

StrongVoices

THESE ARE OUR STORIES

South Asian women improving Type 2 Diabetes prevention after pregnancy

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ABOUT THIS REPORT

Why these voices matter

Every year, many women develop diabetes (raised sugar levels in the blood) during pregnancy. This is called gestational diabetes, or GDM. Having GDM means a much higher lifetime risk of type 2 diabetes, a long-term condition. This risk is even higher for South Asian women, who are more likely both to develop GDM in pregnancy and go on to develop type 2 diabetes later, often at a younger age.

Regular blood testing after pregnancy can identify type 2 diabetes and those at high risk of it early, when there is most opportunity to prevent it or slow it down. Yet, many women never receive this testing, and South Asian women are among those most often missed.

To understand why, and how follow-up and prevention could be improved, women with lived experience were invited to help shape a funding application for research on this topic.

This report shares what they told us, in their own words.



HOW THIS REPORT WAS MADE

Listening, Together



These stories were gathered through three public involvement workshops. Public involvement means research carried out with or by the public rather than about or for them. Two workshops were held in person in London, and one online with women in Liverpool.

Seventeen women of Bangladeshi and Pakistani heritage took part. Eleven had experienced GDM in at least one pregnancy, at least two of these had gone on to develop type 2 diabetes. Among those who had not had GDM, some had personal experience of type 2 diabetes or pre-diabetes. Others had no personal diagnosis, but had relatives and friends affected by diabetes.

The sessions aimed to lower the barriers that can make taking part in research difficult. They were held in trusted, women-only community settings, including a community centre and a children's centre local to the women's homes. Language interpretation was available. One session was supported by Rong Lu (collaborator and NHS diabetes specialist midwife at Barts Health NHS Trust).

Through shared meals, storytelling, mapping their experiences of care, and open discussion, women helped shape what this research should ask and how care could be improved.

FOOD IS A LANGUAGE OF CARE

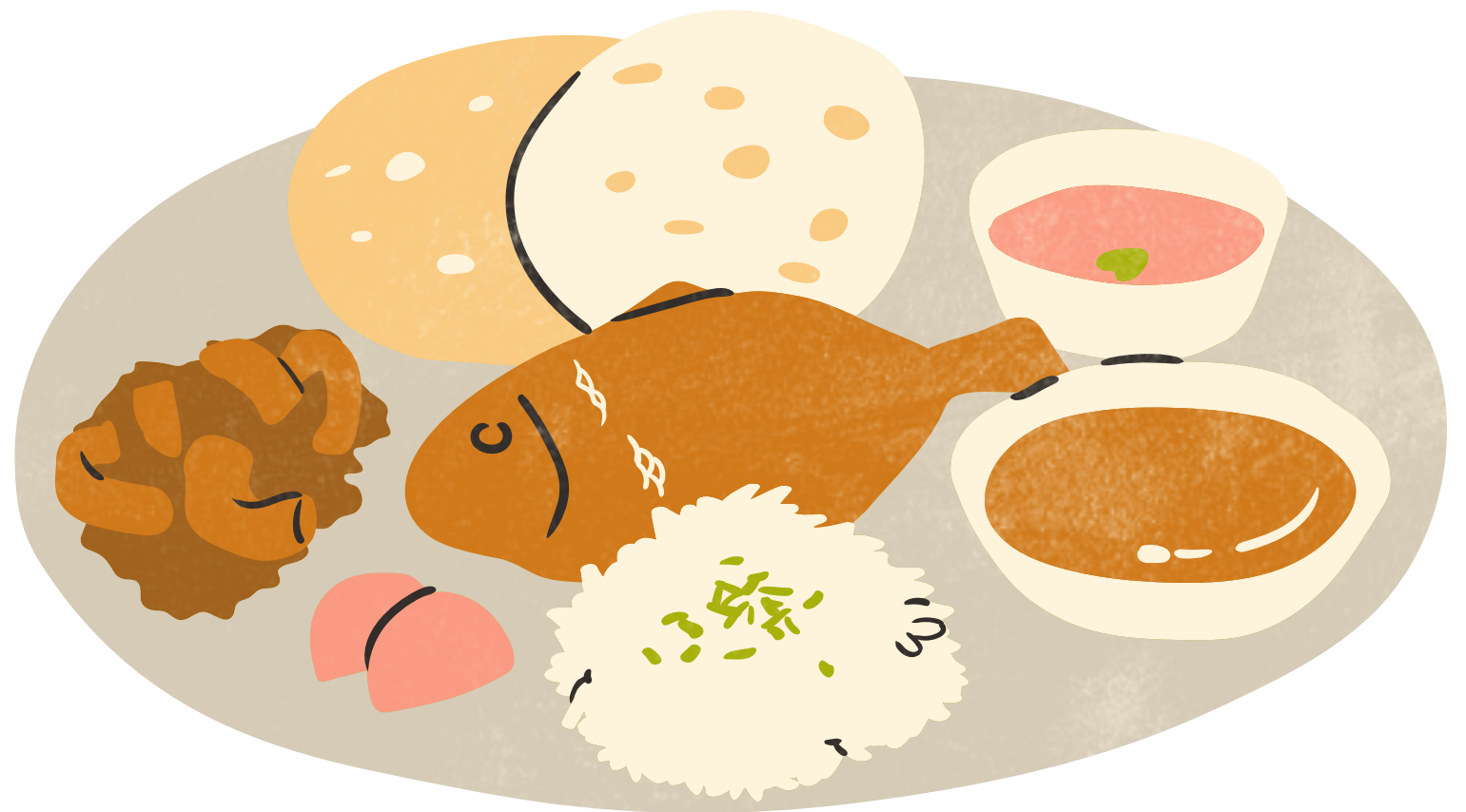
At The Heart of Family Life

For these women, food is woven into family, culture and identity. They spoke of the dishes at the heart of their homes with warmth - meals that bring people together and pass tradition from one generation to the next.

“In my family, we eat a lot of biryani. It’s our favourite dish and my children love it too.”

“We eat mainly fish or chicken curry and vegetables. This is our normal food, not something special.”

“Paratha is a non-negotiable.”



SMALL CHANGES, REAL DIFFERENCE

Adapting, Not Abandoning

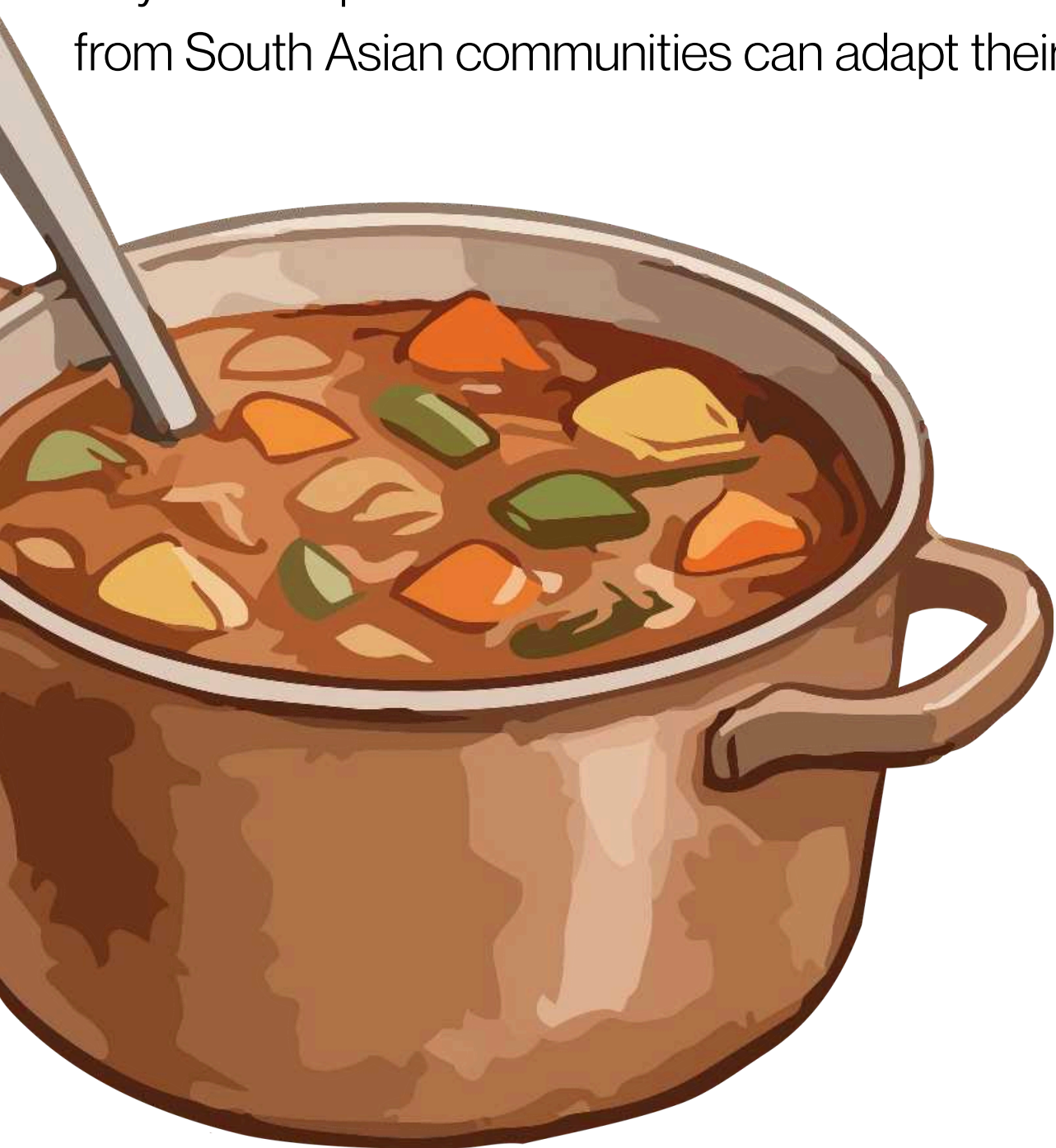
For many women, the challenge was not in seeing that their diet needed to change, but knowing how to apply that to their everyday cooking and family meals. Over time, and often through trial and error, some found their own practical ways to adapt the food that matters rather than give it up. These examples highlighted the practical ways women from South Asian communities can adapt their diets after a diagnosis of GDM or type 2 diabetes.

“I changed my oil. Now I use olive oil for everything.”

“Instead of white potato all the time, we use sweet potato, pumpkin or turnip in curries.”

“I changed to multigrain roti and brown rice instead of white flour and rice.”

“We eat a lot of carbohydrates, like rice. Now, I try to control the portions.”



MORE THAN WILLPOWER

The Daily Struggle

Making lasting changes to long-held habits and traditions is rarely easy. Women described many things that made it harder, including cravings, stress and the demands of family life.

“Now it’s mango season, so it’s hard. My mind is telling me no, but I want to try.”

“After the baby, I craved sweet food so much.”

“Gestational diabetes is always on your mind. You’re stressed about everything.”

“When I visit my family, it’s hard to explain that I can’t have paratha and mango. They don’t fully understand.”



These pressures were often reinforced by multiple factors. Relatives may not have fully understood the diagnosis. Celebrations, and cultural beliefs about food and activity during and after pregnancy, added their own weight. So did the constant mental load of monitoring their own health.

THEIR OWN HEALTH WAITS

Holding It All Together

In the months after birth, mothers manage a great deal, and their own health is often the last priority.



“Yesterday, when I was cooking, my baby wouldn’t sleep and was crying. I was also looking after my two other daughters. My husband was at work.”

“I have six children, so I am very busy with housework. Everything else can slip from my mind.”

“I do a lot of walking because I drop my children to school and collect them five days a week.”

For many, exercise is built into daily life, through the school run or housework, as there is rarely time set aside for it. Tiredness, aches, and limited women-only exercise classes nearby make it more difficult. Once the baby arrives, support from many sources, including healthcare services, can fade away, often when a mother needs it most. So, anything offered therefore has to fit around life with a newborn.

SLIPPING THROUGH THE CRACKS

The Test That Never Happened

Following a pregnancy affected by GDM, women should be offered a blood test for diabetes within six to thirteen weeks of giving birth, and a test every year after that. Across these workshops, however, many women were still waiting for that test, or had never been offered one at all.

“I didn’t have a blood test. They didn’t call me.”

“I’m still waiting. My baby is four months old.”

The gaps were clear. One woman had received no information in the seventeen years since her diagnosis. Another, a year on from giving birth, had never been invited for testing. None of the women had been referred to the NHS National Diabetes Prevention Programme, the main way to access support to prevent diabetes after pregnancy.



Discussion between the women, diabetes specialist midwife and GPs pointed to a system problem behind these experiences. A diagnosis of GDM, especially where it is managed by diet alone, may not reliably reach a woman's GP record from the hospital. Without it, the follow-up that should happen may never begin. The diagnosis is not always included in letters sent from hospital maternity care. Where it is recorded on paper, it may not be added to the electronic record, leaving nothing clear for the practice to act on. Even where a diagnosis does reach the GP, the practice's system may still not automatically send an invitation for a blood test.



UNSPOKEN RESULTS, UNCLEAR RISK When Silence Feels Like Safety

Even where a blood test had been carried out, some women were never told the result. When results are not clearly explained, or risk is described in vague words, it is understandable that women assume all is well.

“I had the blood test, but not the result. Maybe I don’t have diabetes.”

“They said borderline. It didn’t sound serious.”

Yet a normal result after GDM is not an all-clear. It marks the start of a lifelong, higher risk of type 2 diabetes and other long-term conditions, including heart and kidney disease. It also means an ongoing need for monitoring. Left unexplained or unspoken, a normal or unspoken result can make a woman's sense of that risk quietly fade, and with it the motivation to keep up yearly checks and prevention.

NOT HERS TO CHASE

A System That Should Reach Out

Women felt the responsibility for follow-up should not fall on them alone. In the busy months after birth, remembering to arrange a test can easily be lost among the many needs of a new baby and family.

“It should be automatic. They should send the appointment to us.”

“Sometimes, we don’t remember that we have to book it. There is so much stress, especially with the kids and appointments for the new baby too.”



Women suggested it would help if the system took the lead, rather than leaving it to them. Expecting women to seek out the test themselves risks widening the very gaps it should be closing.

WHAT WOMEN WANT TO CHANGE Recommendations

Taken together, the three workshops pointed to several clear priorities for change:

Make follow-up automatic: Send the appointment rather than waiting for women to request it, so testing doesn't depend on them remembering or chasing it up.

Always share results, and explain them: Communicate every result, including normal ones, together with what it means for a woman's future health and why ongoing checks matter.

Use clear, honest language: Describe risk in a way that shows how serious it is. Words such as "high risk" land very differently from "borderline," which many women did not see as significant.

Open the door to prevention: Refer women to prevention support, offered in a form that fits around family life and cultural context.

Offer face-to-face contact where possible: Many women found conversation easier to trust and remember than text messages, and valued being able to ask questions directly.

Start the conversation early: Information given early, and communicated well, is more likely to be understood and remembered, helping women stay engaged with their health, monitoring and follow-up for years to come.

MUM COMES FIRST

Summary

“Mum comes first. If the mother isn’t healthy, the whole household goes downhill.”



This quote captures the idea at the heart of this work. A mother's health matters far beyond herself, reaching her children, her family and her wider community. Its effects can also carry across generations, shaping the health of the children who grow up around her. Yet a mother's own health, despite this wider importance, is too often overlooked once pregnancy is over.

Across three workshops, a consistent picture emerged. Women described food that is inseparable from family and culture, the real difficulty of keeping up changes, and the competing demands of caring for others. They also pointed to clear opportunities to strengthen follow-up, so that risk is found and acted on more reliably.

Together, these accounts point to what more effective care would involve: reaching women proactively, explaining results and risk clearly, and providing support that fits the realities of their lives.

These findings set the direction for the research that follows, which aims to improve how women at risk are identified and supported in primary care. The goal is a fairer, more reliable approach to follow-up after GDM, built to address inequalities, and with the potential to inform primary care nationally.

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