DIABETES DECODED

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The compassion and care diabetes requires



Society must replace judgement with understanding and recognize diabetes as a serious but manageable medical condition.

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In an interview with The Daily Star Prof. Dr. Indrajit Prasad, Head of the Department of Endocrinology at Dhaka Medical College Hospital and Secretary General of the Association of Clinical Endocrinologist & Diabetologist of Bangladesh (ACEDB) discusses how diabetes-related stigma, shame and social misconceptions affect patients' emotional well-being and treatment and why families and society must respond with empathy, understanding and support.

The Daily Star (TDS): When we talk about diabetes stigma, what exactly does it mean? How is it different from a general lack of awareness about the disease?

Prof. Dr. Indrajit Prasad: Lack of awareness means not knowing the facts about diabetes. Stigma goes further, involving negative attitudes, unfair judgement and discrimination. People with diabetes may be labelled weak, careless or greedy or blamed for their condition.

In my clinics, I see how shame causes emotional distress, discourages patients from discussing their condition and ultimately keeps them away from necessary treatment.

TDS: In Bangladesh, diabetes is sometimes perceived as a disease of older or wealthy people. How do these misconceptions affect younger patients and people from lower-income backgrounds?

IP: Diabetes knows no age or economic boundaries. Type 1 diabetes usually begins in childhood or adolescence, while type 2 is increasingly diagnosed among people in their twenties and thirties, sometimes even teenagers. South Asians also tend to develop type 2 diabetes at younger ages and lower body weights.

When diabetes is considered an elderly or wealthy person's disease, young people may ignore symptoms out of embarrassment, while lower-income families may assume they are not at risk. Such beliefs delay screening and treatment.

TDS: How often do you encounter patients who hide their diabetes from friends, colleagues or even family members out of fear of social judgement, embarrassment or self-blame? What psychological and medical consequences can this secrecy have?

IP: Many patients hide their condition from colleagues, in-laws or relatives for fear of judgement, appearing physically weak or losing opportunities at work.

Secrecy creates anxiety, social isolation and depression. Patients may skip medication or insulin, avoid glucose monitoring and neglect dietary restrictions to avoid drawing attention. Poor control increases the risk of short-term hypoglycaemia and long-term damage to the eyes, kidneys, nerves, heart and feet. When patients feel safe to be open, they manage diabetes with greater confidence.

TDS: How significantly does family support influence a patient's ability to manage diabetes? Can a supportive family really change the outcome?

IP: Yes, substantially. Diabetes is managed daily at home not just in the doctor's chamber. Families can improve treatment adherence and glucose control by encouraging healthy cooking, exercising together, reminding patients about medication and accompanying them to follow-up visits.

- Shame and secrecy can lead to anxiety, depression, delayed treatment and poor blood glucose control.
- Family support can improve treatment adherence and diabetes management but patients need partnership, not policing.

Emotional support also reduces stress and diabetes burnout. Relatives should learn to recognise low blood glucose and know how to respond. What helps is partnership, not policing.

TDS: In Bangladesh, health conditions can sometimes become a concern during marriage negotiations. Have you encountered cases where a diabetes diagnosis has affected someone's marriage prospects, particularly for women? What misconceptions lie behind this?

IP: Unfortunately, yes. I have seen families hide a young woman's diagnosis, particularly type 1 diabetes, and marriage proposals withdrawn once it becomes known. Men face this too, but the pressure on women is usually greater.

Misconceptions include believing that people with diabetes cannot have normal married lives or children, or that they can transmit the disease to their spouses. Diabetes is not contagious.

TDS: How does diabetes stigma affect women differently from men, particularly in terms of marriage, pregnancy, motherhood and family responsibilities?

IP: Women face additional social pressure, particularly regarding marriage, fertility and pregnancy. Many also priorities their families' health while neglecting their own check-ups.

Women with diabetes should consult their doctors before conceiving so blood glucose can be controlled, medication reviewed and folic acid started. With proper control, monitoring by endocrinologists and obstetricians, and insulin when needed, most can have healthy pregnancies.

TDS: How should society respond when someone needs to check their blood glucose, take insulin or follow a particular dietary routine in a public setting? Why should these everyday practices be normalised?

IP: Checking glucose, injecting insulin, eating a scheduled snack or declining dessert are routine parts of treatment, not reasons for shame.

Schools, offices and social gatherings should accommodate these needs, allowing children to check glucose or eat snacks in class and providing private spaces for injections when preferred. Normalising these practices reduces stress and helps prevent dangerous hypoglycaemia and long-term complications.

TDS: Some patients discontinue medication, avoid insulin or turn to alternative treatments because they fear being judged by family members or society. How serious is this problem?

IP: It is very serious. Stopping treatment can cause uncontrolled glucose and life-threatening emergencies such as diabetic ketoacidosis, particularly among people with type 1 diabetes, who need insulin to survive.

Insulin is surrounded by myths, but it is a natural hormone, not addictive, and starting it early can protect against complications. Some patients also abandon proven treatment for unverified remedies promoted on social media, losing valuable time. Treatment decisions must be guided by medical evidence, not social pressure.

TDS: What is the biggest misconception about diabetes in Bangladeshi society that you believe needs to be challenged, and why?

IP: The biggest misconception is that diabetes results simply from eating too much sugar or living carelessly and is therefore the patient's fault. The reality is more complex. Type 1 diabetes is an autoimmune condition unrelated to diet or lifestyle. Type 2 involves genetic predisposition, family history, ageing, ethnicity and environmental factors. Although lifestyle matters, even people who eat sensibly and stay active can develop it.

Blaming patients creates guilt and discourages treatment. Society must replace judgement with understanding and recognise diabetes as a serious but manageable medical condition, not a personal failure. Families, schools, workplaces and the media all have a role in changing this attitude.