

Moving forward on women, gender equality and diabetes

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**At the Expert Group Meeting on Diabetes, Women and Development
Organized by the Global Alliance for Women's Health (GAWH),
WHO and the World Diabetes Foundation
In cooperation with the Permanent Missions to the United Nations of the
Commonwealth of the Bahamas, Bangladesh, Finland, Niger and Tanzania**

New York, 8 April 2008

Distinguished participants and organizers

I thank the organizers for the opportunity to make some opening remarks on the very important topic of women, gender equality and diabetes.

Resolution 61/225, adopted by the United Nations General Assembly in January 2007, constitutes a break-through in recognition of diabetes as a major health problem in all parts of the world. The resolution recognized that diabetes is a chronic, debilitating and costly disease associated with severe complications, which poses serious risks and challenges for the achievement of internationally agreed development goals, including the Millennium Development Goals.

The resolution designated 14 November, which had been observed as World Diabetes Day by the International Diabetes Federation since 1991, as a United Nations Day to be observed every year beginning in 2007. Member States, relevant organizations of the UN and other international organizations, as well as civil society, were invited to observe World Diabetes Day in order to raise public awareness of diabetes, including through education and the media. In addition, the resolution called on Member States to develop national policies for the prevention, treatment and care of diabetes.

The General Assembly resolution does not mention women or gender equality. Nonetheless, together with the outcomes on women, gender equality and health of the Fourth World Conference on Women in 1995, the 23rd special session of the General Assembly in 2000 and the 43rd session of the Commission on the Status of Women in 1999, the resolution provides a strong mandate for work in this area.

My presentation will provide a background on the existing mandates on women, gender equality and health which can be used strategically to move the important and urgent work on women, gender equality and diabetes forward.

The consequences of diabetes

WHO estimated that, by 2020 chronic diseases will account for almost three-quarters of all deaths worldwide, and that 71 per cent of deaths due to ischaemic heart disease (IHD), 75 per cent of deaths due to stroke, and 70 per cent of deaths due to diabetes will occur in

developing countries. Diabetes cannot be assumed to be a disease which predominates in developed countries. The number of people in the developing world with diabetes will increase by more than 2.5-fold, from 84 million in 1995 to 228 million in 2025. On a global basis, 60 per cent of the burden of chronic diseases will occur in developing countries. The public health and development implications of this phenomenon are staggering, and are already becoming apparent.

In many parts of the world, diabetes is given increased attention as the serious health problem it is. The seriousness of the consequences of the disease can be illustrated by recent WHO data:

- More than 180 million people worldwide have diabetes and it is estimated that this number is likely to more than double by 2030;
- Diabetes causes about 5 per cent of all deaths globally each year;
- Contrary to common perceptions, almost 80 per cent of diabetes deaths occur in low and middle-income countries;
- Almost half of diabetes deaths occur in people under the age of 70 years; and
- Diabetes deaths will increase by more than 50 per cent in the next 10 years unless urgent action is taken.

The economic costs of diabetes are enormous. Reliable and comparable statistics are limited but telling estimates of costs have been made in a number of countries – both developing and developed countries. It is estimated, for example, that between 2006-2015, China will lose \$ 558 billion in foregone national income due to heart disease, stroke and diabetes alone. The total annual cost associated with diabetes in Latin America and the Caribbean – both direct and indirect costs - was estimated as more than US\$ 65,216 million (direct US\$ 10 721; indirect US\$ 54 496. In 2000–2001, direct health care expenditure on diabetes in Australia totalled almost \$784 million, with over one-third (\$289 million) of this spent on hospital services and another quarter (\$204 million) on diabetes-related pharmaceuticals.

A projection model used in a Canadian study showed that if the increase in the prevalence of diabetes follows current trends, healthcare costs for people with diabetes in Canada will increase by 75 per cent between 2000 and 2016. In United State, direct medical and indirect expenditures attributable to diabetes in 2002 were estimated at \$132 billion. Direct medical expenditures alone totalled \$91.8 billion and comprised \$23.2 billion for diabetes care, \$24.6 billion for chronic complications attributable to diabetes, and \$44.1 billion for excess prevalence of general medical conditions.

These estimated costs probably underestimate the true burden of diabetes, even economically because, apart from omitting intangible human costs such as pain and suffering, they do not always include care provided by non-paid caregivers – usually women, and areas of health care spending where people with diabetes are likely to use services at higher rates than people without diabetes (for example, dental care, optometry care, and the use of licensed dieticians). In addition, the cost estimates exclude undiagnosed cases of diabetes.

The implications of these cost estimates need to be established in the broader framework of the internationally agreed development goals, including the Millennium Development Goals. It is important that diabetes, including its differential impact on women, is given increased attention in both developing and developed countries.

General mandates on women, gender equality and health

The **Platform for Action** adopted in 1995 identified Women and Health as a Critical Area of Concern and outlined five strategic objectives, all of which are directly relevant for work with diabetes:

- C.1. Increase women's access throughout the life cycle to appropriate, affordable and quality *health care, information and related services*;
- C.2. Strengthen *preventive programmes* that promote women's health;
- C.3. Undertake gender-sensitive initiatives that address sexually transmitted diseases, HIV/AIDS, and sexual and *reproductive health issues*;
- C.4. Promote *research and disseminate information* on women's health;
- C.5. Increase *resources and monitor follow-up* for women's health.

There are a number of important general health messages in the Platform for Action. Firstly, women have the right to the enjoyment of the highest attainable standard of physical and mental health. Women's health is determined by the social, political and economic context of their lives, as well as by biology. The enjoyment of this right is vital to their life and well-being and their ability to participate in all areas of public and private life. The right of all women to control all aspects of their health is basic to their empowerment. (paras 89 and 92).

Women, gender equality and health was taken up as a priority theme at the **43rd session of the Commission on the Status of Women in 1999**. Among the important agreements reached at this session were the need to allocate, and reallocate where appropriate, adequate resources to ensure that quality health services are accessible to those women who are living in poverty, are disadvantaged or socially excluded (para 7/1f).

The obstacles to achieving the goals set for women's health were elaborated in the outcome of the **23rd special session of the General Assembly in 2000**. These included the absence of a holistic approach to health and health care for women and girls, including because of the predominant focus of health-care systems on treating illness rather than maintaining optimal health, and continuing insufficient attention to the role of social and economic determinants of women's health (para 12). In addition, poverty and the lack of development continued to affect the capacity of many developing countries to provide and expand quality health care for women. A shortage of financial and human resources, as well as restructuring of the health sector and/or the increasing trend to privatization of health-care systems, resulted in poor quality and insufficient health-care services and limited attention to the health of the most vulnerable groups of women. (para 12).

Women, gender equality and diabetes

Although the Platform for Action, the outcome of the 23rd special session and the recommendations from the 43rd session of the Commission on the Status of Women do not specifically mention diabetes, they do call for action on **non-communicable diseases**. For example, the Platform for Action called for increased research on women's health and on the social, economic and political causes and consequences of women's health problems, including the impact of gender and age inequalities, especially with respect to chronic and non-communicable diseases (para 109d). The outcome of the 23rd special session noted that in some countries non-communicable diseases, such as cardio/pulmonary diseases,

hypertension and degenerative diseases, remain among the major causes of mortality and morbidity among women (para 12).

The focus in the recommendations of the Commission on the Status of Women on **preventative measures**, within the primary health-care system, to respond to the broad health needs of women and men (para 7/1d), and on appropriate **screening services** for women, within the context of national health priorities (para 7/1j), is particularly relevant for work on women and diabetes.

The problems created by the lack of **gender-specific health research and technology** and insufficient gender sensitivity in the provision of **health information and health services** was highlighted in the 23rd special session. It was noted that women do not always receive full information about options and services available. (para 12). These aspects need to be taken into account in work on diabetes.

Of particular relevance for the issue of diabetes, is the call for the prioritized adoption and implementation of **measures to address the gender aspects of emerging and continued health challenges, such as diseases which have a disproportionate impact on women's health**, including those resulting in the highest mortality and morbidity rates (23rd special session, para 72a). Diabetes should clearly be included in this category. Measures were also called for to redesign health information and services in order to make them gender-sensitive (para 79a).

One of the important recommendations in the Platform for Action, which is addressed in all subsequent work on women and health, is the need for a **life-cycle approach**. Since women's health is affected by the socio-economic conditions of their lives and their relationships with men, the risks, causes, consequences and appropriate strategies in relation to diabetes will change over time. The situation of the unborn child, girls, adolescents, women of reproductive age, women in menopause and older women needs to be explicitly considered in developing strategies for prevention and treatment of diabetes. The life-cycle has particular relevance at this expert meeting with its focus on diabetes during pregnancy.

Diabetes as a reproductive health issue

Diabetes has long been recognized as a critical factor in ensuring reproductive health, in particular because it can affect the health and wellbeing of both mothers and their unborn children. The 23rd special session defined reproductive health care as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It noted that access to appropriate health-care services is critical for enabling women to go safely through pregnancy and childbirth and for providing couples with the best chance of having a healthy infant (para 72i).

Given the increasing evidence on the risks and serious consequences of gestational pregnancy for the health and wellbeing of both women and their children, it is critical to ensure more effective prevention action through education and screening as well as appropriate treatment, care and follow-up.

About 1.85 million women of reproductive age (18-44 years) have diabetes; about 500,000 of whom do not know they have the disease. Reproductive health care services

should clearly include attention to the risks and consequences of diabetes among pregnant women and for their babies. For expectant mothers with diabetes, these include greater risk for complications such as preeclampsia, cesarean section, and infections and risk for developing type 2 diabetes later on. Children exposed to diabetes in the womb face a great number of risks during the pregnancy and have a greater likelihood of becoming obese during childhood and adolescence and for developing type 2 diabetes later in life.

Women during menopause also experience risks and serious consequences of diabetes. Coronary heart disease is an important cause of illness among middle-aged women with diabetes and the rates are 3-7 times higher among women 45-64 years of age with diabetes than women without diabetes.

Diabetes among older women

The specific health aspects of ageing and the importance of addressing the needs of the growing proportion of older women were recognized in the Platform for Action (para 109d) and the 23rd special session (para 55). The Commission on the Status of Women called for the adoption of preventive and promotional health policies at an early stage to prevent health problems and dependence of older women and enable them to lead independent and healthy lives (para 7/1h) and highlighted the importance of research on the interrelationship between poverty, ageing and gender (para 7/6d).

About 4.5 million women aged 60 years and older have diabetes, and one quarter do not know they have the disease. Between 1980 and 1994 the number of recognized new cases of diabetes among women aged 65 and older increased by 45.7 per cent. Being older and having diabetes accelerates diabetic complications such as heart disease, kidney disease, stroke and blindness. Poor social and economic conditions will leave many older women with diabetes living alone and poor. Because women live on average 7 years longer than men in USA, there are nearly twice as many older women as older men with diabetes. Attention to, and development of research and policies on older women must include attention to diabetes, and diabetes research, policies and programmes must give attention to the specific needs of older women.

Prevalence among women of low socio-economic status

In both developing and developed countries, low socio-economic status is associated with higher risk of diabetes. The Centres for Disease Control and Prevention has estimated that the socioeconomic status of women with diabetes in the US in 2000 was markedly lower than that of women without diabetes. Women with diabetes were more likely than women without diabetes to be non-white; divorced, separated, or widowed; living alone; retired or unable to work. Overall, women with diabetes were approximately twice as likely as women without diabetes to have an annual household income <\$25,000.

The links with nutrition (under-nutrition, malnutrition, obesity), hunger and poverty make very clear the importance of work on diabetes for the achievement of all the Millennium Development Goals, in particular those on poverty, gender equality and health. The links to poverty and low-socio-economic status have implications, for example, for screening and management. The low levels of resources of poor households and communities requires an effective public health response which takes into account all constraints and hinders faced by those suffering from diabetes to access information, treatment and follow-up

care and services. These constraints can include access to transport, possibilities to take time off work and lack of income. It is important to also realize that these constraints may be different, and even more extensive, for women than men.

In many poor countries experience has shown that expensive treatment is not a viable option and that more effective prevention strategies (often directly involving communities) need to be developed. Experience is also showing that a stronger focus on gestational diabetes, which directly benefits women and their babies in the short term and reduces the longer term risk of developing diabetes later in life, may be the way forward.

Nutrition and physical education

Just yesterday, US health department statistics reported on National Public Radio indicated that there has been a 17 percent increase in both obesity and diabetes rates in New York city, which is higher than the statistics for the country as a whole (with a 6 percent increase on obesity and no change in diabetes rates during the same period). This is one manifestation of a world-wide trend.

Urbanization and mechanization in many parts of the world are associated with changes in diet and behaviour – with diets becoming richer in high-fat and high energy foods and lifestyles more sedentary. In many developing countries undergoing economic transition, rising levels of obesity often coexist in the same population (or even the same household) with chronic under-nutrition.

Increases in obesity over the past 30 years have been paralleled by a dramatic rise in the prevalence of diabetes. In the Arab region, for example, there is a distinct link between rapidly changing lifestyles, obesity and diabetes. The spread of late-onset diabetes is a cause for concern. It is important to note that more women than men suffer from the problem in all the Arab countries where statistics are available.

Nutrition, poverty and hunger are also linked. For example, deficiencies in calories and micronutrients, together with malnutrition, are associated with diet-related diseases such as obesity, diabetes and hypertension in the Caribbean.

Nutrition and physical exercise are two key elements in preventing and coping with diabetes. The Commission on the Status of Women called for efforts to encourage women to practise regular sport and recreational activities which have a positive impact on their health, well-being and fitness throughout the whole life cycle, and to ensure that women enjoy equal opportunities to practise sport, use sport facilities and take part in competitions (para 7/1k).

The nutritional status of girls and women was taken up by the 23rd special session of the General Assembly which recognized the effects of severe and moderate malnutrition, the lifelong implications of nutrition and the link between mother and child health (para 79d). This requires attention to inequalities in eating patterns of women and men in different parts of the world which can lay the ground for mal- and under-nourishment.

The critical issues of sound nutrition and physical exercise need to be inculcated from as early as possible to ensure adequate prevention of diabetes. The foundations of a healthy lifestyle which forms the basis of effective prevention strategies must be laid early, starting when the child is in the womb.

In 2007, the Commission on the Status of Women considered as its priority theme: “Eliminating all forms of discrimination and violence against the girl child.” One of the recommendations adopted was to pay attention to adequate food and nutrition and the effects of communicable diseases and to the special needs of adolescents, including raising awareness about eating disorders... (para 14.4). That this is important can be illustrated in the US, where the increased prevalence of obesity among adolescent girls may play a role in the increase in type 2 diabetes among adolescents in the 1990s. The Caribbean is also facing the emerging problem of childhood obesity which places children at risk for serious health problems, including diabetes.

In this context I would like to inform you that the Division for the Advancement of Women has recently launched a new publication on women, gender equality and sport, which has been very well received by women in the sporting world. I hope that this publication can also make a contribution in the context of efforts to prevent diabetes and other diseases related to lack of physical exercise among women. The publication mentions the particular needs of adolescent girls and older women in this respect.

Care-giving

In many societies women take on responsibilities for care-giving roles for family members with diabetes and related complications, particularly in contexts where public health services are not adequate and there are no alternatives provided by private sector or non-profit organizations. This can have a significant impact on women’s own health and opportunities to earn income and secure sustainable livelihoods for their families. In many cases women who are sick themselves, cannot seek treatment because of their caring responsibilities

Research has also shown that the social consequences for women and men can vary greatly. In some parts of the world, women and girls may be discriminated against if their diabetic status is known. They may have difficulties in marrying or, if already married, may be deserted or divorced, leaving them in them in difficult economic circumstances and undermining their potential to receive adequate treatment and care.

The serious consequences of gestational diabetes for women and their babies should be a concern for men as well as women. Child bearing and child rearing are not the sole responsibility of women. Efforts need to be made to increase understanding and engagement of men, as husbands and fathers, in preventing diabetes in pregnancy and providing adequate care and support.

Methodologies for addressing diabetes among women

I have provided an outline of the existing important mandates which should support work on women, gender equality and diabetes – the general mandates on health and others with more specific direct relevance for diabetes. These provide a strong basic framework for work on diabetes.

The need to bridge the gap between commitments on women’s health and implementation, was raised in the Commission on the Status of Women in 1999 (para 7/1b)

and again at the ten-year review of implementation of the Platform for Action in 2005 (Declaration). Intensified efforts and investments are required.

The critical question is what can be done to ensure that these mandates are utilized effectively in the work on women and diabetes. I will briefly outline some of the key elements for bridging the gap between policy and implementation.

Gender approach

Women's health is affected directly by their relationships with men. A gender approach – a comparison of the situation of women and men and their priorities, needs and contributions - is therefore critical in dealing with any health issue, including diabetes.

The Platform for Action highlighted women's right to the enjoyment of the highest standard of health in equality with men. It also noted that although women are affected by many of the same health conditions as men, women experience them differently (PfA, paras 89 and 92). In this context, the Commission on the Status of Women called for clinical trials of pharmaceuticals, medical devices and other medical products to include women, with their full knowledge and consent, and to ensure that the resulting data was analysed for sex and gender differences (para 7/6i).

The WHO resolution on a global strategy on diet, physical activity and health (WHA57.17) adopted in 2004, noted that the prevalence of non-communicable diseases related to diet and physical activity may vary greatly between women and men. Patterns of physical activity and diets differ according to sex, culture and age. National strategies and action plans should therefore be sensitive to such differences (para 32).

It is important to understand, however, to be aware that it is not just a question of differences between women and men in relation to nutrition and physical exercise, as well as other aspects of health, but also of unacceptable inequalities which need to be identified and addressed.

Work on diabetes should include a focus on both men and women and the relations between them. In many societies, for example, women are economically dependent on men. In contexts where men make all the economic decisions it may be difficult for women to achieve equality in access to information, prevention activities, and services and support for diabetes. For this reason, it was pointed out at the 23rd special session that the lack of communication and understanding between men and women on women's health needs may endanger women's health, particularly by increasing their susceptibility to diseases and affecting their access to health care and education, especially in relation to prevention (para 12).

To illustrate why it is important that comparisons be systematically made between women and men, research from the Centres for Disease Control and Prevention in the US shows that the risk of heart disease, the most common complication of diabetes, is more serious among women than men. Among people with diabetes who have had a heart attack, women have lower survival rates and a poorer quality of life than men.

A Rand Corporation study in 2007 showed that women with heart disease and diabetes are less likely to receive several types of routine outpatient medical care than men

who have similar health problems. The routine medical care received by women for their heart disease and diabetes was not as good as the care received by men. Women with diabetes and heart disease do not receive the available low-cost treatments that can forestall serious health problems in the future as often as men with similar problems. The disparities were found among women even though they generally see a doctor or other health care provider more often than men. The disparities also remained after researchers accounted for socioeconomic factors that may influence care. More research is needed to understand the causes of these gender differences in outpatient care.

The Commission on the Status of Women called for developing collection methodologies that would capture the differences between women's and men's life experiences, including through the development and use of gender-specific qualitative and quantitative health indicators that go beyond morbidity, mortality and social indicators, to capture quality of life and the social as well as mental well-being of women and girls (para 7/6c). All data and information on women and health, including on diabetes must, therefore, be always disaggregated by sex and age.

Gender mainstreaming

In the context of methodologies to support work on women, gender equality and diabetes, the importance of the gender mainstreaming strategy should be highlighted. Gender mainstreaming was initiated as a key strategy for promoting gender equality in all areas, including in the health sector, in the Platform for Action in 1995. The Platform noted that, “(i)n addressing inequalities in health status and unequal access to and inadequate health-care services between women and men, Governments and other actors should promote an active and visible policy of mainstreaming a gender perspective in all policies and programmes so that, before decisions are taken, an analysis is made of the effects for women and men, respectively” (para 105). Further guidance on gender mainstreaming in the health sector was provided in the outcome of the 23rd special session of the General Assembly and the consideration of health issues in the 43rd session of the Commission on the Status of Women.

Put simply, gender mainstreaming means that any work on diabetes – research, data collection, policy development, advocacy and information activities, development of programmes and interventions, including treatment, services and monitoring should always take into account relevant gender perspectives, i.e. consider the situation and needs and priorities of both women and men. This is, in fact, simple common sense.

.The use of gender analysis and gender impact assessments has been called for throughout the health sector as well as monitoring of health sector development to ensure that women benefit equally (CSW 43, para 7/7b). Gender perspectives should also be mainstreamed into the training curricula of all health-care and service providers in order to eliminate possible discriminatory attitudes and practices by health professionals which can impede women's access to health services; and to ensure that a gender perspective is developed and applied to treatment and prevention practice in the health sector (CSW 43, para 7/6f).

There are not many examples of successful mainstreaming of gender perspectives in diabetes policies and programmes. One publicized example is the Ministry of Health programme in Mexico on "Incorporation of a Gender Perspective in Priority Health Programs: Program for Prevention and Control of Diabetes Mellitus" which was a winner in

PAHO's contest on "Best Practices Incorporating a Gender Equality Perspective in Health". The programme used a gender perspective to determine differences in diabetes risk factors and rates among women and men in Mexico and to develop interventions which take those differences into account.

Research and data

There are many mandates on improving the collection, dissemination and use of data disaggregated by sex and age and research findings to support work on women and health. In preparing for this presentation, I was surprised how little information was readily available on women and diabetes. There is clearly a need for research and data on diabetes that encompasses the entire life span of all women, including women from special and diverse groups within populations (CSW43, para 7/6a).

Work on diabetes has indicated that certain groups of women, such as pregnant women or women from different ethnic groups, are more susceptible to risk of diabetes and/or adverse complications than others. It has been estimated by the Centers for Disease Control and Prevention, for example, that the prevalence of diabetes is at least 2-4 times higher among black, Hispanic, American Indian, and Asian/Pacific Islander women than among white women in USA. Research and data collection efforts need to explicitly focus on these groups of women.

The importance of statistics can be illustrated by the following data available from the Centers for Disease Control and Prevention in the US, which highlight the prevalence and consequences of diabetes among American.

- More than half the 17 million people in the United States with diabetes are women (9.1 million);
- Between 1990 to 2000, diabetes rates increased 50 per cent for women;
- Death rates for women aged 25-44 years with diabetes are more than 3 times the rate for women without diabetes;
- Coronary heart disease is an important cause of illness among middle-aged women with diabetes, and rates are 3-7 times higher among women 45-64 years old with diabetes than women without diabetes.

Conclusion: using the General Assembly resolution 61/225 strategically

Let me finish where I began with the General Assembly resolution 61/225. Efforts need to be made to use the resolution strategically to increase attention to women, gender equality and diabetes. The annual observance of the World Diabetes Day provides a unique opportunity to bring attention to women, gender equality and diabetes. Gender perspectives should be fully integrated into whatever theme and approach is chosen for these annual World Diabetes Day, and /or themes on specific aspects of women, gender equality and diabetes be proposed as appropriate.

The resolution calls for education on diabetes, including through the media. One practical example of an initiative focused on advocacy for women and gender equality issues is the Global Alliance for Women's Health's (GAWH) campaign on "Women and the Emerging Diabetes Epidemic." A global network of NGOs is being established to disseminate information on diabetes and call on the United Nations and other relevant

organizations to recognize diabetes as an emerging epidemic and to develop policies and programmes that address diabetes from a gender perspective.

In particular, the call for national plans of action on diabetes in the resolution can provide an important opening for enhancing work on women, gender equality and diabetes. Efforts must be made to ensure that the plans of action are based on sound gender analysis. Sex and age disaggregated data must be collected and disseminated and benchmarks, targets and indicators established. Consultation with women's groups and networks must be assured. Effective monitoring systems should be put in place to ensure that the commitments are implemented in practice.

Efforts need to be made to identify the differences and inequalities between women and men in risks, causes, consequences, treatment and coping strategies in relation to diabetes. In developing policies and programmes, it must be ensured that there are no inequalities in access to information, prevention activities, services, and all treatment options for diabetes and related complications. Good practice examples of mainstreaming gender perspectives in data collection, research, policy and programme development and budget allocations should be documented and disseminated.

In discussing costs and resources, it is necessary to both estimate the costs of adequately addressing women, gender equality and diabetes. It is equally important to assess the costs to society if no action is taken.

I hope that these brief comments have been useful as an introduction to the meeting. I wish you a very successful outcome.

Thank you.