Moving forward on women, gender equality and diabetes

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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 Carribean – 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.

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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,

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.

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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.

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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 is 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 differenced (para7/6i).

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. It 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

organizations to recognize diabetes as an emerging epidemic and to develop policies and