



DELIVERING HEALTHY LIVES AND WELL-BEING FOR WOMEN AND GIRLS

Noncommunicable Diseases
and Universal Health Coverage



With Noncommunicable Diseases (NCDs) causing two of every three deaths of women each year, action to implement Universal Health Coverage (UHC) must recognise and address sex and gender differences in NCD risk factors, care pathways and outcomes if services are to be targeted effectively and deliver healthy lives and well-being for women and girls around the world.

Delivering healthy lives and well-being for women and girls

Noncommunicable Diseases and Universal Health Coverage

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Introduction

Despite a plethora of United Nations (UN) resolutions, World Health Organization action plans and national targets, recent data shows that of 193 countries in the world, only 35 countries for women and 30 for men will achieve Sustainable Development Goal (SDG) target 3.4: a one-third reduction, relative to 2015 levels, in the probability of dying between the ages of 30 and 70 as a result of NCDs.¹



Meeting of "Mais Médicos" (More Doctors) programme to reduce inequalities in access to health services in Santa María city, Brasília (Brazil), March, 2015.

While this may seem a dismal projection, progress can be accelerated and governments can achieve the NCD- and other health-related targets if they take urgent action to address the social, political, environmental, commercial, and gender determinants of health – all of which are included in the SDGs.

In order to drive forward progress on both NCDs and the achievement of the SDGs, a gender-sensitive lens must be applied to health services delivery. We know that women and girls are exposed to risk factors for poor health differently than men and boys; that women and girls face multiple barriers in seeking health services; and that gender equality and equity, both components of basic human rights, remain a lofty goal for the majority of women and girls around the world.

The first UN High-Level Meeting on Universal Health Coverage (UHC), to be held in September 2019 in New York, is an opportunity for governments to recognise that health systems must mainstream gender-sensitive services that address gender-related barriers to health for people of all genders, and secure equitable access to services across the continuum of care, prioritising the most marginalised women and girls.

This policy brief outlines some of the gender-specific dimensions of NCDs that UHC must address, and presents a number of recommendations to improve the health and well-being of girls and women.

¹ [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(18\)31992-5/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31992-5/fulltext)

Burden of disease

NCDs kill 41 million people each year, which is equivalent to 71 per cent of all global deaths. They cause two out of every three deaths among women annually – in fact, NCDs have been the leading causes of death among women around the world for at least the past thirty years.² The burden of death and disability due to NCDs is expected to increase, especially in low- and middle-income countries (LMICs).³

In addition to the NCDs that affect both women and men, women may be affected by a number of sex-specific NCDs, such as gynaecological cancers, as well as experiencing the impacts of gender-based violence. The burden of these conditions is often under-reported and little understood.

Causes of death for women globally in 2016:*


NCDs caused **19.4 MILLION DEATHS** (of 26.5 million), which means


73%
OF DEATHS AMONG WOMEN WERE DUE TO NCDs

*Source: https://www.who.int/healthinfo/global_burden_disease/estimates/en/

CxCa stat for 2018: <https://www.who.int/cancer/cervical-cancer/for-women-and-girls>



CVD caused **8.8 MILLION DEATHS** among women



861,000 DEATHS were due to **DIABETES**



1.5 MILLION women died due to **RESPIRATORY CONDITIONS**



18-25% of women who live in LMICs are living with **DEPRESSION**



Over **300,000** women died from **CERVICAL CANCER** in 2018

² <https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases>

³ <https://www.who.int/global-coordination-mechanism/ncd-themes/NCD-and-women/en/>

“
Through delays, your cancer
can go from stage 1 to stage 3.”

A woman with breast cancer in Kiambu, Kenya, part of the NCD Alliance's Our Views, Our Voices consultation

In many LMICs, underlying determinants such as traditional gender roles, illiteracy and low socio-economic and political status limit the ability of women to protect themselves from NCDs and injuries and seek essential services and care. Social and traditional customs related to gender may impact a woman's exposure to risk factors, such as a lack of mobility; this is reflected in disparities between women's and men's physical activity levels.⁴ Women also experience different exposure to the other main risk factors for NCDs – unhealthy diet, tobacco and alcohol use, and air pollution. Current and future NCD risk can often be predicted by gender norms across cultural contexts.

In addition to the variation in exposure to NCD risk factors between women and men, the impacts of these risk factors also differ, as do experiences with the healthcare system. Women in settings constrained by poverty, limited health infrastructure, and human-resource capacity, are far less likely than women in high-resource settings to access timely, adequate, or affordable diagnosis and care. Many female-specific conditions – such as breast and cervical cancer – carry a stigma which acts as a barrier to detection and treatment. As a result, many NCDs are often detected at a late stage, increasing the likelihood of largely preventable, premature death.

The disadvantages that women face are not uniform. Women with low socio-economic status are often at higher risk of exposure to NCD risk factors and more likely to sustain negative health outcomes due to limited access to quality health services. Women with a minority status related to their ethnicity or tribe, homeless women and women with disabilities all experience multiple disadvantages that overlap and interact. It is vital that we understand these underlying determinants if we are to effectively meet the health needs of the most marginalised women and girls.

⁴ <https://www.bmj.com/content/363/bmj.k4247>



^ The National Cancer Institute (INCAN) in Mexico has offered free treatment and care to women affected by breast cancer since 2007, detecting and successfully treating the disease in thousands of women.

“
I live in the area where traditional
customs and practices prevent
people from doing even exercise.”

A person living with an NCD in Bagamoyo, Tanzania, part of the NCD Alliance's Our Views, Our Voices consultation

**Raising awareness of sex differences
in risk factors**

Women's health research has focused predominantly on maternal and child health and breast cancer, with little attention given to sex and gender differences in chronic diseases that are not specific to women. However, a growing body of research suggests that there are significant sex differences in the impact of risk factors, with implications for health promotion and NCD prevention. For example, a UK study showed that smoking, diabetes and high blood pressure increase the risk of a heart attack more in women than in men, highlighting the need to **ensure that women, as well as men, have access to guideline-based treatments** for diabetes and high blood pressure, and to smoking cessation resources.⁵

⁵ <https://www.bmj.com/content/363/bmj.k4247>

⁶ <https://www.sciencedirect.com/science/article/pii/S0012369216623164>

⁷ <https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002513>

**Addressing biases in healthcare
providers' awareness of diseases**

Chronic Obstructive Pulmonary Disease (COPD) is a highly debilitating disease not traditionally considered a 'women's health' issue, but rather as a problem for older, male smokers. However, evidence shows the prevalence of COPD globally is increasing more rapidly in women than in men, and that the number of female COPD-related deaths now surpasses the number in men in some countries, including the US. COPD is especially prevalent in LMICs, where women in particular are exposed to fumes from biomass fuel for cooking and heating for several hours each day. COPD occurs at a younger age in women and at a lower threshold of exposure to cigarette smoke than in men. These findings highlight the need to **address biases in physicians' awareness of diseases and their symptoms**, to prevent delayed or misdiagnosis of women, leading to poor health outcomes.⁶

**Adopting more integrated models of
healthcare**

Recent decades have seen a sharp rise in the global burden of multimorbidity (multiple health conditions in one individual), with evidence suggesting that women and other groups are particularly affected. A UK study found that the proportion of people experiencing heart disease and stroke who have five or more other health conditions quadrupled between 2000 and 2014; a rise that was not driven by age. The number and type of health conditions experienced varied with gender, as well as age and socio-economic status. Among women, 19.1% of those diagnosed with heart disease and stroke had five or more other health conditions, compared with 12.5% of men, and the proportion of women experiencing depression and anxiety was double that of men. The study highlights the urgent need for a **shift to more integrated models of healthcare and better guidelines to address the management of multiple conditions**, which may need to be tailored to different groups according to gender, age and income.⁷

Delivering UHC for impact

To deliver better outcomes for women and future generations, governments must adopt a gender-sensitive, evidence-based approach to NCD prevention and control across the life-course as a key part of progress towards ensuring UHC for all.

Adopting a life-course approach not only has implications for the way a person's health is considered; it provides a framework for the way health workers are trained, and the way health systems are designed and developed to meet people's needs across the continuum of care. By identifying chains of risk, we can develop targeted interventions, addressing risk factors for chronic disease over the life course and preventing their transmission from generation to generation.

To do this, we need more research to understand the impact of sex and gender on health throughout the life-course - going well beyond the reproductive years - and the factors that influence health trends for women and men. However, in many cases, health data is still not collected and analysed separately for women and men, making it impossible to take a gendered approach. We need both sex- and gender-disaggregated analyses if we are to effectively address the determinants of NCDs, the barriers to women seeking care, and the factors that affect pathways and quality of care for women within healthcare systems.

In many countries, there is a foundation of strong maternal and child health services that was driven by the Millennium Development Goals agenda. We can build on those achievements to support progress towards the SDG targets, but it will require breaking down traditional silos. We need to foster new collaborations and partnerships with the maternal and child health community and others in order to integrate the prevention, screening, and treatment of NCDs into existing maternal, child, and adolescent health programmes, as well as those tackling HIV/AIDS.



^
School girls at an HPV vaccination campaign event in Vietnam.

“

I have had diabetes for 22 years now; treatment drugs are expensive and even more expensive for dialysis - it's so hard that I am just waiting for my day to go to my creator.”

A person living with an NCD in Kampala, Uganda, part of the NCD Alliance's Our Views, Our Voices consultation

“

Because of the poverty, the preoccupation about the basic needs is more important than worrying about NCDs or their risk factors.”

A person living with an NCD in Huye, Rwanda, part of the NCD Alliance's Our Views, Our Voices consultation

Primary healthcare and health services can play an essential role in promoting low-cost and accessible prevention and treatment to marginalised women and girls. Comprehensive UHC that spans the continuum of care from health promotion and prevention, screening and diagnosis to treatment and care, including rehabilitation and palliative care, is particularly important for women and girls, as in many countries, they are the last to receive care or health information. We need to ensure that women and girls have access to education about the importance of screening for diseases, especially when they aren't experiencing any signs or symptoms.

If healthcare provision is to be relevant to users, we also need to involve communities in the design, development and monitoring of services; for example, by adopting one of a number of successful models of citizen representation, such as community-elected boards that provide oversight of health service functions. These boards should have a grassroots focus and be underpinned by strong regulatory frameworks to ensure accountability, with metrics around the numbers of boards, membership and sustainability. The Aboriginal Community Controlled Health Sector in Australia is an excellent example, and there are similar models for First Nations services in Canada and New Zealand. Ensuring equal gender representation in these boards is key.

We must also be mindful of the strong, reciprocal links between NCDs and poverty. Disadvantaged communities are at greatest risk of experiencing chronic conditions and poor outcomes, while out-of-pocket expenditure on healthcare can see a family's finances deteriorate catastrophically.⁸ UHC ensures that all people receive the health services they need without incurring financial hardship, but we need to recognise and address the intersecting inequalities that determine health inequity, and the many non-financial barriers that pose challenges for women and girls.

⁸ [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(18\)30667-6/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30667-6/fulltext)



There is nothing for us without us. Policymakers should involve the people who are affected in policy making.”

A person living with an NCD in Nairobi, Kenya, part of the NCD Alliance's Our Views, Our Voices consultation

Addressing the under-treatment of women

Cardiovascular disease is the leading cause of death among women globally, but it has traditionally been seen as a 'man's problem'. Women often experience cardiovascular disease in a different way to men, but this is poorly recognised, and there is evidence that women are undertreated compared to men as a result.⁹ For example, research shows that women in the United States who have experienced heart attacks are less likely than men to receive the high-intensity statins recommended to prevent further heart attacks and strokes. To address this, we must **raise awareness among physicians of the importance of adhering to guidelines on treatment for women as well as men.**¹⁰

Identifying the barriers women face to accessing health care

In India, research that is highly relevant for the drive towards UHC shows that providing access to free hospital care may not ensure equal access between women and men. Despite an insurance scheme for poor households across the state of Andhra Pradesh, a smaller proportion of women than men received hospital care for sex-neutral conditions across all age groups and most disease categories.¹¹ This highlights the need to **identify non-financial barriers that women might face to accessing healthcare, which may include families prioritising the healthcare needs of men over those of women.**

⁹ <https://www.mdpi.com/1660-4601/16/7/1165>

¹⁰ <http://www.onlinejacc.org/content/71/16/1729>

¹¹ <https://gh.bmj.com/content/3/3/e000859>

¹² <https://www.tandfonline.com/doi/full/10.1080/13697137.2018.1439917>

¹³ <https://www.georgeinstitute.org.uk/projects/smarthealth-pregnancy-improving-womens-life-long-health-in-rural-india>

Adopting innovative screening methods in low-resource contexts

The estimated cervical cancer burden is more than ten times greater in LMICs than in high-income countries. This health gap is thought to be primarily due to limited access to effective screening and treatment programmes in such settings, where providing every woman with a pelvic examination is often not feasible because of limited clinical staff capacity within health systems, and may not be culturally acceptable. However, recently an innovative, easy-to-use and highly accurate test has been developed for the human papillomavirus (HPV) that causes cervical cancer. Trialled in Papua New Guinea, the test can be provided at the point of care, and could **enable LMICs to implement 'test and treat' approaches for cervical cancer screening.**¹²

Integrating prevention of NCDs into maternal health services

In many settings in LMICs, community health workers have traditionally focused on maternal, newborn and child health issues. With the burden of disease for women shifting, we urgently need to **integrate the screening and treatment of NCDs into existing maternal and primary healthcare services;** particularly as health workers such as India's ASHAs (Accredited Social Health Activists) are such a trusted resource in the community. Projects such as SMARThealth Pregnancy in India are investigating how some community health workers can be supported to use smartphone-based technology to improve the screening, detection and management of chronic diseases in women, improving their health over the life-course.¹³

Addressing stigma and social exclusion associated with NCDs and injuries

Globally, burns are a leading cause of disability, with over 11 million years of life lost each year. India has one of the largest burdens of burns, with an estimated seven million burn injuries per year, and disfigurement and permanent disability in 250,000 people annually. According to the National Burns Programme, there are 91,000 burns deaths among women each year; a figure higher than that for maternal mortality. Women of childbearing age are on average three times more likely than men to die of burn injuries.¹⁴ Burns survivors and healthcare providers have identified the stigma attached to burns as a significant challenge within the healthcare system, as well as in the community, highlighting the urgent need to **provide access to appropriate first aid, immediate acute care, and community-based rehabilitation.**¹⁵

Developing appropriate services through engagement with communities

Women from minority groups in particular may need specialised, targeted services in order to overcome barriers to access, and these can only be designed with their meaningful involvement. For example, research in Australia is investigating how the primary healthcare workforce can be supported to provide services for Aboriginal and Torres Strait Islander women who have experienced violence. Developed in response to engagement with end-users from Aboriginal Community Controlled Health Organisations, the project will provide evidence and critical insight into how the primary healthcare workforce can be supported to **provide trauma-informed care that is culturally safe.**¹⁶

¹⁴ <https://www.ncbi.nlm.nih.gov/pubmed/27578343>

¹⁵ <https://bmjopen.bmj.com/content/8/3/e020045>

¹⁶ <https://www.lowitja.org.au/page/research/research-categories/family-and-community-health/womens-health/projects/first-response>



Women at a training event for smartphone-based data collection in their roles as Resident Enumerators (RE) for the PMA2020 project in Rajasthan, India.



Low-income group communities surely face challenges in accessing quality health care; they often tend to delay treatment, which leads to complications.”

A person living with an NCD in Chennai, India, part of the NCD Alliance's Our Views, Our Voices consultation

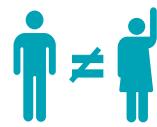
Untapped economic potential: Women in the workforce

Women are often the sole caregivers for other members of their family who are living with an NCD.

This makes them unable to participate in the formal economy and access social benefits, further increasing women's impoverishment. The current rate of women in the global workforce is 49 per cent, compared to 75 per cent of men.¹⁷ Women who are in the labour force are more likely than men to secure certain types of jobs that are lower-status and lower-paid. They are also subject to discrimination, and may be under the threat of violence in some contexts.¹⁸ If the gender gap between men and women in the workforce decreased by 25 per cent, GDP would increase in all regions and global tax revenue could grow by 1.5 trillion USD.¹⁹

PROJECTIONS OF ADDITIONAL GDP growth in 2025

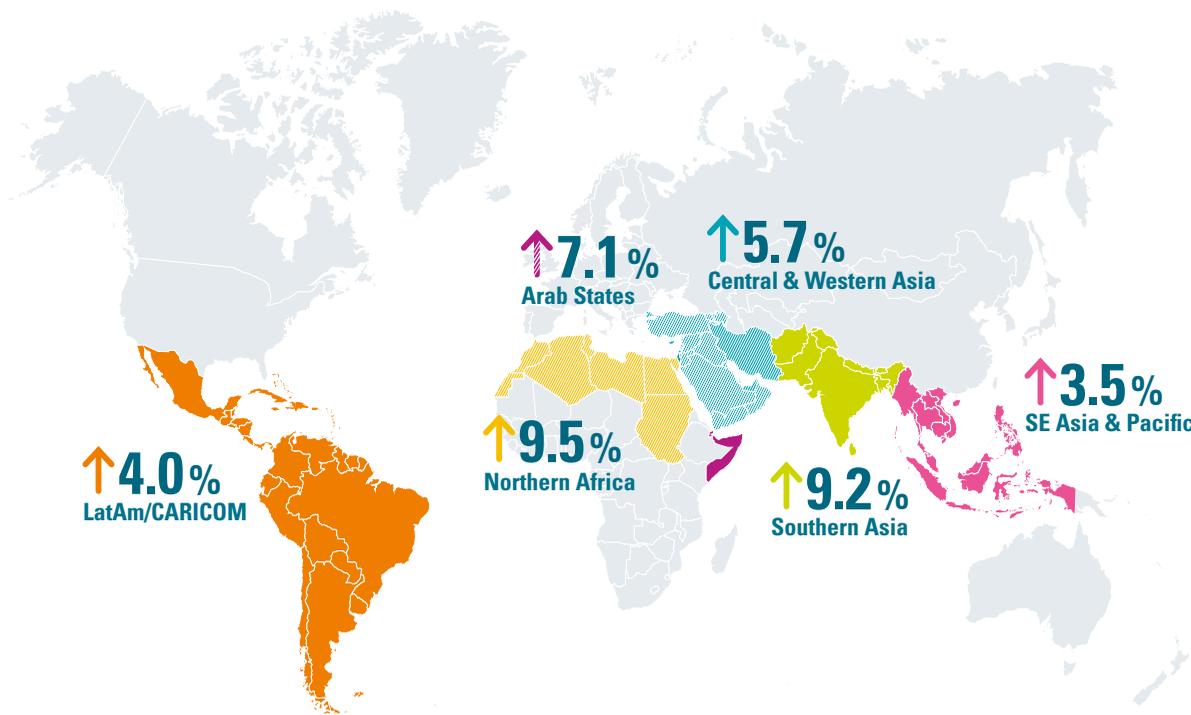
where the



**GENDER GAP
in labour force
participation is
REDUCED by**



25%



In the global health workforce, the gender gap is even more apparent. Though women account for 70 per cent of the health and social care workforce and deliver care to approximately 5 billion people, they remain in lower-status, unrecognised, and lower-paid jobs. Women in health contribute approximately 5 per cent, or 3 trillion USD, to global GDP, out of which almost 50 per cent is unpaid or unrecognised.²⁰ The potential gains for increasing women's participation in the formal labour market are clear, and have benefits that go beyond economics. Women who are part of the workforce are more likely to have financial stability, purchasing power, and better health outcomes – for themselves and for their families.

Community health workers have traditionally focused on reproductive, maternal, newborn and child health services, and in many contexts act as links between communities and health systems. With the growing burden of NCDs, and shortages of trained nurses and physicians to staff the roll out of UHC, community health workers are increasingly being tasked with conducting screening, treatment adherence and follow up for common NCDs as members of multidisciplinary teams. While there are many benefits to this expansion of their skillsets and knowledge, there is an urgent need for training, supervision, access to supplies, and remuneration. It's also vital that they are recognised as active change agents, and involved in decision-making at every level in line with global guidelines.²¹

Recognising women's role in delivering healthcare

India has one of the largest frontline health worker programmes in the world. Almost one million ASHAs, or Accredited Social Health Activists, have been trained since the programme was launched in 2005. Traditionally engaged as volunteers, ASHAs receive performance-based payments rather than regular salaries, but many see themselves as workers deserving recognition and payment as government employees. A study of one of the few community programmes to be scaled up successfully, in Chhattisgarh, suggests that a key factor was the state's willingness to **recognise the livelihood rights of community health workers, and ensure opportunities for professional growth.**²²

WOMEN ACCOUNT FOR



70%
**OF THE HEALTH
AND SOCIAL CARE
WORKFORCE**

¹⁷ <https://www.ilo.org/infostories/en-GB/Stories/Employment/barriers-women#global-gap>

¹⁸ <https://apps.who.int/iris/bitstream/handle/10665/311322/9789241515467-eng.pdf?ua=1>

¹⁹ <https://www.ilo.org/infostories/en-GB/Stories/Employment/barriers-women#gender-gap-matters/effects>

²⁰ <https://apps.who.int/iris/bitstream/handle/10665/311322/9789241515467-eng.pdf?ua=1>

²¹ <https://www.georgeinstitute.org/profiles/hope-of-the-health-system-daughter-in-law-of-community-reflections-on-indias-community>

²² <https://www.tandfonline.com/doi/full/10.1080/23288604.2016.1148802>

Assessing the equity of UHC

Health systems and policies have the potential to reduce inequities, but unless carefully designed and appropriately targeted, they will perpetuate or exacerbate structural inequalities, with interventions targeting already advantaged groups.

It is therefore critical to incorporate inequality measurement in the rollout of UHC in order to monitor intersecting health inequities in access, care pathways and outcomes, and assess the mechanisms underpinning them. Health systems and providers should be given incentives to reduce inequalities, and held accountable if they fail to do so.

In practice, monitoring health inequalities can prove difficult; we urgently need a better understanding of how to systematically identify who is being 'left behind' in order to adopt measures to ensure their inclusion.²³ Where high-quality, disaggregated data are available, tools such as WHO's Health Equity Assessment Toolkit can be used to reveal health inequities,²⁴ but addressing them requires political commitment. Findings should be linked to qualitative, participatory research with communities facing vulnerability, and used to inform decision-making around health policies and services at local levels.²⁵

“
NHIF (insurance) does not cover chronic illnesses. Getting treatment for chronic diseases is very expensive...we are neglected.”

A person living with an NCD in Kiambu, Kenya, part of the NCD Alliance's Our Views, Our Voices consultation

Measuring and incentivising equity to ensure no one is left behind

Over the past 25 years, the UK has introduced several programmes to evaluate and improve the quality of care received by heart failure patients. However, a recent study revealed critical care shortcomings in diagnostic tests, drug prescriptions, and follow-up patterns, and found that women and those over 75 were disproportionately affected. For example, women were 13% less likely than men of the same age to receive a prescription for the two most important drugs in heart failure management within three months of diagnosis.²⁶

Building capacity for health inequality monitoring

Capacity building for health inequality monitoring is a critical step for strengthening equity-oriented national health information systems and eventually tackling health inequities. In 2016-2017, a series of workshops and activities were undertaken in Indonesia after the government expressed interest in incorporating health-inequality monitoring into its national health information system. Key steps included capacity building in identification of the areas of interest; mapping data sources and identifying gaps; conducting equity analyses using raw datasets; and interpreting and reporting inequality results. As a result, Indonesia developed its first national report on the state of health inequality.²⁷



World Mental Health >
Day 2008.

²³ <https://www.georgeinstitute.org.in/news/monitoring-health-inequalities-in-indonesia-moving-from-commitment-to-practice>

²⁴ <https://bmcmmedresmethodol.biomedcentral.com/articles/10.1186/s12874-016-0229-9>

²⁵ <https://www.georgeinstitute.org.in/news/monitoring-health-inequalities-in-indonesia-moving-from-commitment-to-practice>

²⁶ <https://www.georgeinstitute.org/media-releases/women-and-older-people-are-most-likely-to-be-exposed-to-shortcomings-in-heart-failure>

²⁷ <https://www.tandfonline.com/doi/full/10.1080/16549716.2017.1419739>

Recommendations

Gender inequities in health are a reflection of the broader disadvantages women face around the world.

The actions to address health inequities set out here must therefore be backed by a broader agenda of social support, education and empowerment for women and girls; an agenda that requires a whole-of-government approach, concerted investment in social programmes, and strong legislative action.

Governments

- Develop appropriate health policies and services through engagement with communities
- Adopt more integrated models of healthcare and better guidelines to address the management of multiple conditions
- Integrate prevention of NCDs into maternal and child health and HIV/AIDS services
- Build capacity for health inequality monitoring to support action to tackle inequities
- Measure and incentivise health equity to ensure no one is left behind

Health professionals and civil society

- Expand the evidence base and raise awareness of sex and gender differences in risk factors
- Identify and address biases in healthcare providers' awareness of diseases and their symptoms
- Address the under-treatment of women living with NCDs by improving adherence to guidelines

All stakeholders

- Recognise and professionalise women's role in delivering healthcare and expand the health workforce
- Adopt innovative screening methods for NCDs in low-resource contexts where appropriate
- Identify and address the barriers women face to accessing healthcare, including financial barriers
- Address the stigma and social exclusion associated with some NCDs and injuries

< Women collecting water walk on a paved road in Dharampur, Valsad, Gujarat, India.

Edited by NCD Alliance, June 2019

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