professionals.

Physical Devotion and Physical Pain:

The observation, “Sometimes I have bruises on feet. I am Muslim so when we pray on the floor, on the prayer mat, it hurts,” connects a core tenet of faith (prayer) with a common complication of diabetes (foot problems). It shows how the disease can intrude upon and complicate acts of spiritual devotion.

3. Next Steps

The Path Forward is Cultural Fluency:

The lived experience of Bengali women with diabetes in Camden is one of navigating a complex landscape of cultural traditions, family duties, and a healthcare system that often feels generic and inaccessible. For a Bengali woman, managing diabetes is not just about counting carbohydrates; it is about balancing a path between her duty to her family and her duty to herself, between her doctor's advice and her grandmother's recipes. Successful interventions must therefore be:

1. Culinarily Competent:

Providing specific, recipe-based guidance, using visual aids and portion guides, on how to cook ‘aloo dum’ or ‘biryani’ in a healthier way, acknowledging that food is heritage, not just fuel. The struggle with high glycaemic load diets like rice is not just a nutritional issue, but a deeply cultural one, making simplistic dietary recommendations ineffective and often distressing.

2. Structurally Accessible:

This means increasing funding for, promoting and improving access to female-only facilities at accessible times and locations, potentially offering home-visits or virtual options for those with mobility or childcare issues. The low awareness of existing programs like the NHS DPP and DESMOND suggests that national programs are not effectively reaching this demographic, a known issue in public health implementation. Healthcare providers need to ensure that referral pathways provide clear information on eligibility, benefits, and how to access them.

3. Community-Embedded:

Moving services out of clinical settings and into trusted community centres (e.g., KCBNA, Third Age Project) or faith institutions, at times that accommodate family schedules (e.g., evenings, weekends), as explicitly demanded by the respondents. This demand echoes best practices in health promotion, which stress the importance of community-based participatory research.

4. Inclusive of Family:

Programs should aim to educate and engage husbands and children, transforming the household into a unit of support rather than a source of temptation. This encapsulates the need for a safe, relatable, and empowering ecosystem of care. Current services should do more to involve family members in diabetes education and management, recognising the interconnectedness of household health decisions.

The voices of Bengali women in Camden reveal that Type 2 Diabetes is not merely a clinical condition but a socio-cultural crisis too. The data compels a singular conclusion: without interventions that are as culturally intelligent as they are clinically sound, the health system will continue to fail a generation of women at high risk. Success lies not in asking Bengali women to abandon their culinary traditions, but in empowering them and their families with the knowledge and tools to adapt them.

The path to prevention and effective management is currently blocked by a key barrier: the conflict between health and heritage. The central role of rice, the social significance of shared feasts, and the gendered expectation of self-sacrifice are not lifestyle choices; they are the bedrock of cultural identity. When healthcare advice ignores this reality–prescribing salads where practical guidance on modifying 'biryani' is needed–it becomes irrelevant, leaving women to navigate this complex journey alone.

As one respondent's plea for support, "by women for women" underscores, generic solutions only deepen the sense of isolation and helplessness.

The consequences of inaction are severe and deeply personal. The fear expressed by these women is not hypothetical; it is born from firsthand experience of caring for relatives with devastating complications. This fear is also coupled with an understanding of the barriers they face.

Therefore, the way forward is unequivocal. Services must pivot from a deficit-based model that blames cultural practices, to a strengths-based model that works within them. This means:

Translating medical guidelines into culinary heritage, providing more hands-on, Bengali-language cooking classes that teach how to prepare traditional dishes in healthier ways.

Transforming community centres into local diabetes support hubs, delivering trusted, female-only services that overcome structural and social barriers to physical activity and peer support.

Empowering families as units of care, educating husbands and children to become allies, thereby shifting the domestic environment from a source of stress to one of support.

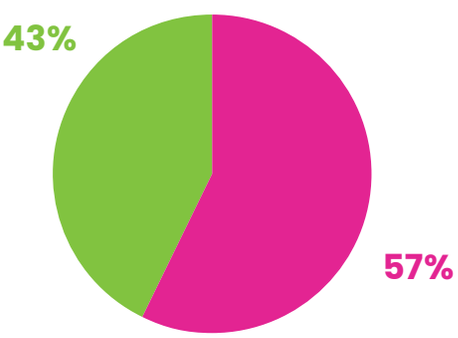
The high prevalence of diabetes in this community is not inevitable. It is a signal of a systemic failure to provide equitable care. The women of this survey are not passive patients; they are motivated individuals seeking practical, relatable tools to protect their health and their families' futures. The responsibility of services is to build a support system that doesn't ask them to choose between their well-being and their culture but honours both.

4. Appendix

Demographics

A total of 61 women, all Bangladeshi ethnic background, completed the survey. Their age ranged between 22 – 85 years old with an average age of 45 years old.

- Diagnosed with Type 2 Diabetes, 35 people
- Diagnosed with Pre-Diabetes, 26 people



Methodology

This snapshot report is based on responses to qualitative surveys completed by Bengali women diagnosed with Type 2 diabetes or pre-diabetes. The questions covered aspects including diagnosis impact, behavioural changes, awareness and use of diabetes services (e.g., NHS DPP, DESMOND, Camden Community Diabetes Service), dietary habits, physical activity barriers, and family/community support. We approached our local community partners in Camden - KCBNA, Third Age Project, Think and Do, The Surma Centre, Queens Crescent Community Association, Castlehaven Community Association, to help disseminate the survey (English/Bengali online link and English/Bengali physical copies) and to request attendance at their activities where we could conduct the surveys in person. For those women for whom English wasn't their first language, we requested either their family members to complete the English/Bengali survey on their behalf, or the community leaders to provide interpretation. We received responses in both English and Bengali which we then translated accordingly.

About us

Healthwatch Camden is an independent organisation formed to give patients, service users, carers, and residents a stronger voice to influence and improve how health and social care services are provided to the people of Camden. Our duties (which are set out under the Health and Social Care Act 2012) are to support and promote involvement of Camden residents in the planning, running, and monitoring of services; to produce reports and make recommendations for services based on their views and experiences; and to offer information on choices they can make in accessing and utilising services. Our remit extends across all publicly funded health and social care in the borough.

References

1. Long-term conditions – JSNA Hub

2. Camden Council. Gender inequalities in health: Camden. May 2018. Accessed June 17, 2025.

   https://www.google.com/search?q=0+Gender+inequalities+in+health%3A+Camden+Pu&oq=0+Gender+inequalities+in+health%3A+Camden+Pu&gs_lcrp=EgZjaHJvbWUyBggAEEUYOTIHCAEQIRiPAjIHCAIQIRiPAjIHCAMQIRiPAtIBBzg2MGowajmoAgCwAgE&sourceid=chrome&ie=UTF-8#vhid=zephyr:0&vssid=atritem-https://opendata.camden.gov.uk/download/usyt-x9gy/application/pdf

3. Grace C, Begum R, Subhani S, Kopelman P, Greenhalgh T. Prevention of type 2 diabetes in British Bangladeshis: qualitative study of community, religious, and professional perspectives BMJ 2008; 337 :a1931 doi:10.1136/bmj.a1931

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