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Investigating the experience of type 2 diabtetes among a Somali population in the UK

I declare that the research contained herein was granted approval by the SPAIS Ethics Committee.

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Acknowledgments

فَإِنَّ مَعَ ٱلْعُسْرِ يُسْرًا ٥

“Verily with hardship comes ease” (94:5)

I am in constant gratitude to Allah swt for guiding me and granting me ease through the hardships of being diagnosed with a neurological disease during my university years. Through truly the hardest moments of my life, it was my faith that reminded me of my strengths, capabilities, and bigger purpose. It was Allah’s unconditional love for me that kept me going.

ٱلْحَمْدُ لِلَهِ

“Praise be to Allah”

Our mothers…

My next acknowledgement goes to our Somali mothers, the women who are the backbone of our community and dedicate their lives to their children in hopes of better chances and opportunities. More specifically, my mother, the women who has given her whole life to her children and is a tireless advocate for others. Though she was never given the privilege to attend school, she instilled in me the value of education with a passion that has shaped the person I am today. Her strength in conquering a new world as a refugee, raising her children alone with compassion and purpose continues to inspire me. I dedicate this degree to her, for everything she has given and everything she is, I am forever grateful.

To my supervisor…

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To me…

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It will all happen for you.

إن شاء الله.

Introduction

This dissertation seeks to explore the unique experiences of the Somali population in the UK in relation to type 2 diabetes, addressing a critical gap in how health disparities are often understood and documented. Existing literature frequently adopts a hegemonic approach to health disparities, grouping diverse communities under broad categories such as black African or BAME (Nagar et al., 2021; Whyte et al., 2019). While this may be methodologically convenient, it overlooks the specific cultural, socioeconomic, and historical factors that influence health outcomes wihtin subgroups. Such as the Somali community, whose experiences are shaped by migration patterns, economic marginalisation, and cultural beliefs about health. By focusing on the Somali population in Bristol, this research responds to the limitations of current public health discourse and data collection that fail to differentiate between African heritage groups. The findings of this study demonstrate the value of centring Somali voices and lived experiences, showing that their understanding and management of diabetes is influenced by several factors, both wider social implications and factors within the community's control. Through a qualitative, community-engaged approach, this research aims to produce knowledge that can inform policy and health initiatives, ultimately advocating for more culturally competent and community-specific healthcare provision. In doing so, it contributes to a developed understanding of type 2 diabetes in the UK and challenges the homogenisation of African heritage populations in health policy and academic discourse (Gebrial, 2022).

Literature review

The existing body of literature examining health disparities in the UK reveals significant ethnic inequalities in the prevalence, diagnosis, and management of type 2 diabetes (Whyte et al., 2019; Mathur et al., 2020). These disparities are not only medical but are embedded in structural and systemic patterns that shape access to healthcare. A key example is the variation in the frequency of HbA1c testing, which is an essential diagnostic and monitoring tool for diabetes (Whyte et al., 2019). Research has found that South Asian, black African, and black Caribbean populations are less likely to receive consistent HbA1c testing when compared to their white British counterparts (Whyte et al., 2019). This inconsistency contributed to later diagnosis and inadequate monitoritung, which in turn exacerbates long-term health outcomes for these communities (Mathur et al., 2020). While this research

highlights patterns of inequality, much of the existing literature takes a broad, often hegemonic approach by grouping multiple ethnic groups into overarching categories such as “Black” or “South Asian” (Nagar et al., 2021). Such classification risk overlooking the nuanced, community-specific factors that shape health outcomes, including language barriers, migration histories, cultural understandings of illness, and generational differences in health education. Meaningful differences across communities, including those between East African and West African groups, or between Pakistani and Bangladeshi populations, whose lived experiences and health needs diverge significantly are obscured by hegemonic data sets. This project responds to that gap by offering a more targeted investigation into the experience of type 2 diabetes within Bristol’s Somali community; a group that is often underrepresented in health research despite facing both ethnic and socioeconomic disadvantage (Centre on Dynamics of Ethnicity (CoDE), 2017). Drawing on qualitative research, this study explores not only disparities in diagnostic practices but also the broader institutional, cultural, and economic structures that shape them. While comparative studies have largely focused on South Asian and black Caribbean populations in relation to white British groups (Thomas et al, 2012), this project seeks to decentre those dominant frameworks and foreground a less-examined population whose experience may offer fresh insight into the structural mechanisms of inequality.

Alongside ethinic inequalities in the experince of type 2 diabetes in the UK, socioeconomic deprivation adds another important layer to our analysis, as the Somali community in Bristol is among the most economically disadvantaged ethnic group in the city (CoDE, 2017). Economic marginalisation often intersects with low health literacy, limited access to culturally appropriate care, and language barriers, further compounding health risk (Hill-Briggs et al., 2020). Therefore, this review is not only concerned with literature revealing disparities but also with understanding why they persist and how institutional frameworks can either mitigate or reinforce them. What follows is a review of the literature on type 2 diabetes in the UK, with a focus on ethnic disparities, healthcare acces, and the sociological dimensions of health inequalities that will benefit this study in investigating the unique experince of Bristol’s Somali population and type 2 diabetes. By situating this research within broader academic insights on race, class, and health justice, this reviewed aims to lay

the groundwork for a more contextualised and community-specific understanding of diabetes in under-researched populations such as Bristol's Somali community.

Diabetes health inequalities

The literature often highlights the key role of socioeconomic status (SES) when examining the experience of diabetes and its disproportionate effects on ethnic minority groups (Hill-Briggs et al, 2020: Whyte et al., 2019). For example, earlier use of the cultural deprivation theory often draws on the effects of cognitive competence in schools for disadvantaged children (Taba, 1964; Das, 1973). The current literature draws on this sociological concept, where marginalised communities particularly ethnic minority groups with low SES can experience a communicative disadvantage of understanding the health literacy surrounding health issues, which my research project will investigate, particularly how this effects a Somali community (Woodward et al., 2024). The issue, however, with much of the research surrounding ethnic inequalities of type 2 diabetes in the UK (Negar et al., 2021; Thomas et., 2012; Whyte et al., 2019) is the grouping of communities of Black African heritage into the same data. Instead, we should avoid the issue of hegemonic approaches to understanding health disparities, for example, by focusing on separate groups within the large category of Black Africans in the UK. Therefore, this project will call attention to the Somali community in Bristol who experience significant ethnic and economic disadvantages that ultimately impact their health experiences (CoDE, 2017). While literature on the UK's Somali population has considered what factors drew many Somali refugees to the UK (Day and White, 2002), this research project aims to develop an understanding of the emotional impact of their migration patterns and how this has effects on their health and experiences of type 2 diabetes. Previous literture has suggested the effects of living in unsafe neighbourhoods as triggering anxiety and contributing to the development of health conditions such as type 2 diabetes (McEwen and Gianaros, 2010).

Furthermore, some pieces of research points to the role of socioeconomic determinants and risk of diabetes as well as the effects of seeking asylum and developing health issues due to traumatic experiences (Feldman, 2006; Kinzie et al., 2008; Wieland et al., 2011). Research carried out in America on psychiatric patients from four different refugee backgrounds, including Vietnam, Cambodia, Bosnia, and Somalia, found a significant link between trauma through asylum seeking processes and medical diseases such as diabetes and hypertension

(Kinzie et al., 2008). Similarly, the research project I will be conducting will investigate the social status and impact of seeking asylum originally for the Bristol Somali population and what effects they feel that process has had on their health experiences and how such stressful experiences have impacted their health. Additionally, I will investigate the effects of living in unsafe areas in Bristol and how the Somali community feel this effects their mental and physical health. The literature which focuses on cultural elements predetermining diabetes among ethnic minority groups (Nagar et al., 2021) is limited in their data analysis, as wider social structures should also be considered as explaining divisions in the experience of diabetes in the UK. As the sociological concept of cultural deprivation does include a deficit in appropriate educational resources, my research will investigate the extent to which this impacts the Somali population in Bristol, who face educational inequalities and their health risks (Lipton, 1962; CoDE, 2017). This research will add to the literature of pushing health policies and professionals to provid appropriate educational resources on the risks and implications of diabetes.

Economic concentration

The literature consistently demonstrates that socioeconomic status (SES) plays a pivotal role in shaping the health outcomes of ethnic minority communities in the UK, particularly in relation to type 2 diabetes. Hill-Briggs at al. (2020) emphasise the significant of social determinants of health, including income, education, and housing, in shaping chronic disease outcomes, arguing that these factors are not peripheral but central to understanding why certain populations, such as Black and ethnic minority groups, suffer disproportionately from diabetes. Importantly, this highlights the need for a more nuanced analysis of how lived socioeconomic realities influence diabetes risk and management, especially among marginalised groups such as the Somali community in the UK. Current studies support this claim by establishing a direct link between economic deprivation and heightened diabetes risk (Thomas et al., 2012; Woodward et al., 2024). Thomas et al. (2012) reveal that ethnic minority groups such as South Asian, black African, and black Caribbean communites in the UK experience a higher prevalence of type 2 diabetes compared to their white counterparts. While ethnicity has often been discussed in cultural or biological terms, this research will consider, similarly to Hill-Briggs et al. (2020), that socioeconomic deprivation plays a far more determinant role in shaping health outcomes than cultural differences alone. This is

echoed in Woodward et al. (2024), who demonstrate that low-income status exacerbates both the risk of diabetes onset, and the complications associated with poor self-management, particularly through reduced access to healthcare, nutritious food, and safe environments for physical activity. The risk is not only in disease development but also in the transition from pre-diabetic conditions to full type 2 diabetes. Chatzi et al. (2023) provide compelling evidence that socioeconomically disadvantaged populations are more likely to progress from non-diabetic hyperglycaemia (NDH) to type 2 diabetes, suggesting that limited resources, stress, and environmental constraints significantly impair opportunities for effective prevention. These findings imply that public health interventions must move beyond surface-level cultural awareness and instead address the structural economic factors that constrain health-promoting behaviours among low-income ethnic communities.

To further contextualise these issues, Wilkinson and Pickett (2009) offer a foundational sociological framework by linking income inequality with chronic illness, noting that psychological stress, poor living conditions, and social exclusion exacerbate both physical and mental health conditions. Their analysis highlights how the cumulative effects of poverty, such as living in overcrowded or unsafe housing, experiencing food insecurities, and reduced access to adequate care, create a climate in which the self-management of chronic illnesses like diabetes becomes exceptionally difficult. Matheson and Patterson (2020) also contribute to this discussion by drawing attention to how healthcare systems themselves can be exclusionary for populations with lower levels of formal education or digital literacy, which often coincides with economic hardship. In the context of the Somali population in Bristol, these structural disadvantages are further amplified by racialised labour market dynamics and migration histories. Gebrial's (2022) discussion of racial capitalism provides a critical lens for understanding how migrant communities are often situated in low-paid, precarious labour, which compounds their risks of chronic illness by fostering long-term instability and stress. This project will draw on the concept of racial capitalism to examine how job precarity and underemployment within the Somali community in Bristol, contributes to the development and poor management of type 2 diabetes. By focusing on the Somali community in Bristol, a population marked by both economic and ethnic marginalisation, this research aims to fill a gap in the existing literture and shed light on how

the community themselves understand intersectional mechanisms that perpetuate health inequalities.

Improving health policies

This next section will focus on the literature surrounding the theme of improving health policies that are culturally competent as well as challenging epistemic injustice (Fricker, 2007). Before suggesting ways in which the health policies and prevention initiatives can improve, literature suggests that while there is an over-representation of ethnic minority groups in the UK needing diabetes prevention programmes, the result of participation in the intervention stage are of low engagement (Chatzi et al., 2023). Some would suggest that this is due to a poor relationship between the health sector and ethnic minority communities (Korsch, Gozzi and Francis, 1968). Moreover, sociological literature suggests these gaps in communication occur as health professionals either perform a more expressive role that emphasises the social and psychological relationship with their patients or an instrumental role that involves dealing with patients through a technical approach, such as giving a diagnosis, which may come across as blunt (Parsons, 1951; Korsch, Gozzi and Francis, 1968; Kidd and Carel, 2016). This functional lens also recognises doctors' perceived biases towards some patients, which can be racially motivated leading to the mistreatment of ethnic minorities (Korsch, Gozzi and Francis, 1968). Parsons (1951) also discusses the role of "illness" in society as a performative function. A key function of the role of "illness," is being exempt from common social activities (Parsons, 1951). As the literature on the Muslim South Asian community has highlighted some diabetic Muslims cannot engage in the obligatory religious practice of fasting (Macaden and Clarke, 2006). Previous literature has highlighted the necessity for developing a trusting relationship between marginalised communities, who face health risks at a disproptionate rate, and the healthcare sector (Matheson and Patternson, 2020). This literature reveals several structural barriers that cause marginalised communities for being less likely to engage with health services. These include internal barriers such as a lack in education or external barriers such as discrimination (Matheson and Patternson, 2020). My current research project aims to analyse the implications of systemic barriers and its impacts on the Somali community in Bristol and their experience of type 2 diabetes. We will investigate how descriminative experiences and economic deprivation can lead to psychological influences causing a distrust with the healthcare

system. Additionally, research on refugee and asylum seekers suggests an increase in stress due to post-migration patterns (Feldman, 2006). My research's focus on a Somali population in the UK aims to investigate their migration patterns such as experiences of marginalisation and economic deprivation leading to heightened stress and an increased risk of type 2 diabetes. Communicative and informational barriers will also be explored as a potential factor in the increased risk of diabetes (Feldman, 2006). Moreover, the literature surrounding the concept of epistemic injustice describes the issues of communication between ill persons and healthcare professional as disparaging the patients' own knowledge (Fricker, 2007). The literature surrounding this issue of epistemic injustice is beneficial to my approach in research as rather than making assumptions as to why the Somali population in the UK experience diabetes at a disproportionate rate, I will amplify this community's own opinions, knowledge, and understandings on the disproportionate effects of diabetes in ethnic minority groups. Previous literature also highlights how language functions not just as a medium for communication but as a mechanism of institutional power (Kupiers, 1989). Focusing on the Somali population in Bristol, this research will investigate how medical discourse impacts the community's experience of dealing with type 2 diabetes. Epistemic injustice raises the concern for improving health policies, services, and programmes (Zeh et al., 2012). The literature surrounding culturally competent health care interventions call for tailored and culturally appropriate services that reach marginalised communities in effective ways (George, Thornicroft and Dogra, 2015).

Cultural attitudes to health

Previous studies have explored the impact of cultural beliefs and perceptions in the self-management of type 2 diabetes (Omodar, Gibson and Bowpitt, 2021). However, such studies are limited in their heterogenous approach to understanding cultural impacts to health experiences. Instead, my research will draw on the specific cultural perspectives and attitudes surrounding diabetes in a Somali population in the UK. Still, the insights from earlier studies are beneficial to further research as they highlight the impact of cultural beliefs and knowledge surrounding diabetes as well as its influence on self-management (Abubakari et al., 2013; Omodar, Gibson and Bowpitt, 2021). The literature surrounding ethnic differences in their perceptions of diabetes and its effects have revealed patients from different ethnic backgrounds, including white British and black Africans, that are taking

specifc medication such as insulin are equally likely to have some diabetes-specific knowledge (Abubakari et al., 2013). The research compares this attitude to patients that are treated with lifestyle treatments such as diet and exercise as being less likely to have diabetes-specific knowledge (Abubakari et al., 2013). This is an important contrast that I will be exploring with the Somali community in Bristol, particularly discussing whether patients within the community take their diabetes more seriously if they are treated with medication and if recommended lifestyle changes are culturally appropriate and therefore likely to be followed.

Essentially, literature on ethnic differences in illness perceptions emphasise the importance of diabetes specifc knowledge as a supportive factor for self management and tackling diabetes (Abdubakarki et al., 2013; Omodar, Gibson and Bowpitt, 2021). It is suggested that difference in diabetes-specifc knowledge is a key determinant for ethnic disparities in the experience of type 2 diabetes (Abubakari et al., 2013). Misconceptions of diabetes, such as it being a less serious condition is a notion found among ethnic minoirty populations (Abubakari et al., 2013). Incorrect perceptions of type 2 diabetes should be corrected by health initiatives for communities to fully grasp the disease they are facing or ar at risk of. By focusing on the Somali community and their own knowledge surrounding this issue, my research will encourage health care professionals and policy makers to create informed initiatives that are culturally appropriate to ensure the understandings of type 2 diabetes and self-management are available for this community. Furthermore, the literature surrounding the South Asian population in the UK and their experience of diabetes has found the overall impact of social stigma within the community to have an effect on the control and management of diabetes for patients (Singh, Cinnirella and Bradley, 2012). My research will add to the literature on cultural stigmas surrounding diabtetes by finding out if there are any social stigmas in the Somali community and what negative impacts could they have on diabetes management. According to research on the South Asian population in the UK, diabetes management would be far more effective, for this particular ethnic minoirty group, if they were designed to include close family members involvement (Singh, Cinnirella and Bradley, 2012). Such studies show the significance of focused research on specifc groups as diabetes initiatives can be developed and tailored to support different groups. Therefore, my research will call attention to the perspective of a Somali population in the UK and the

ways in which they would like to be supported in tackling the issue of type 2 diabetes. Literature surrounding traditional Somali dietary habits finds that within the traditional culture a diet consisting of red meat, rice and pasta are seen as a sign of affluence while a diet consisting of vegetables and fruits are seen as less desirable (McEwen, Straus and Croker, 2009). As explored in previous studies, this research will investigate the relationship between social status and food as a leading factor in diabetes risk (Wilkinson and Pickett, 2009).

In sum, there is much literature surrounding the topic of type 2 diabetes and how it effects ethnic minority populations. However, the most specific focus is on the South Asian population in the UK or a heterogenous focus on the black African and black Caribbean population alike (Abubakari et al., 2013; Mathur et al., 2020; Omodar, Gibson and Bowpitt, 2021; Macaden and Clarke, 2006). My research aims to add to the current literature on the specific experience of a Somali population in the UK. As considering different cultural understandings and backgrounds independently is key to creating diabetes initiatives and prevention programmes that are suited and tailored to be successful for at-risk populations.

Methodology

The primary aim of this research was to explore the lived experiences, understandings, and knowledge of type 2 diabetes among Brisol's Somali community, with a particular focus on how structural inequalities and cultural barriers influence health outcomes. In doing so, the study adopted a qualitiative methodology to centre the voices and interpretations of community members themselves. This methodological choice was driven by the need to understand deeply rooted, context-specific social processes that cannot be adequately captured through quantitiative means alone. Given that diabetes, more specifically type 2 diabetes, is not only a biological condition but a socially and culturally mediated one, this research adopted a reflexive, community-oriented lens to investigate how Somali individuals perceive and experience diabetes, self-management, and healthcare systems in the UK.

1. Focus groups as method

Why qualitative research?

Qualitiative research provides rich, in-depth insights into peoples lived experiences and is especially valuable when exploring under-researched or marginalised communities (Mason,

2018). Unlike quantitative methods, which often reduce the experiences to numeric indicators, qualitative approaches capture meaning, emotion, and context. Given that the Somali community in the UK is often overlooked or homogenised within broader 'black African' health data categories (Nagar et al., 2021), a qualitative approach was essential for capturing the nuances of this population's specific experiences with type 2 diabetes.

Why focus groups?

Moreover, this study used focus groups as the primary method of data collection. Focus groups are particularly suited to community-based research because they allow participants to engage in dialogue with each other, helping to co-construct meaning in a socially dynamic setting (Kitzinger, 1995). Rather than viewing participants as isolated subjects, I chose focus groups to ensure a space in which shared cultural knowledge and collective concerns can be discussed. Furthermore, focus groups are especially useful for exploring how people discuss health issues in everyday life (Morgan, 1997). In this research, participants were not only providing answers but were also reflecting on each other's experinces, building on shared experinces, and revealing community-specific attitudes. One notable example involved a participant who worked in a local clinic providing culturally appropriate diabetes care. As she shared her experience working with Somali patients, other participants engaged, asked questions, and learned form her input. This dynamic exchange, for example, during the Somali women's focus group: *"Is it true that type 2 diabetes is reversible?" F*ollowed by "*my doctor never told me it was reversible. Thank you."* Illustrates how focus groups allowed for real-time learning and reflection, which supports our aim of developing an image of how the Somali community in Bristol understand type 2 diabetes.

Focus groups helped identify community knowledge gaps, such as the confusion between type 1 and type 2 diabetes, and a shared sense of concern at not being taken seriously unless visibly ill. These moments would likely not have emerged in the same way through individual interviews, which tend to be more formal and private (Barbour and Kitzinger, 1999). The collective nature of focus groups as a method was vital for unpacking the intersections between health, stigma, and socio-cultural expectations in Bristol's Somali community.

2. Thematic analysis

The data collected from the focus groups was analysed using a thematic analysis approach, which provided a flexible yet systematic method for identifying patters and meanings within the participants' narratives. Thematic analysis was particularly well suited to this study given its aim of uncovering community-specific insights into the lived experiences of the Somali community navigating type 2 diabetes in Bristol. Following general social sciences' use of thematic analysis (Braun and Clarke, 2006), I began by familiarising myself with the data through repeated readings of the transcripts, which enabled a deep, contextual understanding of the social and emotional attitudes within the conversations. In line with Mason's (2002) reflections on qualitiative data analysis, I approached the analysis with an interpretivst lens, seeking not just to categorise the content but to explore the meanings participants attached to their words. I began by highlighting key phrases, perceptions, and concerns expressed across the different focus groups. These key opinions were later grouped according to broader social and structural issues, such as healthcare inaccessibility, economic constraints or factors within the Somali culture such as health taboos. The codes were refined and organised into major and minor themes, with care taken to ensure they reflected the participants' perspectives rather than imposing external interpretations.

This transcription process was challenging, however, particularly when participants switched between Somali and English or used culturally specific references. Nonetheless, a key aim of this research was to voice the opinions and perspectives of Bristol's Somali community, therefore it was most necessary to allow them to speak in which ever language they felt most comfortable. Where necessary, translations were done in consultation with the same Somali translator, who was also present during the focus groups. This process reinforced the importance of linguistic sensitivity and cultural context in research with minority groups. Throughout this process, I had to ensure I was aware of my reflexivity by constantly interrogating how my own opinion as a researcher from the Somali community might shape what I noticed or prioritised in the data (Mason, 2018). Thematic analysis allowed me to retain the participants' voices and cultural contexts, offering insights into both individual and collective understandings. Reviewing and refining themes required close attention to the relationships between them, such as how structural barriers like language or healthcare access intersected with lifestyle behaviours or food choices. Thus, I created several tables and copy and pasted direct quotations that fit appropriate themes and sub themes. Once

finalised, the themes became more defined and illustrated with direct quotations from participants to ensure authenticity and transparency.

3. Ethics

This research adhered to the university's ethical guidelines and obtained full ethical approval prior to data collective. Informed consent was obtained from all participants, who were provided with an information sheet. They were informed of their right to withdraw at any time, and verbal and written consent was obtained for recording. The original sample aimed to include Somali men and women aged 20-60. In practice, the participants included those in their year 20s (Somali young people's focus group) and the Somali men's and women's groups ages where from 45-60, leaving an age gap in representation from ages 23-44. Despite this, the depth of discussion provided enough insight into generational and gendered experiences, allowing for generalised but meaningful conclusions about the Somali community in Bristol.

The participants were recruited through word of mouth, given my position as a member of the Somali community in Bristol this process was particualrly easy. Community trust played a key role in parcipant willingness, reflecting the value of insider research in building rapport (Chavez, 2008). An information sheet was distributed explaining the study aims, and sessions were organised in familiar, accessible, safe community settings to ensure engagement. I ensured that the questions remained non-invasive and allowed participants to guide the level of detail they were comfortable with. Despite the limitations of insider research, particularly regarding over-familiarity, I found that being a researcher within the community allowed for participants to feel comfortable with sharing their experiences. There were no notable challenges in recruitment or dat collection due to my insider status, which affirms the potential of culturally embedded research for generating community-informed insights.

The focus group questions were semi-structured and aimed to be non-instrusive, avoiding direct perosnal health disclosures. However, as type 2 diabetes is such a prominent issue in the community, many participants shared their personal experiences of diabetes. Sensitive topics such as personal diagnoses were navigated carefully. When participants voluntarily shared their experiences with type 2 diabetes, these disclosures were handled with empathy and condifentialtity. The fact that participants felt comfortable enough to share such

personal experiences echoes the benefits of discussing community issues as a group, rather than individual interviews.

4. Reflexivity

As a researcher from the Somali community in bristol, my positionality played a key role in shaping this study. Here, it is important to consider the benefits and challenges that come with insider research (Dwyer and Buckle, 2009). For example, insider researchers often gain deeper acces and richer data, as participant feel more comfortable opening up to someone with a shared background (Dwyer and Buckle, 2009). This was certainly the case in this research, where participants expressed appreciation that the research was being conducted by someone from the community who would understand them. However, the insider position also required careful reflexivity. Therefore, I ensured I acknowledged my own biases and emotional ties to the community by analysing the data from an objective perspective.

This methodological approach was used to centre Somali voices in Bristol and provide a culturally grounded understanding of how the community believe structural and social determinants, as well as their own cultural factors, shape their experience with type 2 diabetes. The use of focus groups allowed for community co-construction of knowledge, while thematic analysis helped identify and explore key patterns. Ethical considerations and reflexivity ensured that the research remained community-led and sensitive to power dynamics. By embedding the research with the Somali community, this project contributes not only to academic knowledge but also to the community's own reflections on health.

Data Analysis and Discussion

1. Geographical influences

1.1 Migration patterns

The following section will discuss the ways in which migration patterns, such as seeking asylum (Wieland et al., 2009), can be understood as influencing the risk of type 2 diabetes in Bristol's Somali population. During the focus groups the participants suggested the ways in which their refugee background has affected their health experiences. More specifically, as early research finds, a lot of the population of Somalis living in the UK experienced displacement from Somalia and sought refuge in the UK (Day and White, 2002). The participants in this study referred to these experiences of coming from a refugee background and its implications on their experience of type 2 diabetes.

"When you have been displaced somewhere else other than your country, you have a lot of stuff going on. Stress is one of the major things that have happened to us and has led to diabetes." – Participant from the Somali men's focused groups

This quote illustrates a powerful connection between the experience of being a refugee and the onset of type 2 diabetes. As seen in the literature review, stress is a contributing factor to the increase of type 2 diabetes, which the participants also highlighted (Kelly and Ismail, 2015). Similarly, as a previous study on Somali refugees in the US described the impacts of migration resulting in emotional distress and contributing to chronic illnesses, these participants also expressed the impacts of forced migration (Kinzie et al., 2008; Wieland et al., 2011).

"Our parents were migrating during civil wars and didn't have a place to go to if they had any concerns… our culture is like 'keep it on the low.'" – Somali young person

While this quote suggests cultural attitudes of concealment shaping relationships with health services, we should analyse the role of post-migration patterns and stress levels as a cause for distrust. Feelings of discomfort with health services is very common among marginalised groups, who have experiences of racism, social isolation and economic deprivation, which contribute to the increased risk of health issues (Feldman, 2006).

Furthermore, the cultural expectation to remain resilient and to “keep it on the low,” can be understood as developing as a result of emotional distress during asylum-seeking processes (Feldman, 2006). Furthermore, we can consider the role of stress developing from the challenges of having to adapt to a new cultural environment, economic instability and navigating new healthcare systems.

1.2 Regional risk factors

As described in previous literature, disparities of socioeconomic status account for the increased risk of type 2 diabetes for groups with a low SES (Wilkinson and Pickett, 2009). The quotes below highlight how structural inequalities of low-income areas and high crime rates contribute to chronic stress and ultimately increase the risk of type 2 diabetes (McEwen and Gianaros, 2010). For Bristol’s Somali community, they discussed the implications of their low SES and living in deprived areas. More specifically, the emotional burden of having to raise their families in neighbourhoods with high crime rates was a strong theme discussed. During the Somali women’s focus group many of the participants referred to the areas they live in as having an emotional impact on their stress levels, particularly when worrying about their children’s safety. The fear of their children becoming involved in crime or gang-related activities, particularly among Somali mothers, was described as a source of anxiety and a direct contributor to their increased risk of type 2 diabetes:

“I have seen mums who have boys that have gone on the wrong path and become involved on the roads, which made the mums become so worried they developed diabetes”

“Where we live it is common for our boys to be influenced on the wrong path, which makes us more stressed and worried, so we can't focus on living a healthy life”

These quotes highlight how structural inequalities of low-income areas and high crime rates contribute to chronic stress and ultimately increase the risk of type 2 diabetes (McEwen and Gianaros, 2010). Furthermore, in these quotes, the Somali women raise the difficulties of prioritising their health while living under such circumstances. With these examples, we can consider how a refugee background and the impact of neighbourhood deprivation should be understood as spatial injustices rather than individual risk factors. The support of culturally competent health services should address these experiences of living in deprived and high

crime rate areas as contributing to a cycle of stress, and health decline for many Somali parents in Bristol.

Furthermore, food access emerged as a major theme in understanding the increased risk of type 2 diabetes within Bristol's Somali community. Similarly to earlier research (McEwen, Straus and Crocker, 2009), the participants in this study acknowledged the role their traditional food habits have, such as meals rich in carbohydrates and sweetened teas. However, they also suggested a broader consensus that structural factors like food accessibility and affordability are more influential in their increased risk of type 2 diabetes.

"Cheap unhealthy foods like takeaway shops are what's accessible" – Somali young person

"Most of us we don't eat healthy foods. All the restaurants on Stapleton Road are takeaways. If you look at the food they're selling, it is dangerous." - Participant from the Somali men's focus group

These quotes illustrate how unhealthy foods are not only cheap but also very abundant in the areas where the Somali population in Bristol live. While there is awareness of the health implications of this diet, economic hardship shape what is a realistic possibility for the Somali community in Bristol. Furthermore, the impact of food deserts for communities of a low SES mean that nutritious food is scarce and fast food is abundant, ultimately contributing to the increased risk of health diseases such as type 2 diabetes (Wilkinson and Patterson, 2009). While it could be argued that we should consider individual choice and the individual's ability to challenge food deserts, the findings of this research points towards economic and structural constraints as having a significant impact on Bristol's Somali population and their experience of type 2 diabetes. What appears as 'poor health choices' at the individual level are often structurally enforced decisions made within the context of economic necessity (Hill-Briggs et al., 2020).

2. <u>Occupational patterns</u>

Economic influences including occupational patterns appeared as a key factor in understanding the elevated risk of type 2 diabetes among the Somali community in Bristol. Participants across all focus groups mentioned the ways in which employment patterns, income insecurity, and time poverty influence their health outcomes. As shown in previous data collection (CoDE, 2017), Bristol's black African population, including the Somali

community, experience disproportionately high levels of unemployment or employment in low-wage jobs. Participants described being concentrated in occupations such as care work, cleaning and taxi/ uber driving jobs which are marked by long hours, physically demanding or sedentary routines and low pay. One Somali man explained:
"Economics plays a big role because most of our people are stuggling. They are working domestic work like cleaning or taxi drivers; they don't got good money. They're paying rent and other expenses which are very high."

This reflects how racial capitalism situates racialised groups in undervalued labour sectors that simultaneously sustain the economy and reinforce structural inequality (Gebrial, 2022). These occupational roles also limit them in their opportunities in relation to maintaining a healthy lifestyle. For Somali women in particular, caregiving and cleaning jobs were described as time-consuming and emotionally exhausting, contributing to irregular eating habits and reduced opportunities for self-care.

"I think the work that we do, like the care workers and cleaning means we don't have the time to take care ourselves. Often working long hours, and they don't have time to eat in the morning or lunchtime so sometimes they will eat their meals at 10o'clock in the evening, which is also the wrong foods." – Participant from the Somali women's focus group

These accounts highlight the ways in which economic limitations and insecure employment can increase vulnerability to health issues such as type 2 diabetes (Wilkinson and Pickett, 2009). Furthermore, the participants also mentioned how these jobs enforce a sedentary lifestyle and restricts their physical activity.

"Uber driving and being a security guard is very common for Somali men in the UK "– Somali young person

"There's a lack of exercise, because we don't have time" – Participant from the Somali women's focus group

The time contraints and exhaustion associated with these employment patterns further discourage healthy eating patterns, such as missing mealtimes and having to binge eat at night. Ultimately, this theme illustrates how the labour markets marginalisation of Somali's living in Bristol can cause economic pressures which then cause limitations to their everyday

health practices. Addressing these risks requires structural policy interventions that go beyond individual behaviour, tacking the root causes of occupational health inequality.

3. Cultural influences

This section explores how cultural norms, traditions, and values influence health behaviours among Bristol's Somali community. While the previous analysis on structural barriers and economic limitations has been highlighted as dominating factors in shaping health outcomes for Bristol's Somali population, the participants did also reflect on how cultural expectations and practices interact with these wider determinants to increase the community's vulnerability to type 2 diabetes.

3.1 Traditional food practices

During this research, the participants expressed how traditional Somali cuisine plays a central role in community life and is deeply rooted in tradition, celebration, and hospitality. However, participants acknowledged that their traditional dietary habits, including high-carbohydrate dishes, sweetened teas, and meat-heavy meals, may contribute to poor metabolic health. When asked about their eating habits, a Somali man described their traditional meals as:

"Rice, spaghetti, and meat. Heavy carbohydrates and little vegetables. Unless the vegetables are mixed in the meal, we don't eat it"

Such reflections support earlier research, which identified the Somali diet in the UK to be largely consistent of rice, pasta, red meat and low in fruits and vegetables, which contribute to risks in health (McEwen, Straus and Crocker, 2009). While we can understand how these eating habits can contribute to an increased risk of type 2 diabetes, this current study is interested in investigating *why* these patterns occur in Somali communities in the UK. For instance, we should consider these eating patterns and cultural behaviours within the context of social deprivation, not in isolation. As a Somali women emphasised:

"We think about what we can afford. Sometimes you're not thinking about what you're putting in yourself, it is how can I afford this?"

This quote shows that while traditions may shape eating habits, they are often mediated by material conditions. Moreover, when examining traditional Somali food practices, the responses from the participants suggest that there are difficulties in adapting their traditional eating habits, which they grew up with, and their current environment in Bristol.

"Back home the produce was so organic that they didn't have to change their lifestyles but now that they are in the UK, where the food is processed and they are continuing their lifestyle, you get so many Somali families with type 2 diabetes because they are continuing this lifestyle" – Somali young person

"I also think we bring our food from back home here. Back home it was fine because we were walking, we had the sun and hills, there is no time to sit still." – Participant from the Somali women's focus group

The second quote, in particular, further develops our analysis of their occupational patterns and sedentary lifestyles. The Somali woman is suggesting that the issue is not necessarily the cultural dishes, but also their lack of exercise and therefore we should consider these implications on their risk of type 2 diabetes.

Additionally, the responses in this research found food to be a symbol of social connection and cultural identity, which in the long run can be consequential to their health experiences. For instance, participants described a strong expectation to overfeed guests and family, especially during social events. This practice was described as both an expression of respect and as a sign of cultural preservation.

"My mum trained me to make tradional tea and halwo as soon as guests come. And that's because it shows respect in our culture" – Somali young person

While food practices are often discussed in relation to health outcomes such as type 2 diabetes, it is important to understand how cultural expectations around food are deeply embedded in traditions of respect, social cohesion, and generational continuity. The above quote illustrates not only the practice of preparing traditional, often sugar-rich foods like *halwo* and sweet tea, but also how such practices are passed down generationally. We can

consider this as playing a key role in shaping food environments in the Somali home. For example, another participant summarised:

"There's this expectation of overfeeding people and food is a social part" – Participant from the Somali women's focus group

Over time, this practice of overfeeding during social gatherings may contribute to patterns of overeating, which can exacerbate risks related to type 2 diabetes. These cultural practices, however, are not simply habits to be changed; they are expressions of cultural belonging and identity. For instance, dietary changes can feel emotionally challenging, particularly for the younger Somali generation, who discussed difficulties in trying to balance health advice with their cultural roots:

"It's difficult to reject because you don't want to seem like an outsider, and you want to preserve your culture." Another Somali young person added:

"Because out parents grew up on the foods they've been eating, it's kind of hard to veer away from what they've been doing for so long"

These reflections show that food is not just about individual choice, but it is embedded within family structures, generational expectations, and the desire for cultural continuity in the UK. Similarly to previous literature on social practices of food in marginalised communities, the Somali participants in this study have also shown how eating and feeding others are infused with meaning beyond nutritional value (Wilkinson and Pickett, 2009). In this context, food is a mechanism of respect, love, and inclusion.

When considering heath interventions aimed at reducing type 2 diabetes in the Somali community in Bristol, it is vital to move beyond simply encouraging dietary changes. Health promotion must account for the cultural meanings of food, recognising the emotional and social costs of challenging traditional practices. The responses from this study would suggest that efforts should instead be aimed at working with these cultural values, encouraging healthier adaptations of traditional foods.

3.2 Body image

Another interesting cultural theme discussed, was the perception of body size and social status, particularly among Somali men. The participants mentioned that within the community, larger body types are traditionally associated with wealth, respect, and health. This could suggest that by linking an overweight body type to prosperity and status, Somali cultural standards are unintentionally contributing to their increased risk of type 2 diabetes. As one Somali young person explained:

"There's a saying in our culture that being chubby is some sort of like a standard."

Similarly, a participant from the Somali men's focus group described how these ideals translate specifically to men:

"As a man our age, they want to have a big belly, and that big belly is like wealthy back home. People believe you are wealthy if you have a big belly, it is a sign of wealth."

These accounts highlight how Somali traditional beauty standards are perhaps rooted in historical understandings of food scarcity and wealth in Somalia and continue to influence health behaviours in the UK. Ultimately, however, larger body size no longer reflect prosperity and instead signifys poor dietary habits and sedentary lifestyles, which are often linked to an increased risk of type 2 diabetes (Wilkinson and Pickett, 2009).

Further analysis would instead suggest that while these body ideals are often framed as "cultural norms," they must also be understood in relation to structural inequalities. For example, Wilkinson and Pickett (2009) argue that individuals experiencing long-term stress due to economic hardships and marginalisation, are more likely to store fat around their abdomen. This abdominal fat is especially harmful and associated with insulin resistance and metabolic disorders such as type 2 diabetes (Wilkinson and Pickett, 2009). With this perspective, the prevalence of larger stomachs among Somali men may not soley reflect cultural beauty standards but rather be a physical representation of stress and financial strain. These raise critical questions:

Is the "big belly" truly a sought-after ideal, or has it become a normalised outcome of structural deprivation, reframed as cultural pride in order to cope with its impacts?

Are we misinterpreting embodied responses to inequality as expressions of cultural values?

I prope these questions as they reframe health risks, such as obesity and type 2 diabetes, not as a result of individual or cultural 'choices' but as socially patterned outcomes. As show in earlier chapters, migration, economic challenges, and discrimination all contribute to chronic stress and unhealthy coping mechanisms, including poor diet and low physical activity, shaping the bodies of those impacted (McEwen, Straus and Crocker, 2009). While cultural ideals around weight play a role in shaping cultural attitudes, they should not be discounted from the structural realities Somali populations face in the UK.

3.3 Health stigmas

This research found that cultural values surrounding stoicism, modesty, and shame, alongside a mistrust in healthcare systems, significantly influence how Somali individuals in Bristol perceive and engage with diabetes care. A key insight emerging from the focus groups was a clear tendency to seek help within the community before approaching healthcare professionals, suggesting both a cultural norm and a coping mechanism rooted in distrust:

"They'll go to other people in the community first, then after that they might go to the doctor" – Participant from the Somali women's focus group

This hesitancy to seek formal medical advice appears to stem not simply from cultural preferences, but from a broader history of strained relationships between ethnic minority communities and the UK healthcare system. As another participant shared:

"There is a trust issue with the NHS and the Somali community."

Such mistrust is not unfounded. Research has long shown that ethnic minority populations often experience dismissal or minimisation of their symptoms by health professionals, leading to worse outcomes (Korsch, Gozzi and Francis, 1968). These experiences contribute to a cycle of under-engagement, where healthcare is perceived as inaccessible (Korsch, Gozzi and Francis, 1968). This dynamic is particularly evident in many marginalised community's perception and management of diabetes (Abubakari et al., 2013). For example, a participant from the Somali men's focus group shed light on how misconceptions around the seriousness of diabetes persists in their community:

"In our culture, we don't take the diabetes serious. We need more awareness."

While this comment may initially appear to point to a cultural gap in health literacy, it also reflects a broader structural gap in health education targeted at minority populations. Again, misunderstandings about the seriousness of type 2 diabetes are not merely individual but are often compounded by a lack of culturally appropriate health education, leaving communities, like this research group, vulnerable to misinformation (Abubakari et al., 2013).

Another significant theme discussed was the impact of a Somali cultural notion of modesty and shame – "ceeb culture," which participants noted often prevents older generations, particularly women, from speaking openly about their health:

"Being a Somali woman comes with modesty, which we call the "ceeb culture," like a "shame culture." I think the girls in our generation, we're more open, like we can say what's going on with our bodies without feeling that shame. But our mums, who've had to skip that stage of life with education and had to start a new life here and busy raising us. They don't understand that it's not actually shameful to speak about the symptoms you're experiencing." – Somali young person

This insight reveals that while younger Somalis raised in the UK may feel more empowered to challenge cultural silence around illness, older generations experience restrictions shaped by migration trauma, language barriers and unfamiliarity with Western health systems. These structural barriers make it difficult for the older Somali generation to break away from patterns of concealment and self-reliance. Moreover, this stoicism could also be understood as a psychological defence developed in response to structural neglect (Matheson and Patterson, 2020).

4. Health education

4.1 Diabetes-specific knowledge

Health education plays a critical role in the prevention and effective management of type 2 diabetes. Limited health literacy and poor knowledge of diabetes are significant barriers to self-management, impacting ethnic minority group disproportionately (Abubakari, 2013). This research highlights how Somali individuals in Bristol navigate health care systems and how these experiences influence their understanding of diabetes. Within these systems, participants described a distrust in mainstream health services shaped by personal

experiences as well as broader histories of institutional neglect, leading to a gap in diabetes specific knowledge. This research found a generational divide in relation to diabetes awareness and diabetes-specific knowledge, particularly in relation to Western schooling systems. The younger Somali participants, for example, expressed a difference in diabetes awareness and preventive health behaviours:

"From reception we were taught the "eat well" plate, how much carbohydrates, protein, fruits and veg. But our parents didn't have that"

This reflects a key education gap across generations, while younger Somali exposed to British schooling systems have access to foundational health knowledge, older generations may lack the same information and thus experience greater barriers to diabetes prevention and management. However, it is important to recognise the limitations of framing Western health models as the default or only "correct" way of understanding nutrition and wellbeing. As discussed by the participants in earlier chapters, the traditional lifestyle in Somalia involved high physical activity and natural food consumption, meaning that individuals rarely had to consciously monitor their caloric intake or dietary balance. Therefore, we should be critical of how Eurocentric health norms are imposed onto migrant communities without considering their unique cultural contexts.

Instead, this research suggests the Somali adults in Bristol are not rejecting healthy lifestyles but are struggling to adapt with a new health landscape where physical activity is diminished, processed foods are more accessible, and dietary advice is not culturally or economically tailored. As one Somali man explained:

'Sometimes you can be low income and buy healthy food, but they don't understand. They think there is only one option, because they don't have better information"

While financial hardship impact food choices, pariticpants suggested that better-targeted information could empower individuals to make healthier choices even within tight budgets. Another issue found, however, is the lack of culturally appropriate dietary advice:

"When he tells me I need to change my food, where do I get the other food?"

Advice to "eat healthy" may seem straightforward from a clinical perspective, but without offering affordable and culturally relevant options, suhc advice may feel alienated and

impractical. Furthermore, distrust with health services may lead to misinformation on diabetes. One participant suggested:

"The older generation might be like nervous and think they're not going to be taken serious, unless they exaggerate" – Somali young person

"They're also aware that Black women are more likely to be taken less seriously in health care so that is one factor… there's a lot of fear." – Somali young person

This quote reflects how the first-generation Somalis in Bristol may experience anxiety and distrust toward medical instituions, shaped by feelings of discrimination and fear of not being taken seriously. Such sentiments point to more than a lack of knowledge; they reveal the lasting impact of structural inequalities and healthcare marginalisation (Korsch, Gozzi and Francis, 1968).

4.2 Access to diabetes support

As well as fear about the healthcare system itself, this fear also includes how it operates and communicates. For instance, language barriers were described as a significant issue, particularly for the older Somali women, who often feel disempowered during medical consultations.

"The gp is good, but they have the power with their language, and we cannot understand, we need more support" – Participant from the Somali women's focus group

"We need more empowerment and places to go where we are understood" – Participant from the Somali women's focus group

These quotes highlight the larger structural power dynamics embedded within healthcare interactions, particularly the impacts of language barriers. The mention of "power" and language points to medical discouse being rooted in structures of authority, where health professionals, through their control of specialised language, exert power over patients, shaping the course of medical interactions and often silencing alternative voices (Kuipers, 1989). Within this context, language becomes a gatekeeping tool and highlights failures of accessibility (Matheson and Patterson, 2020). Participants emphasised that it was not simply a case of not understanding English, but rather that the health system itself often failed to be accessible, inclusive, and culturally sensitive. The focus groups also highlighted the

positive impact of culturally appropriate services in improving their experiences of diabetes care. One participant, speaking about Caafi Health, a Somali-led health initiative in Bristol, said:

"The GPs are good, but the culturally appropriate clinics are much better" – Participant from the Somali men's focus group.

This reflection indicates that when services are designed with cultural and linguistic competence at their core, Somali patients feel more respected, understood, and empowered. Moreover, the feeling of exclusion in mainstream health services and diabetes support in Bristol was described further during the Somali men's focus group, as one participant shared:

"When I go to the GP, they only show Asians and how it affects them… no one knows about us"

Here we can consider how a sense of invisibility in health messaging contributes to the broader distrust of healthcare systems, leaving communities like the Somali population underserved and underinformed about health issues such as type 2 diabetes. As shown in the literature review, much of the focus on tackling type 2 diabetes in marginalised communities takes a hegemonic perspective. This quote suggests that when patients do not see their identities reflected in health campaigns or education efforts, it not only affects their access to relevant knowledge, such as diabetes prevention strategies, but also reinforces mistrust towards health systems that appear to cater only to certain groups (Matheson and Patterson, 2020). In this sense, exclusion from health messaging adds another layer to language and communication barriers.

Conclusion

To conclude, this research has sought to contribute to a more nuanced understanding of type 2 diabetes within the UK's Somali population, addressing an ongoing gap in both public health literature and policy design. By centring the lived experience and voices of Somali individuals in Bristol, the project has demonstrated the importance of shifting away from hegemonic approaches to ethnicity in heathcare data. Throughout this study, participants articulated a wide range of personal, cultural, and structural factors shaping their experiences of type 2 diabetes. On one hand, certain risk factors identified by participants related to community-specific behaviours and attitudes. For instance, discussions revealed socialising patterns found among older Somali men, who frequently meet in Somali cafes, performing dietary practices that might heighten their risk of diabetes. While dietary misconceptions, such as limited understanding of what constitutes "healthy" food also contribute to the challenges of diabetes self-management. These community-based insights are crucial, as they demonstrate that knowledge gaps and behaviours are not necessarily due to lack of willingness to change, but often due to insufficient or culturally irrelevant health information (Matheson and Patterson, 2020: Woodward et al., 2024).

However, this project has also brought attention to the more significant and often-recognised factors beyond the Somali community's immediate control. Langauge barriers, experiences of disempowerment in healthcare settings, administrative obstacles, and limited acces to culturally competent health services all emerged as key contributors to the community's health inequalities. Rather than framing ethnic disparities in diabetes by placing blame on cultural differences for poor health outcomes, this study takes a grounded, participatory approach to understanding risk. The voices of Somali participants offer a powerful counter-narrative to dominant assumptions, revealing that structural inequalities, including economic deprivation, migration history, and residential concentration in low-income ares (Wilkinson and Pickett, 2009; Chatzi et al., 2023), play a defining role in the development and management of type 2 diabetes. This aligns with wider public heath research suggesting that socioeconomic status is a more significant predictor of type 2 diabetes than cultural factors alone (Hill-Briggs et al., 2020). Ultimately, this research underscores the urgent need for more culturally competent health strategies, focusing on the specific realities of minority communites. For the Somali population in Bristol, and more

broadly across the UK, healthcare interventions must address not only individual behaviours, but also the structural and institutional barriers that shape these behaviours. By amplifying the voices of the Somali community, this project contributes to a broader academic and policy conversation on health inequalities in the UK, calling for a more inclusive and culturally appropriate approach to diabetes care and prevention.

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Appendix 1: Interview transcript (evidence)

Transcripts from the Somali young people's focus group:

Interviewer: considering yourself as second-generation Somalis in the UK, do you think that you have different attitudes towards your health than say your parents generation? Do you think culture still plays a big part in how you perceive your health?"

Participant B: "yeah I think we are more health conscious, maybe because we have grown up with access to a health care and if we have any problems or issues we can always go an get it checked or sorted, so we're more conscious and open to accepting things. Whereas, our parent were migrating during civil wars and they didn't have a place to go to if they had any concerns. Even though they are conscious of their health and they know something is happening they are more likely to deny it or not feel comfortable enough to go to this place and speak a different language in a different culture and say "look ive for this problem". Instead, our cultures is like "keep it on the low". I think for us, we are more open. If something's wrong we'd go to the gp straight. We've always been in this country so we feel more comfortable to get help"

Participant A: "I think it's easier for us to tackle any health issues because we know the language and how the health system works. A lot of the times our parents will know if something's wrong with there health but they don't always have the same confidence to put it our there and go to the doctors, because of the language barrier. They also don't know the system as much as we do. We also had the access to physical activities, pe was always in the school system for us, so we always were health conscious from young"

Participant M2: "also access to knowledge as well. We can find alternative for the foods we're eating but because our parents grew up on the foods they've been eating it's kind of hard to veer away from what they've been doing for so long. Our main foods are pasta and rice, those are the biggest and simple sugars, which can lead to people getting type 2 diabetes, but it's really hard for our parents to veer away from that. You can get gluten free but my mum doesn't know what that is. Once you bring up these conversations as well the lack of knowledge becomes clear. Our parents wouldn't necessarily know the

health benefits for veering away from that stuff. They kind of see it as changing their traditions, which is something they don't want to do"

Particpant A2: "I'd say we're different compared to the older generation. We've got access to a lot of different things, while the older generation might know one thing and stick to it. Resources play a factor in our understandings of diabetes"

Particpant B: "also like we were saying earlier, I think the difference is due to knowledge. Because from reception we were taugh the 'eat well' plate, how much carbohydrates, protein, fruits and veg. But our parents didn't have that, coming from broken systems, that education wasn't really there. They wasn't taught a healthy balance and how to eat healthy and basically show that it is okay to stay away from what you would normally eat"

Participant M: "I think a big difference is that back home the produce was so organic that they didn't have to change their lifestyles but now that they are in the UK, where the food is processed and they are continuing their lifestyle, you get so many Somali families with type 2 diabetes because they are continuing this lifestyle"

Participant B: "I also think it is the lack of sports and being active because back home you would always be on your feet, you wouldn't be dependent on everyone else but instead you'd have to do everything yourself physically. People tend to go shopping for what they need that same day, so that would be getting their steps in the morning, coming back getting what they need for lunch right before. The way life is back home, it kind of prevents, but doesn't stop, such things (T2D) from happening. Here it's way less active, you work, you come home and its too cold to do anything outside."

Participant M2: "its also unheard of as well, like Somali mum's going to the gym. My dad only recently started the gym"

Transcripts from the Somali men's focus group:

Interviewer: "do you believe T2D is an issue in the Somali community in the UK, if so in what ways?

P1: "it's a huge problem, as it effects the majority of people. I am myself a diabetic."

P2: “it a a big problem in our community. When you have been displaced somewhere else other than your country, you have a lot of stuff going on. Stress is one of the major things that have happened to us and that has led to diabetes.”

P3: “we have a number of people in our community who say “oh ive got diabetes,” and they don’t understand. And then nowadays we’ve had a lot of people we’ve lost, we’ve lost mothers, who’ve left behind young children, because of diabetes. It’s a huge problem. I think it good to see people like you studying this, it would be great because we don’t have any research about the community. No one knows. When I go to the GP they only show Asian and how it effects them and the reasons why it happens to them. Not anything about the African. They’ve got more information and better understanding of the Asian community. The focus is only on Asian and not the African”

P1: “I think that many conditions are seen from the white (peoples) point of view. There is very few focus on black people and the black community. We see more from them than us. We are the 10%”

P2: “when you’ve been displaced and you’ve come from somewhere else you don’t really have time to think about the health problems, it takes time to figure out the problems we have because we are also trying to figure out everyday life, so we’re not thinking “oh, maybe ive got this”. We need guidance and knowledge.”

Interviewer: do you think there are particular things in the Somali culture that cause the community to be at high risk of diabetes?

P3: “yes, our food and lifestyle. Most of us we don’t eat healthy foods. Mainly men we eat junk food, all the restaurants on Stapleton road are takeaways. If you look at the food they’re selling, it is dangerous. None of the food they are selling is healthy. We eat a lot of rice, spaghetti and too much sugar. Every shop you go there is a lot of sugar, this is where the men go. And also there is no exercise. If you go to the coffee shops now, there are people drinking teas that have 5 spoons or 3 spoons of sugar and then they’re eating samosas or other stuff like that, and no exercise. They don’t get better advice or awareness from the GP. The Gp will say to them “oh you’re on the borderline of diabetes,” but they’re not saying “oh you need to do this, otherwise this is what will happen”. We have no better education, this is not the country we came from. Back home you would have the sun and you would be walking. Here we’re not getting that. We used to eat organic food, fresh but this is not fresh. The liver and kidney were eating in the morning is coming from the fridge, it is not fresh. The food is the first one and then lack of exercise”

P2: “yes, it is our food and the lifestyle we live. All we eat is rice, spaghetti and meat. Heavy carbohydrates and little vegetables. Unless the vegetables is mixed in the meal, we don’t eat it”

P4: “our food is a problem also the community didn’t believe diabetes is a real and serious disease. They don’t believe that, most of them. For me the doctor told me, I think 6 years ago, that I am type 2 diabetic. But personally I didn’t change my lifestyle and what they told me is that I have to change my food and do more sports and activity. Before we had a program from the Bristol city council that we get free swimming and activity pass but that stopped a long time ago. In our culture, we don’t take the diabetes serious. We need more awareness. Also we need more subscriptions for activity passes and food also”