I recently had the privilege and the opportunity of travelling around the world as one of the three nominees for Director-General of the World Health Organization (WHO). Wherever I went, in addition to presenting my candidature, I utilised the opportunity to visit hospitals, hospices, primary healthcare centres and communities—and everywhere, I found the footprint of diabetes disturbingly ubiquitous. The official figures are estimated at 415 million adults currently living with diabetes and these estimates are projected to increase to 642 million by 2040. Approximately 199 million women live with diabetes which is projected to rise to 313 million by 2040.¹ I fear this may just be the tip of the iceberg.

Girls and women with diabetes experience a range of challenges. Power dynamics, gender roles and socioeconomic inequalities influence vulnerability to diabetes, such as by exposing women to poor diet and nutrition and physical inactivity disproportionately. These factors also affect women’s access to health services and health seeking behaviour, and amplify the impact of diabetes on women, particularly in developing countries.

Diabetes is one of the leading causes of cardiovascular disease (CVD), blindness, kidney failure and lower-limb amputation. In pregnancy, poorly controlled diabetes increases the risk of maternal and fetal complications. Diabetes is the ninth leading cause of death in women globally, and causes 2.1 million deaths per year. Women with type 2 diabetes are 10 times more likely to have heart disease and have significantly increased risk of depression in comparison to men. Globally, there are more deaths attributable to diabetes in women than men.

These are not mere statistics, but facts which incur heavy physical and emotional and economic toll on families. The suffering of four sisters in my country, Pakistan, epitomizes the problem millions of women face worldwide. At 44 years, Rehmat is the youngest of four sisters—all of whom are obese. Recently Rehmat was hospitalised for a diabetic foot amputation, a common and tragic outcome of uncontrolled diabetes, which will place great difficulties and challenges for her ahead, being so scarred at a young age. Two of Rehmat’s sisters are on dialysis, due to end-stage diabetes-related renal disease, and already one sister has undergone a heart bypass operation unsuccessfully. All sisters suffer from serious damage to their eyes—another complication of diabetes. The burden of care for the entire extended family in emotional, physical and economic terms is devastating. The opportunity cost weighs heavily in terms of the wellbeing and future outlook for their respective families.

The ravages of diabetes are not confined to the realm of noncommunicable diseases (NCDs) alone. In technical and public health parlance, diabetes is clubbed together with the other NCDs, and is as such siloed outside of the mainstream public health, which is still dominated by infectious diseases and reproductive and maternal and child health (RMNCH). It is imperative that we recognise diabetes as an issue that straddles both RMNCH as well as NCDs, as diabetes is a serious and neglected threat to the health of mother and child. Two out of five women with diabetes are in reproductive age and half of all cases of hyperglycaemia in pregnancy occur in women under the age of 30, accounting for over 60 million women worldwide. One in seven births is affected by gestational diabetes (GDM). IDF estimates that 20.9 million or a staggering 16.2% of live births in 2015 had some form of hyperglycaemia in pregnancy. Women with diabetes have more difficulty conceiving and may have poor pregnancy outcomes. Many women with GDM experience pregnancy related complications including high blood pressure, large birth weight babies and obstructed labour. A significant
number of women with GDM also go on to develop type 2 diabetes resulting in further healthcare complications and costs.

Most alarming is that the vast majority of cases of hyperglycaemia in pregnancy have been found to be in low- and middle-income countries, where access to maternal care is limited. GDM can also leave its mark on women for life, as approximately half of women with a history of GDM go on to develop type 2 diabetes within five to ten years of delivery. Women with type 1 diabetes have an increased risk of early miscarriage or having a baby with malformations, in any case.

There is, however, a silver lining to this problem. We know that the majority of cases of type 2 diabetes could be prevented through the adoption of a healthy lifestyle. Approximately, seventy percent of premature deaths among adults are largely due to behaviour initiated during adolescence which is where the potential of lifestyle modification is greatest. This is where the role of women and girls is critically important as they are the key agents in the adoption of healthy lifestyles to improve the health and wellbeing of future generations. As gatekeepers of household nutrition and lifestyle habits they have the potential to drive prevention from the household and beyond.

For all these reasons, I would like to lend my voice of support to IDF’s message on World Diabetes Day to its constituencies—a network of thousands of foundations and societies all over the world. This network has an enormous influence to cascade IDF messages in their countries to governments, policymakers, civil society, the scientific community and people in general to catalyse a whole of societies approach to tackling this challenge.

At a broader public health and health systems level, diabetes prevention and management, along with extensive measures aimed at NCD prevention and control need to be mainstreamed in country planning with adequate attention to the specific needs and priorities of women with diabetes. Women and girls should be empowered with access to knowledge and resources to strengthen their capacity to prevent type 2 diabetes in their families and better safeguard their own health. In addition, type 2 diabetes prevention strategies must focus on maternal health and nutrition and other health behaviours before and during pregnancy, as well as infant and child nutrition.

Antenatal care visits during pregnancy must be optimised for health promotion in young women and early detection of diabetes and GDM.

We can no longer afford to treat diabetes and NCDs as the blind spot of our policies. There must be a conscious effort to drive change. Constituents of IDF can be the drivers of that change. They must marshal the much-needed momentum now, and as a matter of right, not choice, not options.

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