

Insights from 10,000 Women on the Impact of NCDs



A 2013 Clinton Global Initiative
Commitment to Action by:



With Partners:



FOREWORD

“This report... helps us to see the breadth of NCDs’ impact on women and to understand that women have a crucial contribution to make in finding and implementing sustainable solutions.”

Non-communicable diseases (NCDs), such as heart disease, stroke, cancer, chronic respiratory diseases and diabetes, are the number one cause of death worldwide. The fight against NCDs is a challenge for developed and developing societies alike. Tobacco-use, pollution, the harmful use of alcohol, poor diet and lack of physical exercise, and mental-health-related diseases place a heavy burden on nations and communities across the world. As always, it is the poorest and most vulnerable who are least resilient, and least able to cope with the impacts on households and their income that can be catastrophic. Families are hit hard – and it is primarily women who bear the consequences.

The rapid rise of chronic diseases, especially in developing countries, and the impact of the environment on health and health security, are now being afforded greater attention on the global health agenda. Increasingly the world is taking behavioural risk factors into account, including major causes of chronic disease, and promoting actions targeting environmental and structural factors.

This report reminds us forcefully of the human face of the NCD toll. As in so many areas, it is a woman’s face. It brings into sharp focus the reality that NCDs are the leading cause of death in women globally. It helps us to see the breadth of NCDs’ impact on women and to understand that women have a crucial contribution to make in finding and implementing sustainable solutions.

In this report the voices of 10,000 women tell us that NCDs are draining their household resources. For nearly one in four women surveyed, some 25% of their household income goes to meeting the cost of NCDs. Four in ten women have to pay out-of-pocket for health care to treat NCDs, and may have to borrow money from family and friends to do so. This is a story about the ubiquity of NCDs, with almost two-thirds of the women surveyed telling us how these diseases have become part of their lives, with at least one person in their household being affected. It is a story of women as carers and the burden they bear, with half the women surveyed tending a family member with an NCD, and two in ten saying their own economic opportunities were diminished as a result. And it is a story of neglect, with women reporting difficulties in accessing health services and crucial testing that could catch NCDs early or even prevent them. It is a salutary story of lack of access, inadequate financing, and insufficient quality of services.

I whole-heartedly welcome this report, and the tireless global advocacy of Arogya World that has drawn on the knowledge and power of women as agents of change. Their work clearly and constructively identifies the linkages to nutrition and healthy lifestyles, and prioritizes prevention of NCDs at the same time as the expansion of responses that address barriers to women’s health.

I applaud Arogya World for providing the space for 10,000 women to make this case so clearly and eloquently, and commend this report to everyone concerned with global health, the struggle against NCDs, the rights of women and girls, and overall human development.



Phumzile Mlambo-Ngcuka
Executive Director of UN Women

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EXECUTIVE SUMMARY

Background: Women and NCDs

Non-communicable diseases (NCDs) represent the world's leading cause of death. While they are the culprit in 63% of all mortalities worldwide, they affect women in unique ways. Collectively these diseases, which include cardiovascular disease, diabetes, cancers and chronic lung disease, kill 18 million women each year and represent the #1 cause of death among females.ⁱ NCDs represent all (10 of 10) of the top 10 causes of death for women in high-income countries, nearly all (9 of 10) in upper-middle-income countries, and half in lower-middle-income countries. Even in low-income countries—such as Afghanistan and Kenya, which have higher rates of fatal maternity complications and contagious disease, 3 of the top 10 causes are NCDs.ⁱⁱ

NCDs are largely preventable—according to the World Health Organization 80% of heart disease, 80% of diabetes and 40% of cancers are preventable by avoiding tobacco, eating healthy foods and increasing physical activity. These serious and treatable diseases come at a staggering price—an estimated \$30 trillion (USD) over the next 20 years alone.ⁱⁱⁱ In addition to the cost of medical care, the opportunity cost for women as they provide care to ailing household members often includes lost earning potential, further exacerbating already impoverished living conditions.

Many women face barriers to receiving the medical care and screenings they need. The barriers include the costs of care, restricted mobility, as well as socio-cultural barriers, especially in countries where women and girls are unable to make decisions about their own care.^{iv}

The four primary risk factors for developing NCDs are: tobacco use, physical inactivity, harmful use of alcohol, and poor diet.^v Emerging research in the field of fetal programming indicates that malnourishment during pregnancy can increase the likelihood of diabetes or heart disease in the offspring when they grow older.^{vi}

Arogya World Survey— A 2013 Clinton Global Initiative Commitment

Though NCDs are the #1 of killer of women, data on women's views on NCDs are scarce. Data will be critical in informing actions and interventions both locally and globally to mitigate the growing impact of NCDs in the years to come. We therefore set out to capture the voices of women from around the world on the impact of NCDs on their lives, and to use the data to move governments to action.

Arogya World and its partners Novartis, Partnership to Fight Chronic Disease, American Cancer Society, UNICEF, Population Services International, Abt SRBI and Jana, designed and launched a global survey of 10,000 women on NCDs, announcing the study as a Commitment to Action at the 2013 Clinton Global Initiative (CGI) Annual Meeting.

We implemented the quantitative study in the first half of 2014 with 10,000 women age 18-40 across 10 low-, middle- and high-income countries. In Afghanistan, face-to-face interviews were conducted with 1,015 women in urban areas March 15-19, 2014, by an in-country market research agency under the direction of Abt SRBI. Surveys via the Web were conducted by Abt SRBI with comparable populations in Mexico (N=1,005), Russia (N=1,004), the United States (N=1,003) and the United Kingdom (N=1,007) between March 25 and April 1, 2014. Surveys on mobile devices were conducted by JANA with comparable populations in Brazil (N=1,000), India (N=1,000), Indonesia (N=1,000), Kenya (N=1,000) and South Africa (N=1,000) March 5-30, 2014.

In a parallel project, we are gathering women's perspectives on NCDs and their impact on families through video interviews with patients and caregivers in the different countries.



In July 2014, as the world took stock of the progress made against NCDs, we shared the study results with multiple stakeholders—ministers, policy makers, public health thought-leaders, civil society and media. We believe this study will influence the global dialogue on NCDs in a post-2015 world. We urge policymakers to implement NCD programs and empower women to steer their families towards healthy living.

Key Results

The Financial Burden from NCDs

NCDs Big Drain on Family Resources

- Nearly one-quarter of the women in our study spend more than 25% of their household income on NCDs, and 7% of women surveyed said that NCD treatment consumes more than half of their household's income.
- This aligns with estimates that health care expenses push 100 million households around the world into poverty each year. The financial impact of NCDs compounds; as household resources dwindle, exposure to risk factors increases, for example, having less money to purchase nutritious food.^{vii} The financial burden is multi-faceted and includes not only direct health care costs, but loss of income by patients and caregivers.

Many Women Pay for Healthcare Out of Pocket, Especially in LMICs

- Although a majority of women have some form of healthcare coverage most of the time, 4 in 10 women report paying doctors directly or borrowing money from friends and family to cover these costs. More than 50% of the women in Afghanistan, India, and Kenya, 50% in South Africa and nearly 50% in Indonesia, pay medical costs out-of-pocket.

"We see the increase of NCDs, especially in developing countries, as a major global health problem. That's why Novartis is proud to collaborate with Arogya World on their 10,000 Women's study, drawing attention to the impact of NCDs on women's lives around the world.

— Jurgen Brokatzky-Geiger, Novartis

Putting a Human Face on NCDs

NCDs Affect Everyday Lives

- Nearly two-thirds of women surveyed say someone in their household suffers from an NCD—heart disease, diabetes, cancer or chronic lung disease. This personal experience is highest in Brazil, India, and South Africa, and lowest in the UK and the US.

Women Burdened as NCD Caregivers; Caregiving Impacts Ability to Work

- Half of the women overall report they provide care for household members affected by NCDs, including 6 in 10 or more in Brazil, India, Indonesia, Kenya, Mexico and South Africa.
- Two in 10 women reported that providing NCD care limits or prevents their participation in the labor force.

Obesity-Related Issues Top Concern

- Being overweight, not getting enough exercise and unhealthy diets are the health issues the women in our study say they are most concerned about for their household.
- Overall, one-quarter of all women said the single most concerning health issue for their household was being overweight (26%).
- In Mexico—the most obese populous country in the world according to the UN—nearly half of women say they are most concerned about their household being overweight.



“The survey deciphers and translates every single letter into the real daily struggles of women for simply being women, and on what it is like to be in the developing world and deal with the devastating impact of diseases that are chronic, super expensive, and hard to treat.

We must work together to empower women to steer their families towards healthy living and influence the global community to make a difference in their lives, because when women are empowered, the whole world can prosper.”

— HRH Princess Dina Mired, King Hussein Cancer Foundation

On Accessing Health Systems

Most Women Have Regular Health Exams...

- With the exceptions of Indonesia and India, most women overall reported being examined by a health professional in the last year.

...But Lag in NCD Testing

- Nearly two-thirds of women in our study report ever having a blood pressure test while half have had a blood sugar test. Among LMICs, the rates were lower for both tests, although the upper-middle-income countries had rates similar to the high-income countries.
- Just 3 in 10 women report having breast exams or cervical cancer screening tests performed by a medical professional. Among LMICs, cervical cancer screening was reported 5-10% less often than breast exams.
- Low cancer screening rates were not limited to low-income countries—South Africa, Indonesia, Brazil and Afghanistan had fairly similar rates for both tests, between 13-22%, and the UK’s rate for breast exams was only slightly higher at 23%.

- The US is the only country in which more than 50% of women report having had both types of tests.

Cost and Wait Times Limit Access to Healthcare

- When asked what reasons prevented them from going to a doctor, overall the most common obstacle reported was cost—as many as one-third of the women in our study said they did not have enough money. Long waiting times also emerged as a common barrier for women in all countries except the US.

About Risk Factors

Cost and Spoilage a Barrier to Eating Healthy, While Eating Out Is Common

- Although nearly three-quarters of women surveyed say they eat healthy foods such as fresh fruits and vegetables and low-fat foods, about 4 in 10 say these foods are too expensive and 3 in 10 say they spoil quickly.
- Eating out is common for today’s woman. A total of 7 in 10 women say they eat food that is not prepared in their home—food from restaurants, street food or take-out food—at least once a week, including 2 in 10 who do this at least 3-4 times per week.

Soda Consumption High; About a Third Drink Soda Every Other Day

- Three-quarters of women in the Arogya study report drinking soda or cola at least once a week, with 3 in 10 drinking three or more days a week. Consumption is highest in Brazil and South Africa, with 9 in 10 saying they drink soda or cola at least one time a week.



Women Engage in Some Physical Activity, but Time and Motivation Limit Exercise

- More than 50% of the women report walking and doing strenuous household chores at least two days a week for 10 minutes each, while one-third report exercising or playing sports and half as many report riding a bicycle. More than 3 and 10 say not enough time is the main challenge, while 2 in 10 say it is lack of interest or motivation.

Tobacco Use Still a Concern

- One-quarter of women surveyed report using tobacco products daily or occasionally, including one-third or more in India, Indonesia, Russia and South Africa.
- Smoking or second-hand smoke is a major household health concern for women Afghanistan, Indonesia and Russia.

Women Concerned about Children's Exposure to Risk Factors

- Women were concerned about children's exposure to tobacco advertising—6 in 10 were very or somewhat concerned about children seeing tobacco ads.
- Women's concern regarding sugar sweetened beverages was somewhat less—about 4 in 10 women registered the same level of concern about soda or cola advertising.

Conclusion

NCDs are our generation's responsibility to fix. It is on our watch that these diseases have reached crisis proportions. We must leave the world a better and healthier place for our children and future generations. We must reduce the impact of NCDs; in fact, it is essential for a sustainable world.

This study—Insights from 10,000 Women on the Impact of NCDs—provides valuable evidence that can help shape NCD policy, influence the post-2015 dialogue and 'The World We Want'. We call on NGOs to access this study report and the accompanying videos, and use the women's voices in their advocacy efforts to make change. We ask governments to review the evidence, listen to the women's voices, and take definite steps to reduce the burden of NCDs for women and their families.

"In my years in global public health, I have observed that the political process is too often divorced from real life. Arogya World's study, in giving voice to 10,000 women on a subject central to their lives, begins to bridge that gap and advance the global dialogue on NCDs in a powerful way."

— Jeff Sturchio, Rabin Martin

"It is well known that NCDs are largely preventable. But that is not being effectively translated into action at the country level. We are eager to use this study's findings to get policymakers to invest in women-centered NCD programs."

— Kenneth Thorpe, Partnership to Fight Chronic Disease



IMPLICATIONS FOR A POST 2015 WORLD

This essay summarizes the views of multiple stakeholders from a side-event we held on July 11, 2014 at the United Nations to mark the 3-year UN Review on NCDs.

<http://arogyaworld.org/putting-women-ncds-agenda-united-nations/>

Non-Communicable Diseases (NCDs) are the #1 killer of women, yet data on the impact of NCDs on women are scarce. These diseases—which include heart disease, diabetes, cancer, and chronic lung diseases—are increasingly acknowledged by global leaders as one of this century’s greatest health and developmental challenges. What ordinary women and families around the world feel, and how they live and cope with these diseases, is less known.

Arogya World set out to gather the missing data by directly asking 10,000 women—1,000 in each of 10 countries around the world—about the impact of NCDs on their everyday lives. Our purpose in doing this research was to gather compelling evidence that would move the hearts and minds of leaders in government and civil society. Essentially we wanted to use women’s voices to inspire broad-based action from multiple stakeholders and advance the fight against NCDs.

We, at Arogya World, believe in the power of partnerships, multi-sectoral approaches, and the use of global platforms to make change. We gathered like-minded organizations from multiple sectors—Novartis, Partnership to Fight Chronic Disease, American Cancer Society, UNICEF, Population Services International, Abt SRBI, and Jana—and together made a commitment at the 2013 Clinton Global Initiative Annual Meeting to:

1. Implement a quantitative, 10-country survey of 10,000 women on the impact of NCDs.
2. Capture on video the voices of some of these women—including patients and caregivers—to show how they live and cope with these diseases.

Our study —“Insights from 10,000 Women on the Impact of NCDs”—was started and completed in 2014. We reached 1,000 women in each country: Afghanistan, Brazil, India, Indonesia, Kenya, Mexico, Russia, South Africa, the UK, and the US Each respondent answered a questionnaire online or on their mobile phones (except in Afghanistan where interviewing was done in-person). On July 11, 2014, we shared preliminary results and a video of Amelia, a caregiver in Mexico, with multiple stakeholders at the United Nations at an event co-sponsored by the governments of United States and Mexico. We believe the views of the 10,000 women and rich perspectives of multiple stakeholders are relevant to the ongoing global dialogue on the post-2015 agenda, and must be used to shape “The World We Want.”

Financial Pain of NCDs

Our study findings confirm that women and families everywhere feel the sharp financial pain of NCDs: about a third of the women reported spending up to 25% of their household income on NCD treatment and care. Moreover, this impact is higher in lower income countries. The most acute financial burden was felt in Brazil, Indonesia, and Kenya, where more than 1 in 10 (13%) women in each country spend a staggering 50% or more of their household income battling NCDs.

By revealing that families spend huge amounts on NCDs, our study findings confirm that NCDs are indeed a monumental developmental challenge experienced by women and families everywhere. The world quite simply cannot be a better place and we cannot have a sustainable future without addressing NCDs.



Impact of NCDs on Women as Caregivers – Paid + Unpaid Work

About half of the women in our study were caregivers and 2 in 10 women said they had to quit their jobs or work less to care for members of their household who have chronic diseases. Paid work, therefore, decreases because of NCDs and makes women become less productive contributors to economies.

“Every woman can be a role model and central to the NCD movement. So we must empower women as actors of change. That can only happen if men and boys live up to their responsibilities and take on their fair share of the burden of unpaid care work.”

— Daniel Seymour, UN Women

At the same time, unpaid work increases because caregiving for NCDs is not generally counted in how we measure the economy. But unpaid work, done largely by women, is core to families and communities and therefore central to sustainable development. We are pleased that unpaid work is being given some consideration in the post-2015 dialogue. Our research results should be used to bolster the arguments we make to advocate for policy changes regarding unpaid care.

Women’s Own Health

In our study we found that women lagged behind on NCD testing. We found that less than 3 in 10 women have ever had breast exams or cervical cancer screening tests. In fact, the US is the only country where more than half the women have had both cancer screening tests. The story is not much better for other NCD tests: only half of the women have had a blood sugar test and less than two-thirds have had a blood pressure test. In a post-2015 world, surely we can do better than that.

“Women are the cornerstone of global health and development. Ensuring they have access to NCD prevention, treatment and care programs helps improve the health of families and communities.”

— Karl Hofmann, Population Services International

Help Women Steer their Families to Healthy Living

One-quarter of the women in our study said the health issue they were most concerned about for their household was being overweight (26%). In Mexico nearly half of the women (45%) expressed this concern.

Women serve as heads of households and make decisions about the food the family eats and how physically active they are. They are a powerful solution to the NCD crisis. Governments and advocacy organizations should improve educational efforts with campaigns geared towards women to help reduce obesity, increase physical activity, and increase access to healthy foods. Specific educational tools such as MyPlate and off-shoots like MyThali (which Arogya World is working to develop for Indians) can empower women to steer their families toward healthier living. Governments should invest in mHealth and mobile apps that help women and their families lead healthy lives. Businesses and the agencies that regulate them can also play a decisive role by restricting marketing that promotes unhealthy diets, smoking, and consumption of alcohol and sugar-sweetened beverages.

With multisectoral cooperation and determined action, and by using women as the conduit for change, we can make great strides in the post-2015 world and help meet the 25 x 25 goal.

Underscoring the Urgent Need for Universal Health Coverage

We wanted to understand how women generally pay for their healthcare. The patterns are different in lower- and higher-income countries. More than half the women in Afghanistan (64%), India (59%), Kenya (55%) and South Africa (51%) shoulder the burden of



their healthcare themselves, by paying doctors directly or borrowing money from friends or family. In contrast, just 5% of the women in the UK pay for healthcare out of pocket—86% of the women surveyed there have access to government healthcare or free health clinics. In the US, 57% of the women enjoy private or employer-provided health insurance.

Our study findings demonstrate distinct differences between low- and high-income countries on multiple counts. Countries where insurance or government clinics are common score better on NCD prevention and control. Giving women a way to pay for their NCD treatment and care without dipping deeply into their household finances helps them cope with the enormous impact of NCDs on them as patients, caregivers, mothers, wives, and citizens.

Our study findings reaffirm the critical importance of universal healthcare coverage (UHC) in all countries, a topic at the epicenter of the health in the post-2015 agenda. We call on government leaders everywhere for urgent action in this regard. UHC is a smart solution to the NCD crisis, and the women in our study in effect, pointed that out.

Let us Listen to 10,000 Women's Voices

Our 10,000 women study has been completed. But the real work begins now. We will work with the governments of the 10 countries where we did our research, and with the UN system including WHO, UNICEF, UNDP and UN Women, as well as with leading NGO organizations and civil society coalitions to analyze the data, identify top priorities and persuade the countries to include them in their action plans.

"Let us use the 10,000 women's voices from this study as a mark of respect for the 10 million or more who die from NCDs each year, who no longer have a voice."

— Sally Cowal, American Cancer Society, Task Force on NCDs and Women's Health

We commit to making sure that the world listens to the voices of the 10,000 women and makes policy changes that will help women and their families prevent NCDs. We commit to sharing the survey's findings and videos with government decision makers, to promoting them widely so that the women's pain and suffering, as well as indomitable spirit and immense fortitude, can inspire action. We commit to using this study to put a human face on NCDs.

Why Should We Care

NCDs are our generation's responsibility to fix. It is on our watch that these diseases have reached crisis proportions. We must leave the world a better and healthier place for our children and future generations. We must reduce the impact of NCDs; in fact, it is essential for a sustainable world. We call on NGOs and members of the NCD community to access this study report and the accompanying videos, and use the evidence to demand that governments partner with multiple stakeholders and take definite steps to reduce the burden of NCDs for women and their families everywhere.

We call on governments to:

1. Make Universal Health Coverage a reality so families are not crippled with NCD treatment costs
2. Improve NCD testing, especially cancer screening for all women
3. Give appropriate weight to unpaid care in their Health and Sustainable Development policies
4. Implement women-centered prevention programs to reduce obesity, encourage physical activity, and improve access to healthy foods.

From all of us at Arogya World and our many partners, we wish women and their families everywhere a life of Arogya or good health, now and after 2015.



Her Story, in Her Voice

WOMEN LIVING WITH NCDS



ANA MARIA'S STORY: DIABETES AND COMPLICATIONS PLUS CANCER (BRAZIL)

I am not married. I have 5 children. I had a long relationship, 30 years. I got diabetes when I was 11 years old. At age 40 I got cervical cancer.

Diabetes made me have a stroke one year and four months ago. And I have a problem in my kidneys. And a problem in my eyes, I can only see with one eye, the other one only has 40% [visibility] left because of the diabetes. My biggest health problems today are my eyes and my bladder,

because I cannot control when [I urinate] due to the diabetes.

My first health problem was when I was 11 years old. I was going to undergo surgery for my throat. After several [medical] exams, they saw I had diabetes. I did not know until then.

I then started taking a medicine but it did not get better. Then I started with insulin. I take it to this day. I used to take [more but now I take less] —at lunchtime and dinnertime. I [test myself] three times a day. It has been under control. Thank God.

Until I was diagnosed with cancer at age 40 (I am now 63), I had a good life in spite of the diabetes. Because here you don't retire, like in some places you do when you have chronic diabetes. Not here. So I lived fine, in spite of living in a slum, [life] is very good.

I am happy because I have my five children and a marvelous aunt...my older daughter has asthma and my other one also had it, but doesn't anymore. And my daughter's son was diagnosed pre-diabetic when he was 11, so he now takes medicine.

My older daughter walks and goes to the gym. The youngest as well. The last one, the fifth, she used to play basketball, but then she got married and gained weight and couldn't anymore. But she goes walking in the morning to keep in shape. The only one that doesn't exercise at all is my son. And he smokes a lot. He is a bus driver.

The doctor I most often see is the urologist because of my bladder problem. They are very concerned because of my diabetes and my heart condition.



To view this video click on:

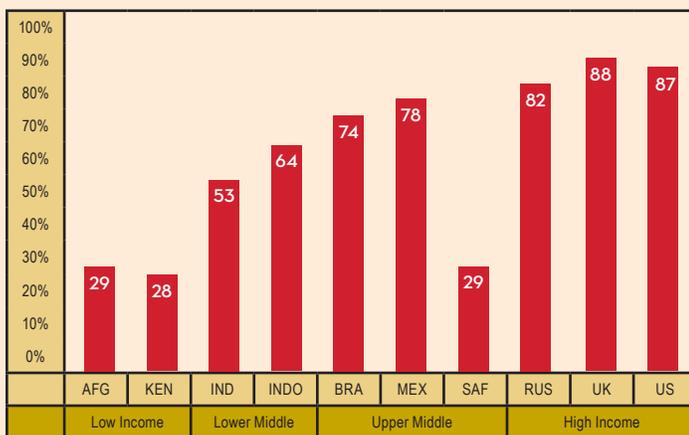
<http://arogyaworld.org/programs/capturing-the-voices-of-10000-women/videos/>

RESULTS

Personal Experience with NCDs

Currently accounting for more than 60 percent of deaths worldwide, NCDs have become the leading causes of global mortality for both men and women. Among the countries in this study, NCDs were estimated to account for 28% of mortality in Kenya and 29% in Afghanistan in 2008. In other countries it was higher; as high as 88% mortality in the United Kingdom and 87% in the United States. Although NCDs are still more common in higher income countries, the burden of these diseases is rapidly rising in low- and middle-income countries.

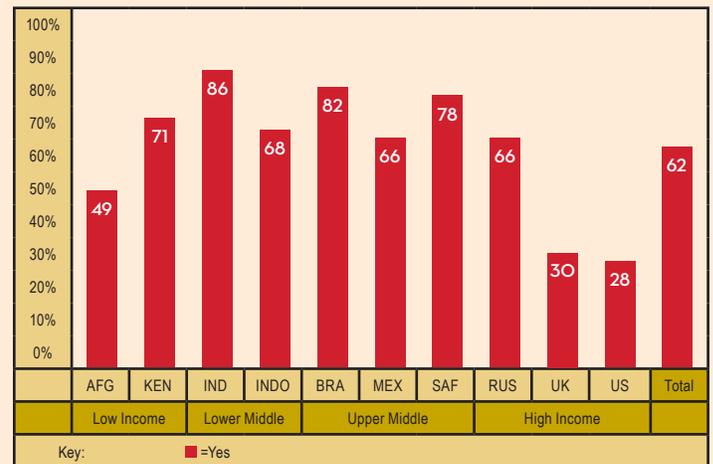
Estimated Proportional Mortality Due to NCDs ^{xii}



Given the widespread nature of NCDs, it is unsurprising that a solid majority of women in our study have personal experience with an NCD. A total of 6 in 10 (62%) women surveyed report that someone in their household, including possibly themselves, has been told by a doctor or medical professional that they have a NCD, which was defined for the respondent as heart disease, diabetes, cancer, or chronic lung disease (such as asthma or chronic bronchitis).

Women in the developing countries surveyed are much more likely to report an NCD compared to women in developed countries. Large majorities in India (86%), Brazil (82%), South Africa (78%), Kenya (71%), Indonesia (68%), Mexico (66%) and Russia (66%) report an NCD. This is in contrast to the 3 in 10 women who report a household diagnosis in the UK (30%) and the US (28%).

Has anyone in your household, including yourself, ever been told by a doctor or other medical professional that they have any of these health conditions: heart disease, diabetes, cancer, or chronic lung disease (such as asthma or chronic bronchitis)?



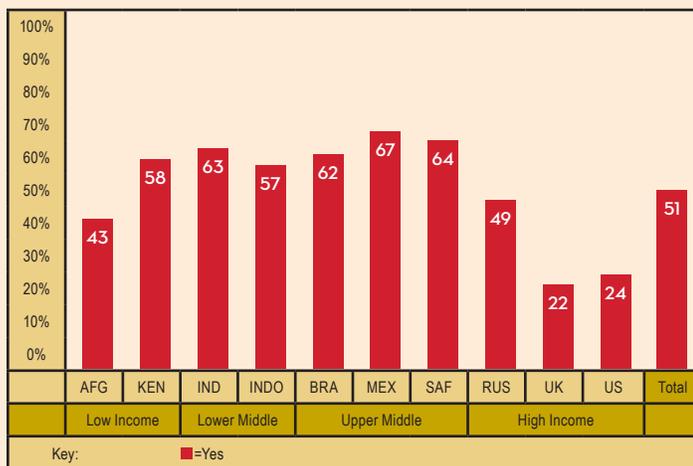
In addition to shouldering most childcare responsibilities in households, women tend to serve as the primary caregivers for other household members who are ill or disabled. Unfortunately, global data on the caregiving burden on women is limited. A 2009 study in the US found that 31.2% of screened households reported at least one household member had served as an unpaid caregiver in the past year and 66% of caregivers are women. These findings are not generalizable to the rest of the world but gender norms and household compositions in low- and middle-income countries suggest that these percentages could be even higher outside of the US.



In our study, half of the women surveyed have shouldered the burden of caring for another household member with an NCD.

This caregiving burden is not even across the countries surveyed, perhaps reflecting differences in standards of living, health systems, family structures within the household, and cultural practices. In Mexico (67%), India (63%), Brazil (62%), Kenya (58%) and Indonesia (57%), 6 in 10 (or more) report ever caring for a household member with an NCD. Less than half in Russia (49%) and Afghanistan (43%) do so. In the developed countries of the UK and the US, less than one-quarter (22% and 24%, respectively), report ever caring for a household member with an NCD.

Have you ever had to provide care for a household member with any of the following health conditions: heart disease, diabetes, cancer, or chronic lung disease (such as asthma or chronic bronchitis)?



“With this global study we are providing data on women’s views on the human toll and economic impact of NCDs, data we believe will compel decision-makers to address these serious diseases, and help women and families lead healthier lives.”

— Nalini Saligram, Arogya World

NCD Financial Impact

In addition to their direct impact on health, NCDs pose a substantial economic burden on individuals, communities, and countries as a result of the costs of treating these diseases and the income and productivity losses due to illness and death. Most research to-date on productivity losses associated with NCDs tends to focus on the individuals with the NCDs, not on the family members providing care to those individuals. As a result, the impact of NCDs on the productivity of caregivers, who are typically women, is not well documented.

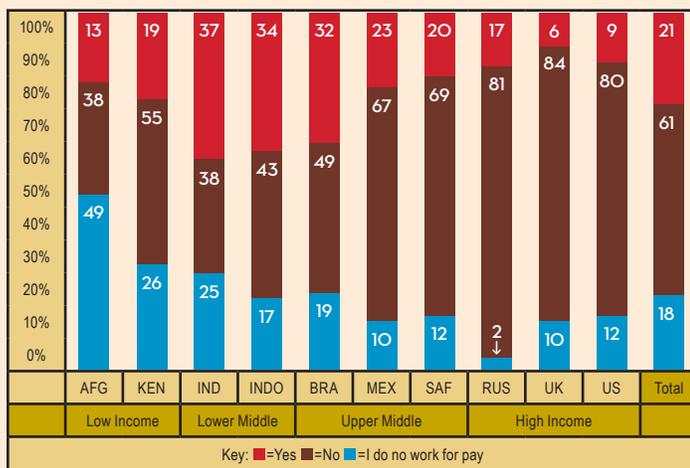
The burden of caring for household members with an NCD can limit women’s participation in the labor force. While not specific to NCDs, the 2009 study about caregiving in the US may provide some insight into the impact of caregiving on productivity. The study found that 70% of caregivers who worked while caregiving had to make changes to their work situation and female caregivers were more likely than male caregivers to do so. Of the employed female caregivers, 16% reduced their hours or took a less demanding job and 12% quit their jobs altogether.^{xiv} Looking beyond the US, a 2007 study in Argentina found that 45% of households of cervical cancer patients reported reduced working hours.”^{xv} Reduced working hours coupled with portions of the household income being dedicated to the costs of care can create financial hardships for those trying to make ends meet.

In our study, for 2 in 10 (21%) women, caring for a household member with an NCD diagnosis necessitated quitting a job or working less. This impact varies by country. More than 3 in 10 in India (37%), Indonesia (34%) and Brazil (32%) report quitting their job or working less to care for someone in their household, compared with 2 in 10 in Mexico (23%), South Africa (20%), Kenya (19%) and Russia (17%). Only 1 in 10 in Afghanistan (13%) report quitting or working less to care for someone in their household,



though nearly half (49%) report not working for pay. In general, labor market participation rates for women in Afghanistan are low for cultural reasons, but when the percentage of those whose ability to work was hindered by caregiving responsibilities is compared to the percent who report working, Afghanistan is no longer an outlier and is similar to the other countries. The contrast with high income countries is stark: less than 1 in 10 in the US (9%) and the UK (6%) report being similarly impacted.

Have you ever had to quit your job or work less in order to care for someone in your household with any of these health conditions: heart disease, diabetes, cancer, or chronic lung disease (such as asthma or chronic bronchitis)?



In addition to the economic stress of lost income due to women leaving the labor force to act as caregivers, there are household costs associated with treating an NCD. Like HIV, the chronic nature of NCDs poses a heavy financial burden on households due to the need for ongoing care. NCD treatment places a particularly significant financial burden on households that are not covered by public or private insurance and must pay for health care out-of-pocket. For example, the cost of asthma maintenance treatment medication would consume 13.7 days' wages for an average unskilled worker in Kenya, but just two days' worth of wages in India. Treatment costs vary widely by condition and country; in Brazil, the asthma treatment costs about

one week of wages.^[i] In contrast, in, coronary heart disease medication costs Brazilians 5.1 days' worth of wages, while diabetes medication consumes 2.8 days and hypertension just .8 days.^[ii] A World Bank study in India estimated the costs of a hospital stay for cancer or heart disease in 2004 as 40-50 % of per capita income in a public hospital and 80-90 % in a private hospital.^{xvi}

In our 10-country study, more than half (53%) of women reported that some portion of household income is used for treatments related to heart disease, diabetes, cancer, or chronic lung disease—3 in 10 (31%) report spending 1%-25% and nearly two in 10 (15%) report spending 26%-50%. Notably, and shockingly, almost 1 in 10 (7%) report spending more than 50% of their household's income to treat an NCD.

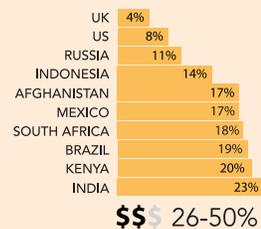
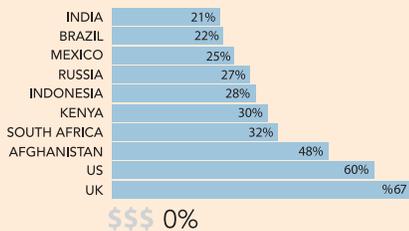
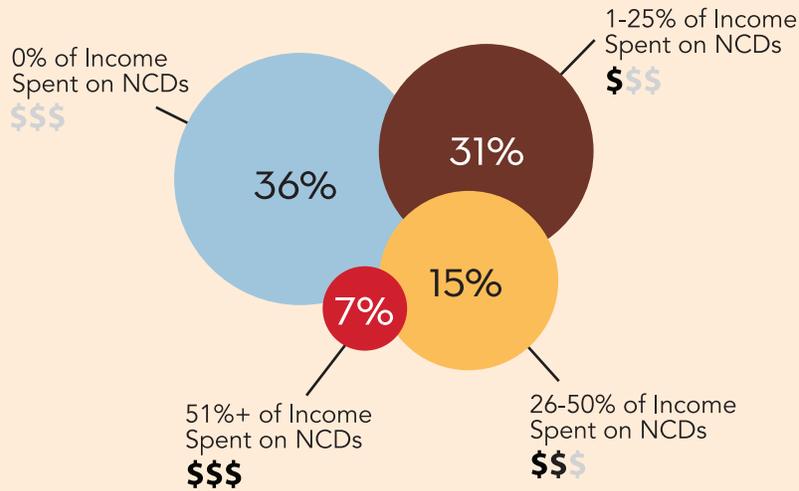
Looking at women who report 26% or more of their household income being spent to treat an NCD, there is a substantial burden across the developing countries. Three in 10 in Brazil (32%), Kenya (33%), India (29%), Indonesia (27%), and South Africa (26%) report this level of financial impact, followed by 2 in 10 in Afghanistan (23%) and Mexico (23%). In contrast, 1 in 10 in Russia (14%) and the US (11%), and relatively few in the UK (5%), report that 26% or more of their household's income is spent treating NCDs.

The most acute financial burden was felt in Brazil, Indonesia and Kenya, where more than 1 in 10 (13%) of women in each country report spending 50% or more on treating heart disease, diabetes, cancer or chronic lung disease.



Financial Impact of Non-communicable Diseases (NCDs)

What percentage of your household income is spent treating these health conditions: heart disease, diabetes, cancer, and chronic lung disease?



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Her Story, in Her Voice

WOMEN LIVING WITH NCDS

AMELIA'S STORY: THE LIFE OF THE CARETAKER (MEXICO)

My name is Amelia Pech Canche. I live and I was born here in Chuburna, Puerto. I have hypertension...and I have diabetes. It's very hard because my father is very sick (blind) and my mother is paralyzed. They told us she had embolism (stroke). She started to get medication but it was expensive. (Amelia's mother has been bedridden for four years now.) These diseases have affected us badly because they are sick, and there's no money. The truth is I had surgery a year ago. Also I get tired because we have to lift my mother, bathe her like a baby. I also have to take care of my father. The truth is I'm tired. Because I am also getting old. Sometimes I wish I didn't have to because it is tiring. But I have to take care of them.



To view this video click on:

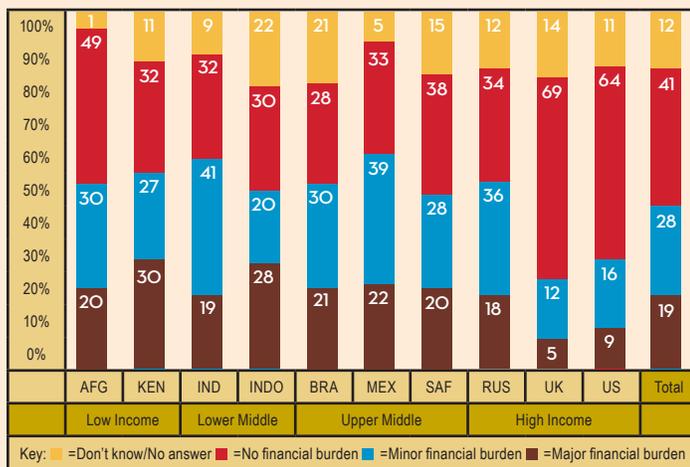
<http://arogyaworld.org/programs/capturing-the-voices-of-10000-women/videos/>



Women in the Arogya 10-country NCDs study were also asked about the overall financial burden their household is now experiencing due to the cost of NCDs, which would reflect the combination of the cost of treatment and care, reduced or lost household earnings, as well as other household financial burdens caused by NCDs. For 2 in 10 (19%) women surveyed, the financial burden on their household from NCDs is major. Another 3 in 10 (28%) say the financial impact is at least minor. In total, half (47%) of women surveyed find NCDs to be financially burdensome for their household.

The pattern is different in developed and developing countries. A total of 3 in 10 in Kenya (28%) and Indonesia (28%) report a major financial burden to their household due to NCDs, compared with 2 in 10 in Mexico (22%), Brazil (21%), Afghanistan (20%), South Africa (20%) and India (19%). Less than 1 in 10 in the US (9%) and the UK (5%) report a major financial burden.

How much of a financial burden is your household experiencing now due to the cost of these health conditions: heart disease, diabetes, cancer, and chronic lung disease (such as asthma chronic bronchitis)?



“Tremendous lessons can be learned from the HIV movement, especially as we realize that policy change is a political process that can be helped by involving people living with and affected by HIV.”

— Susana Fried, UNDP

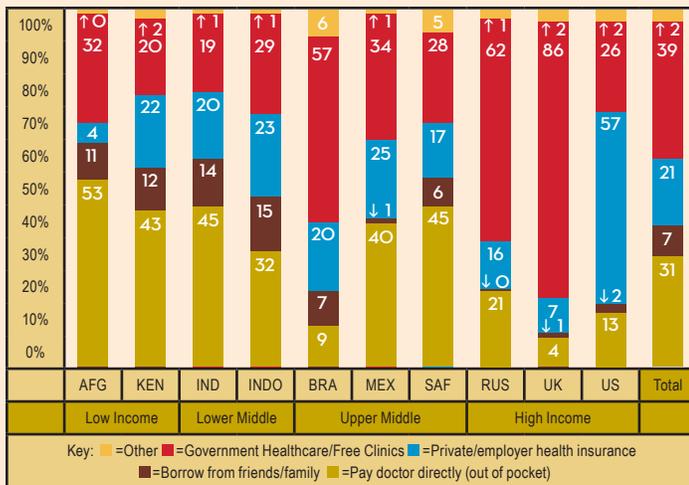
Paying for Healthcare

Although a majority of women say they have some form of healthcare coverage most of the time, a sizeable minority are instead paying doctors directly or borrowing money. About 4 in 10 women (39%) surveyed typically pay for their healthcare through the use of government-provided healthcare or free clinics, while 2 in 10 women (21%) say their healthcare costs are covered through private or employer-provided health insurance. Together, these sources of healthcare provide coverage to 6 in 10 (60%) of the women surveyed. But another 4 in 10 (38%) are self-funding their healthcare, with 3 in 10 (31%) saying they pay their doctors directly or “out of pocket” and 1 in 10 (7%) saying they borrow money from friends or family.

Combining government healthcare/free clinics and private/employer insurance, more than 9 in 10 in the UK (93%) and 8 in 10 in the US (83%), Russia (78%) and Brazil (77%) report having coverage for healthcare most of the time. Healthcare coverage is more than 50% in Mexico (59%) and Indonesia (52%). Notably, fewer women in South Africa (45%), Kenya (42%), India (39%) and Afghanistan (36%) report having government healthcare/free clinics or private/employer insurance. Instead, more than 50% of the women in South Africa (51%), Kenya (55%), India (59%) and Afghanistan (64%) are shouldering the burden of their healthcare most of the time by paying doctors directly or borrowing money from friends or family.

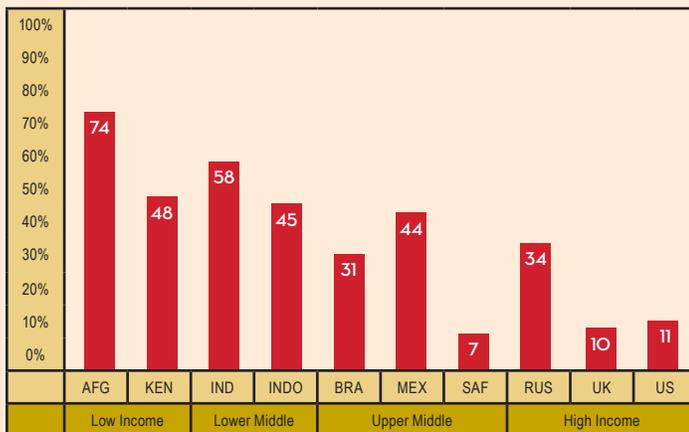


How do you pay for your healthcare most of the time?



Even for those covered by public or private health insurance, out-of-pocket payments for healthcare remain a significant financial burden for many households. According to the WHO, up to 11% of the population in some countries incurs “catastrophic costs” in paying for their healthcare.^{xvii}

Out-of-pocket Payments^{xix}



Out-of-pocket payments for healthcare vary significantly by country. As seen in the table, among the countries targeted by this survey, South Africa has the lowest level of out-of-pocket payments as a percentage of total expenditure on health while Afghanistan has the highest.^{xviii}

Health Services

Women tend to use health services more frequently than men in low- and high-income countries alike. Even when excluding female-specific services, such as antenatal and delivery care, World Health Surveys in 59 countries in 2002-2004 showed that nearly 60 percent of women used outpatient care in the past year compared to about 50 percent of men.^{xx} When comparing utilization of outpatient care between women in low and high income countries, rates are quite similar. For inpatient care, on the other hand, poor women in lower income countries have much less access to inpatient care than wealthy women in higher income countries.

In our 10-country study, a large majority of 8 in 10 (81%) women report being examined by a doctor or other medical professional within the last year (62%) or two (19%). Another 8% were examined two to five years ago, while 4% report their last examination was five or more years ago. Just 4% have never been examined by a doctor or other medical professional. At least 6 in 10 women in each country have had an exam in the last year, with the exception of those in Indonesia (48%) and India (41%).



IMPACT OF NCDs: By the Numbers

At-A-Glance

Insights
from 10,000
Women on the
Impact of NCDs



THE FINANCIAL BURDEN OF NCDs

NCDs Big Drain on Family Resources



NEARLY **ONE-QUARTER**
OF THE WOMEN IN
OUR STUDY SPEND
MORE THAN

25%

OF THEIR HOUSEHOLD
INCOME ON NCDs.



SHOCKINGLY, NEARLY
1 IN 10 WOMEN SAID
THAT NCD TREATMENT
CONSUMES MORE THAN

50%

OF THEIR HOUSEHOLD'S
INCOME.



THE MOST ACUTE FINANCIAL BURDEN
WAS FELT IN **BRAZIL, INDONESIA AND
KENYA**

13%
WOMEN



**SPENDING 50%
OR MORE**
ON TREATING HEART
DISEASE, DIABETES,
CANCER OR CHRONIC
LUNG DISEASE.

Many Women Pay for Healthcare Out of Pocket, Especially in Low- and Middle-Income Countries



4 IN 10 WOMEN REPORT PAYING DOCTORS
DIRECTLY OR BORROWING MONEY FROM
FRIENDS AND FAMILY TO COVER HEALTHCARE
COSTS.

MORE THAN 50% IN
AFGHANISTAN, INDIA, AND KENYA



50% IN
SOUTH AFRICA



NEARLY 50% IN
INDONESIA



50% PAY MEDICAL COSTS
OUT-OF-POCKET.





PUTTING A HUMAN FACE ON NCDs

NCDs Affect Everyday Lives



NEARLY TWO-THIRDS OF WOMEN SURVEYED SAY SOMEONE IN THEIR HOUSEHOLD SUFFERS FROM AN NCD — **HEART DISEASE, DIABETES, CANCER OR CHRONIC LUNG DISEASE.**



Women Burdened as NCD Caregivers Caregiving Impacts Ability to Work



50% REPORTED THEY **PROVIDE CARE** FOR HOUSEHOLD MEMBERS AFFECTED BY NCDs



20% REPORTED THAT PROVIDING NCD CARE LIMITS OR **PREVENTS THEIR PARTICIPATION IN THE LABOR FORCE.**

Obesity-Related Issues Top Concern



25% WOMEN SAID THE SINGLE MOST CONCERNING **HEALTH ISSUE** FOR THEIR HOUSEHOLD WAS **BEING OVERWEIGHT.**



50% **IN MEXICO** THE MOST OBESE COUNTRY IN THE WORLD, NEARLY HALF **50%** OF THE WOMEN ARE CONCERNED ABOUT OBESITY.



ON ACCESSING HEALTH SYSTEMS

Most Women Have Regular Health Exams



THE EXCEPTIONS OF **INDONESIA AND INDIA**

MOST WOMEN OVERALL REPORTED BEING
**EXAMINED BY A HEALTH PROFESSIONAL IN
THE LAST YEAR.**



...But Lag in NCD Testing

66%

**WOMEN IN OUR STUDY REPORT
EVER HAVING A BLOOD
PRESSURE TEST**

30%

REPORT HAVING **BREAST EXAMS
OR CERVICAL CANCER SCREENING**
TESTS PERFORMED BY A **MEDICAL
PROFESSIONAL**

50%

**HALF HAVE HAD A
BLOOD SUGAR TEST**

LOW CANCER SCREENING RATES WERE NOT LIMITED TO LOW-INCOME COUNTRIES



**BETWEEN 13-22%
FOR BOTH TESTS
IN SOUTH AFRICA,
INDONESIA, BRAZIL
AND AFGHANISTAN**



**IN THE UK
BREAST CANCER
SCREENING AT 23%**



**U.S IS THE ONLY COUNTRY
WITH A GREATER THAN 50%
BREAST AND CERVICAL
CANCER SCREENING**

Cost and Wait Times Limit Access to Healthcare



COST

33% OF THE WOMEN REPORTED
COST AS THE MAJOR CONCERN.



LONG WAIT TIMES

**MAJOR BARRIER FOR WOMEN
IN ALL COUNTRIES EXCEPT US**

ABOUT RISK FACTORS

Cost and Spoilage a Barrier to Eating Healthy, While Eating Out Is Common



THREE-QUARTERS OF WOMEN EAT HEALTHY FOODS FRESH FRUITS AND VEGETABLES



4 IN 10 SAY THESE FOODS ARE TOO EXPENSIVE



3 IN 10 SAY THEY SPOIL QUICKLY



EATING OUT IS COMMON FOR TODAY'S WOMAN



70% WOMEN EAT FOOD FROM RESTAURANTS, STREET FOOD OR TAKE-OUT FOOD



2 IN 10 EAT IN RESTAURANTS OR USE STREET FOOD, TAKE-OUT FOOD AT LEAST 3-4 TIMES PER WEEK

Soda Consumption High; About a Third Drink Soda Every Other Day



THREE-QUARTERS OF WOMEN DRINKING SODA OR COLA AT LEAST ONCE A WEEK



3 IN 10 WOMEN DRINKING THREE OR MORE DAYS A WEEK



CONSUMPTION IS HIGHEST IN BRAZIL AND SOUTH AFRICA, WITH 9 IN 10 WOMEN DRINKING SODA OR COLA AT LEAST ONE TIME A WEEK.

Women Engage in Some Physical Activity, but Time and Motivation Limit Exercise



50%

MORE THAN 50% WOMEN REPORT WALKING AT LEAST TWO DAYS A WEEK FOR 10 MINUTES EACH



33%

EXERCISE OR PLAY SPORTS



16-17%

RIDE A BICYCLE



4 IN 10 WOMEN SAY NOT ENOUGH TIME IS THE MAIN CHALLENGE



WHILE 2 IN 10 WOMEN SAY IT IS LACK OF INTEREST OR MOTIVATION.

Tobacco Use Still a Concern

25%

OF WOMEN SURVEYED REPORT USING TOBACCO PRODUCTS DAILY OR OCCASIONALLY.

33%

IN INDIA, INDONESIA, RUSSIA AND SOUTH AFRICA.

Women Concerned about Children's Exposure to Risk Factors

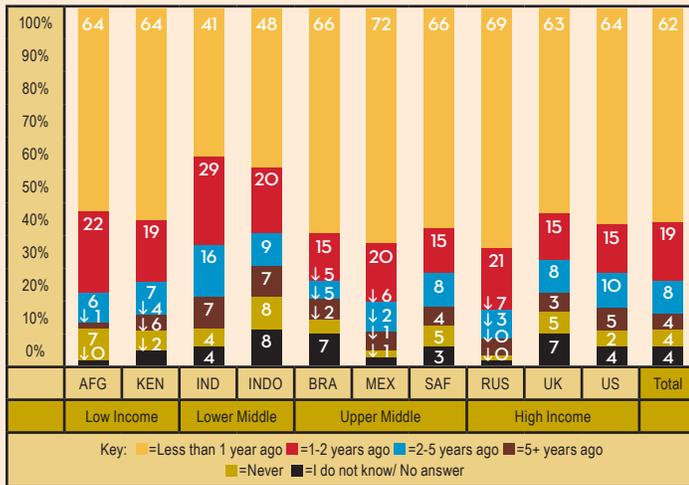


6 IN 10 WOMEN WERE VERY OR SOMEWHAT CONCERNED ABOUT CHILDREN SEEING TOBACCO ADS.



4 IN 10 WOMEN REGISTERED THE SAME LEVEL OF CONCERN ABOUT SODA OR COLA ADVERTISING.

Talking about your health in general, when were you last examined by a doctor or other medical professional?



While a majority of women were examined at least once within the last year, several factors prevented women from accessing the healthcare services if and when they needed them. A number of barriers may influence whether an individual chooses to seek healthcare when needed, including: cost of services; waiting times; information on healthcare choices/providers; indirect costs, such as travel costs and opportunity costs; household preferences; community and cultural preferences.^{xxi} Household, community, and cultural barriers affect women in particular. In some cultures, women may not be allowed to leave the home, make decisions about their own healthcare, or access household resources.

When the women were asked about the reasons that prevented them from going to a doctor or other medical professional in the past year, cost is the most common answer given, with one-third (34%) of women saying they did not have enough money. Nearly as many women (30%) cite waiting times being too long as a reason. And one-quarter (25%) selected issues related to access, such as the health facility being too far away (14%) or not having transportation (11%).

In the past year, which of the following reasons prevented you from going to the doctor or other medical professional?

I did not have enough money	58	39	24	44	25	37	42	24	10	34	34
Health facility was too far away	27	12	26	26	13	6	5	13	7	8	14
I did not have transportation	25	5	20	16	10	3	12	3	6	9	11
Waiting times were too long	43	26	29	35	46	32	19	41	19	11	30
None of the Above	0	25	19	13	24	29	30	28	62	48	28
Other	0	3	1	13	3	7	2	15	5	6	5
N	1015	1000	1000	1000	1000	1005	1000	1004	1003	1007	10034
	AFG	KEN	IND	IINDO	BRA	MEX	SAF	RUS	UK	US	Total
	Low Income	Lower Middle	Upper Middle	High Income							

Delving deeper into the data, we found that more than half (58%) of women in Afghanistan and significant minorities in all except the UK—ranging from 44% in Indonesia to 25% in Brazil—cite cost as a factor that prevented doctor visits in the past year. Waiting times are also an issue in most countries surveyed, including nearly 5 in 10 women in Brazil (46%) and nearly as many in Afghanistan (43%) and Russia (41%), as well as 3 in 10 or more in Indonesia (35%), Mexico (32%), India (29%) and Kenya (26%). In the US and South Africa, 2 in 10 (19%) women cite waiting times as a reason preventing a healthcare visit in the past year. Only 1 in 10 (11%) women in the UK do so, which is understandable given the social system of healthcare in the UK. Access to healthcare—facilities being too far away and not having transportation—stands out in Asian countries. More than half of women in Afghanistan (52%), and nearly half in India (46%) and Indonesia (42%), say these access problems have prevented them from going to the doctor or other medical professional in the past year.



NCD Testing

Testing for early detection and management of disease is essential for controlling the burden of NCDs worldwide. Most countries report the general availability of NCD testing at the primary care level but limited evidence exists regarding the prevalence of NCD testing in most countries.^{xxii}

Research on the prevalence of blood pressure measurement among women in low- and middle-income countries tends to focus on antenatal care visits. The frequency of blood pressure measurement among women in non-antenatal care settings is not well documented. In antenatal care settings, blood pressure measurement appears to be quite common. According to recent DHS surveys, among women with a live birth in the previous five year, 64 percent had their blood pressure measured in India (DHS 2005-06), 96 percent in Indonesia (Indonesia DHS 2012), and 85 percent in Kenya (Kenya DHS 2008-09).

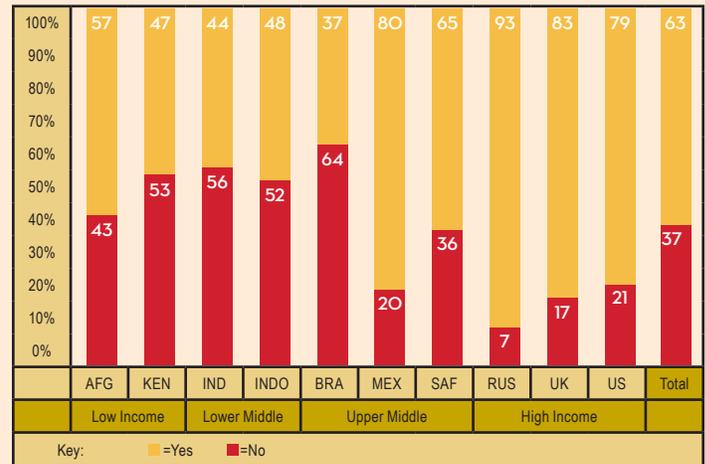
“We must not forget that women have atypical heart attack symptoms, that there are more women in the aging global population, and that 90% of cervical cancer deaths are in developing countries. We cannot win until we become more responsive to the needs of women.”

— Rama Lakshminarayanan, WHO

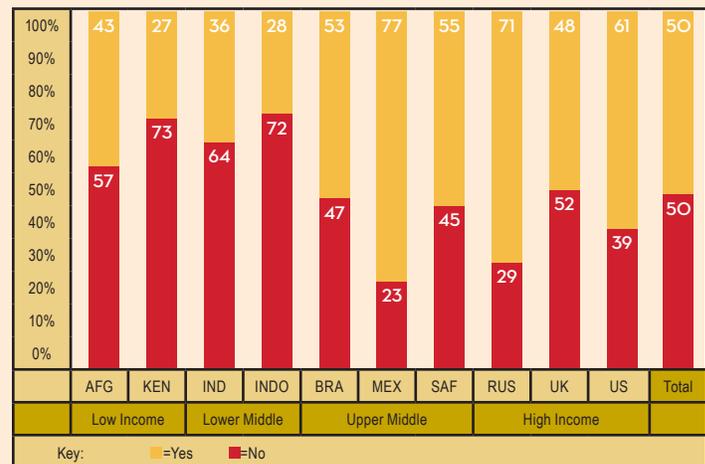
Among Arogya survey participants, blood pressure testing is relatively widely reported, with about two-thirds (63%) reporting they have had the test, a common screening test for hypertension, a risk factor for heart disease. Nearly all women in Russia (93%) report having had a blood pressure test, as well as 8 in 10 in the UK (83%), Mexico (80%) and the US (79%). Six in 10 or more in South Africa (65%) and Afghanistan say they have ever had a blood pressure test. Lower rates for blood pressure testing are reported by women in Indonesia (48%), Kenya (47%), India (44%) and Brazil (37%).

Have you ever had any of the following medical tests?

Blood Pressure Test



Blood Sugar Test



Most countries report capacity for diabetes testing by blood glucose measurement, OGTT, or HbA1c. With the exception of Afghanistan, all of the countries targeted in this survey reported that diabetes testing was generally available at the primary healthcare level in 2010.

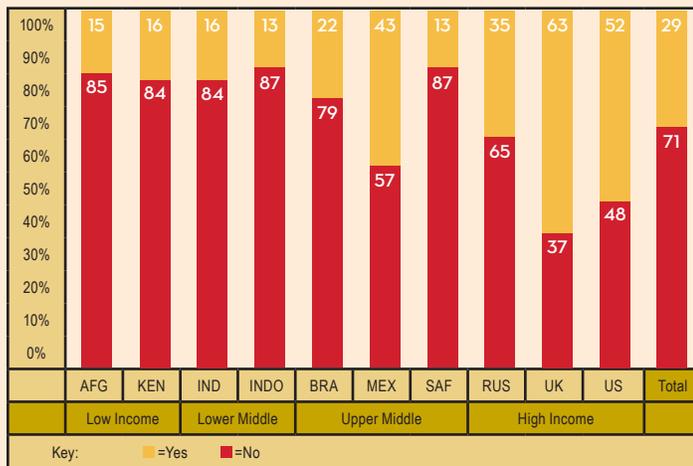


In our 10-country study, half (50%) of women surveyed report having had a blood sugar test, a main tool used in the diagnosis of diabetes. More than half the women in Mexico (77%), Russia (71%), the US (61%), South Africa (55%) and Brazil (53%) report ever having a blood sugar test, compared with fewer women in Afghanistan (43%), India (36%), and Kenya (27%). The UK is split evenly, with about half (48%) reporting a blood sugar test and half (52%) saying they have not had the test.

Regarding cancers that primarily affect women, it is known that capacity for cervical cancer screening is less common in lower income countries than higher income countries. Cervical cancer screening tests are generally available at the primary healthcare level in Brazil, Mexico, Russia, South Africa, the United States, and the United Kingdom, but not in Afghanistan, India, Indonesia or Kenya.

In our 10-country study, just 3 in 10 (29%) say they have ever had a cervical cancer screening test. Only in the UK (63%) and the US (52%) do a majority of women report being screened, while rates for the eight other countries ranged between 13% in Indonesia and South Africa to 43% in Mexico.

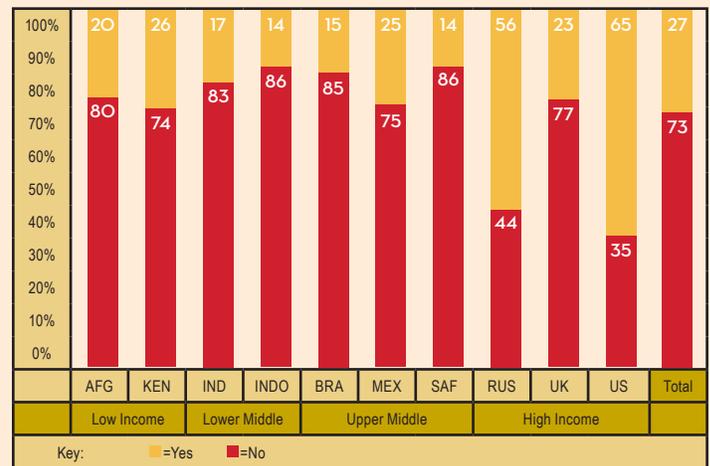
Cervical Cancer Screening Test



Breast cancer screening capacity appears to be more common in lower income countries than cervical cancer screening, although reports of breast exams conducted by health professionals was highly similar to cervical cancer screenings. Breast cancer screening is generally available at the primary healthcare level in all of the countries included in this survey except for Indonesia.^{xxv}

The US had the highest percent reporting ever having a breast exam, 65%, followed by Russia at 56%. Among the other eight countries, less than one-quarter of women report ever having this screening.

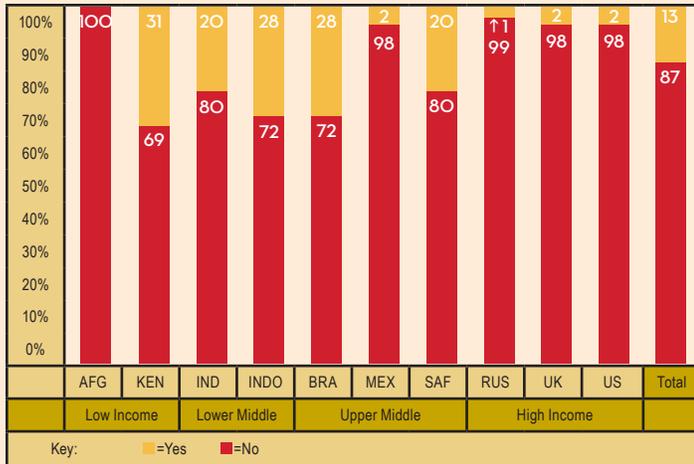
Breast Exam by a Medical Professional



A small minority of women have not received any of these tests for NCDs. A total of 1 in 10 (13%) women surveyed report that they have never had a blood pressure test, blood sugar test, cervical cancer screening test, and breast exam. The lack of NCD testing stands out in five countries—sizable minorities in Kenya (31%), Brazil (28%), Indonesia (28%), India (20%) and South Africa (20%) say they have not had any of the tests, compared with 2% or less in the remaining countries.



None of the Above



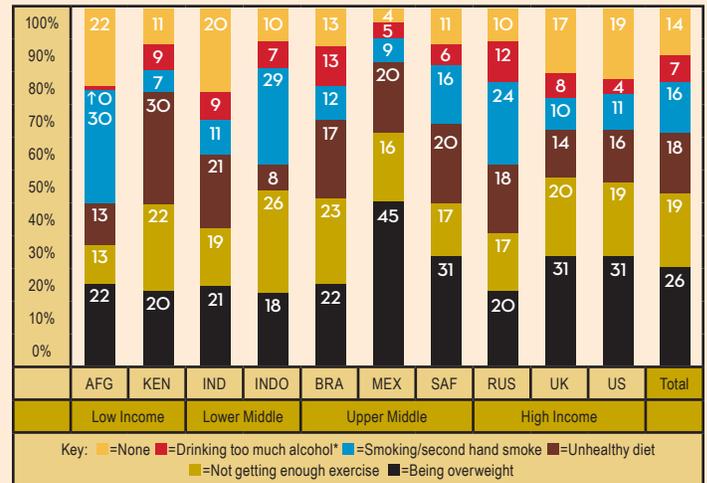
In Mexico, the most obese country in the world according to the UN, nearly half (45%) of women say being overweight is their top concern for their household, compared with 3 in 10 or less in the remaining countries. Not getting enough exercise is the top concern for roughly 2 in 10 or more women in all countries except Afghanistan, where women face more cultural barriers than other countries in terms of the ability of women to exercise. Unhealthy diet stands out in Kenya, with 3 in 10 (30%) citing this as their biggest concern, compared with 2 in 10 or less in the other countries surveyed. Concern over smoking or second-hand smoke stands out in Afghanistan (30%), Indonesia (29%) and Russia (24%).

NCD Risk Factors

Low- and middle-income countries are seeing an increased prevalence of the behavioral risk factors – smoking, physical inactivity, unhealthy diet, and harmful consumption of alcohol – and consequent metabolic/physiological risk factors – high blood pressure, overweight/obesity, high blood glucose, and high cholesterol – that lead to NCDs. For example, in 2013, an estimated 38% of women worldwide were overweight or obese.^{xxvi} Of the ten countries targeted by this survey, the estimated overweight and obesity prevalence among women in 2013 ranged from 19.9% in India to 71.1% in Mexico.^{xxvii}

A clear pattern that emerges in all ten countries surveyed is the concern about risk factors related to obesity. Nearly 3 in 10 of all women say the single health issue they are most concerned about for their household is being overweight (26%). And 2 in 10 cite not getting exercise (19%) or unhealthy diet (18%) as the most concerning issue. Nearly as many say smoking or second-hand smoke (16%) is the health issue they are most concerned about for their household. Drinking too much alcohol is less of an issue, with 1 in 10 (7%) women saying this is the primary health concern for their household.

Thinking about your household, which health issue are you most concerned about?



*Drinking too much alcohol was not asked in Afghanistan

“Governments must make it easier for people to adopt healthy behavior and implement the right programs and policies designed for impact. NCDs are a shared responsibility.”

— Jeff Meer, Public Health Institute, NCD Roundtable



Her Story, in Her Voice

WOMEN LIVING WITH NCDS

INDRA'S STORY: SURVIVING CANCER (INDIA)

I was born in Pakistan. We moved from place to place and my education was done in many places. I'm now 76 years old. And...I got this thing, cancer. In the month of July, it will be exactly 16 years since I got it.

I think it's very very troubling. What is a person afraid of? A person is afraid of dying. A person is afraid of pain. And a person is afraid of becoming dependent on another person. And these are the three things which are very much related to cancer.

So, not one thing. Your whole body changes. The changes in your body, the financial, the emotional...

The whole personality changes. And then the fear of relapse. That's always, I think, in your head.

Previously, people never used to talk about this disease. There was a stigma attached to the disease. And that brings a lot of depression, a lot of frustration, anxiety in the person. Because people do not know how to cope with it.

Because I had found it in the very first stages, I was not even given chemo. All I was given was radiation. So all the message that I am sharing is that you can save yourself from so many things by just having the knowledge.



To view this video click on:

<http://arogyaworld.org/programs/capturing-the-voices-of-10000-women/videos/>

Healthy Food and Eating Out

Insufficient fruit and vegetable consumption is one of the top ten risk factors for global mortality. Worldwide, low fruit and vegetable consumption is responsible for about 1.7 million (2.8%) of deaths.^{xxviii} Although fruit and vegetable consumption data is not available for many countries, studies from some of the countries targeted by this survey provide some insight into general consumption levels. For example, surveys from the US and several states in India have suggested that the average consumption of fruit and vegetables is lower than the minimum recommendation.^{xxix xxx}

Some of the barriers to consumption of healthy foods include cost, time, access, and knowledge. According to a global online survey of 27,000 consumers in Asia, Europe, Middle East/Africa, North American and Latin America, the largest reported barrier to healthy eating was time. Other reported obstacles included cost, availability, confusion about which foods are healthy, substandard taste, and personal preferences.^{xxxi}

A large majority of women (7 in 10 (72%) surveyed report eating healthy foods such as fresh fruits and vegetables and low-fat foods. Despite this, they do have concerns about the price and spoilage of healthy foods. About 4 in 10 women say healthy foods are too expensive (39%) and 3 in 10 say healthy foods spoil too quickly (30%). Although the affordability and stability of healthy foods is a concern for some women, only 1 in 10 say healthy foods—fresh fruits and vegetables and low-fats foods—are too hard to prepare or cook (14%). Women in India (54%) and Indonesia (56%) are less likely to report eating healthy foods, while healthy food consumption is widely reported in Mexico (90%) the UK (86%), US (83%) and Afghanistan (83%). Women in Afghanistan, the UK and the US are more likely to say that these foods are too expensive, with nearly 6 in 10 (58-59%) citing cost as a factor.

Majorities in Russia (59%), the UK (54%) and the US (53%) cite spoilage as an issue with fresh fruits and vegetables and low-fat foods. Spoilage is less of an issue in South Africa (6%), Kenya (9%) and Brazil (12%).

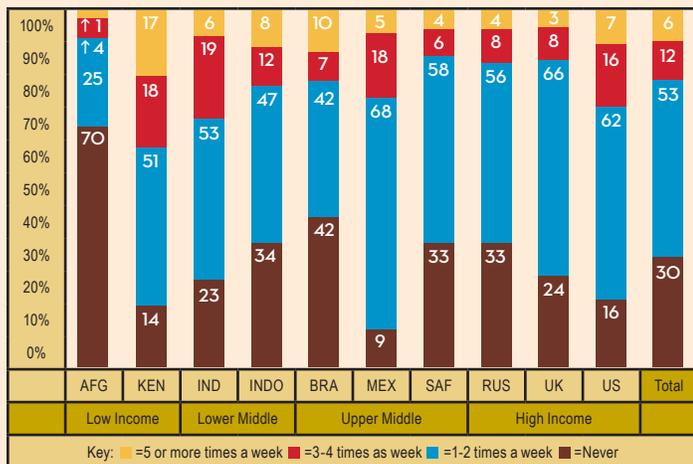
Thinking about healthy foods (such as fresh fruits and vegetables, low-fat foods), which statements do you agree with?

I eat healthy foods	83	66	54	56	67	90	63	72	86	83	72
Healthy foods are too expensive	59	22	24	27	31	37	30	45	59	58	39
Healthy foods spoil quickly	36	9	16	23	12	35	6	59	54	53	30
Healthy foods are too hard to prepare/cook	30	6	18	20	8	13	7	10	16	15	14
None of the Above	0	7	6	7	8	1	9	1	2	2	4
N	1015	1000	1000	1000	1000	1005	1000	1004	1003	1007	10034
	AFG	KEN	IND	IINDO	BRA	MEX	SAF	RUS	UK	US	Total
	Low Income		Lower Middle		Upper Middle			High Income			

Despite positive attitudes toward eating and preparing healthy food, most women surveyed report eating food prepared outside of their homes. A total of 7 in 10 (70%) women say they eat food that is not prepared in their home—such as food from restaurants, street food or take-out food—at least once a week, compared with 3 in 10 (30%) who say they never eat outside the home. Although 5 in 10 (53%) report eating out 1-2 times a week, a sizable minority of 2 in 10 (18%) say they do so 3-4 times a week (12%) or 5 or more times a week (6%).



In a typical week, how many times do you eat food not prepared in your home, such as food from restaurants, street food, or take-out food?



Afghanistan was the only country in which a majority of women report never eating out (70%). In Mexico, 9 in 10 (91%) women report eating outside the home at least one time a week, followed by roughly 9 in 10 in Kenya (86%) and the US (85%), 8 in 10 in India (78%) and the UK (77%), then 7 in 10 in Russia (68%), South Africa (68%) and Indonesia (67%), and 6 in 10 in Brazil (59%).

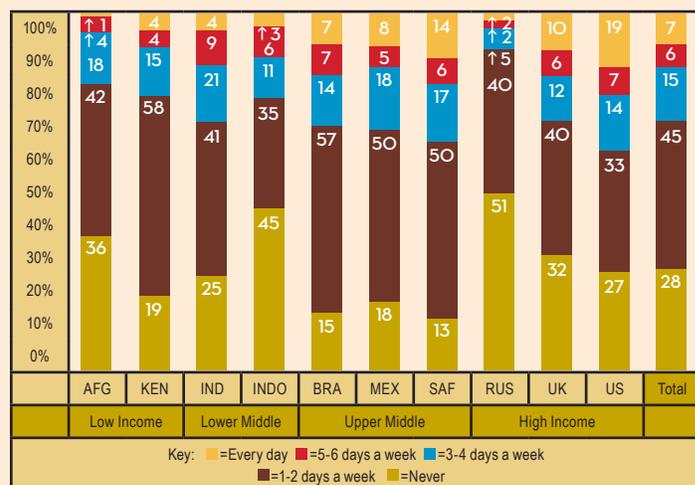
With the exception of Afghanistan and Brazil, the majority of women report eating out 1-2 times per week. Specifically, majorities in Mexico (68%), the UK (66%), the US (62%), South Africa (58%), Russia (56%), Indonesia (53%) and Kenya (51%) say they eat food not prepared in their home 1-2 times a week. In Brazil, just as many women say they eat out 1-2 times per week (42%) as say they never eat out (42%), and less than 3 in 10 (25%) of women in Afghanistan say they eat out 1-2 times per week. Women in Kenya (35%) are most likely to report eating out three or more times a week followed by women in India (25%), the US (23%), Mexico (23%), Indonesia (20%), Brazil (17%), Russia (12%), the UK (11%), South Africa (10%) and Afghanistan (5%).

Sugar-Sweetened Beverages

Along with eating prepared food outside of the home, another risk factor for obesity and diabetes is the consumption of sugar-sweetened beverages like cola or soda. Data on sales of soda show that global average consumption of soda was 11.4 gallons per capita in 2010. Mexico had the highest rate of soda consumption in the world with 31.5 gallons of soda consumed per capita in 2010, followed by the US with 31.2 gallons per capita. For the most part, soda consumption is higher in higher income countries. ^{xxxii}

More than 7 in 10 (72%) women surveyed report drinking soda or cola at least once a week, with 3 in 10 (28%) drinking three or more days a week. Consumption of soda or cola at least one time per week is reported by 9 in 10 in South Africa (87%) and Brazil (85%). While relatively lower rates of consumption are reported in Indonesia (45%) and Afghanistan (35%), only in Russia do a majority (51%) of women report never drinking soda or cola.

In a typical week, on how many days do you drink soda or cola?



Her Story, in Her Voice

WOMEN LIVING WITH NCDS



NATASHA'S STORY: MANAGING HEART DISEASE (USA)

My name is Natasha Fleishman. I am 45 years old. I currently live outside of Minneapolis in a town called Stillwater.

My health crisis has been a long ordeal for the family. 12 years ago it started when my heart stopped, completely out of the blue. We didn't know I had any heart problems. And so certainly over the last 12 years, there has been a great deal of stress at certain times.

I have idiopathic dilated cardiomyopathy with troubles with arrhythmias, so bad rhythm problems with my heart where I can go into ventricular fibrillation and then die, though I have an implanted defibrillator to take care of that.

I am married, for over 20 years, and I have two boys that are turning into young men. My husband and I are currently self-employed. I own a Great Harvest Bread Company bakery, in Minnesota. We specialize in making whole-grain, healthy breads with no preservatives and grind our own wheat to preserve the nutrition. And bread baking is really a passion of my husband's.

We own this business, which means we had to pay out of pocket for our own health insurance, which gave us a policy with a very high deductible. At one point I had an \$8,000 medical bill from the hospital that I just paid a little bit every month to get rid of. At various times over the last twelve years, I've been out of work for up to a year after open-heart surgery or something like that. So when I don't have a paycheck that's an additional strain on the family.

Even though there's nothing currently problematic, it's something that we all live with every day. One day I was feeling a fluttering in my chest and I thought, 'Oh boy, what if my heart stops right now and I get an ICD shock?'

So it's always in the back of your mind. But it's something you learn to live with and just keep moving forward because that's really the only option available.

To view this video click on:

<http://arogyaworld.org/programs/capturing-the-voices-of-10000-women/videos/>

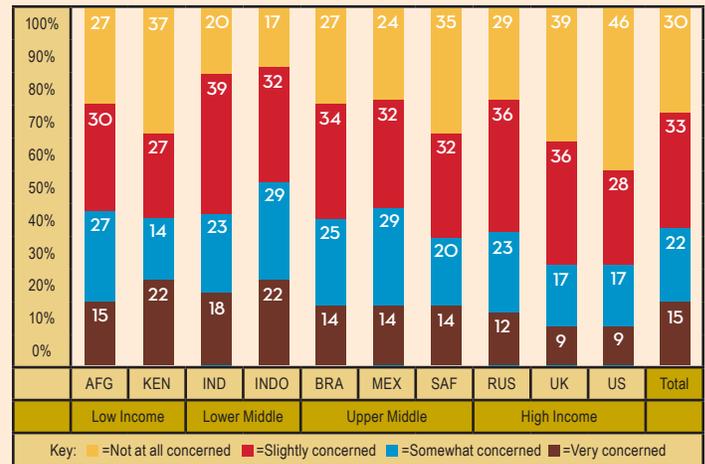


With childhood overweight and obesity rates on the rise worldwide, children’s exposure to soda advertisements is an increasing area of concern. A study of TV food advertising to children in 13 mostly high income countries found that children were exposed to high volumes of unhealthy food marketing. ^{xxxiii}

Despite public health campaigns in the US and elsewhere citing sugar-sweetened beverages such as soda and cola as contributors to weight gain and obesity, most women are not too concerned about children seeing soda advertisements on TV, billboards or other public places. More than one-third (37%) of women are concerned about children being exposed to sugar-sweetened beverage advertising, though most of these women are only somewhat concerned (22%) rather than very concerned (15%) about this type of advertising. Another one-third (33%) of women are slightly concerned about children seeing ads for soda or cola, while nearly one-third (30%) are not concerned at all.

Women in Indonesia are the most concerned about children being exposed to ads for sugar-sweetened beverages. A majority of women in Indonesia (51%) are very or somewhat concerned. Fewer women, but still sizable minorities, say they are very or somewhat concerned in Mexico (43%), Afghanistan (42%), India (41%), Brazil (39%), Kenya (36%), Russia (35%) and South Africa (34%), followed by smaller minorities in the US (26%) and the UK (26%).

How concerned are you about children seeing advertisements for soda or cola on TV, billboards and other public places?



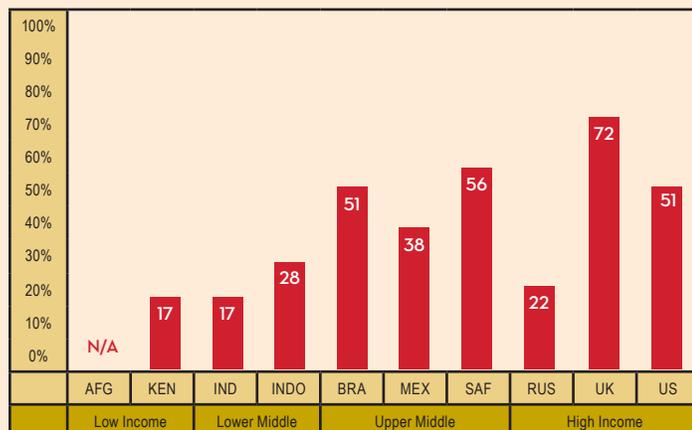
Physical Activity

The WHO defines sufficient physical activity as at least 30 minutes of moderate intensity physical activity every day. In 2008, approximately 31% of the global adult population over the age of 15 did not engage in sufficient physical activity. ^{xxxiv}

High-income countries have the highest rates of physical inactivity, but rates of inactivity are increasing in middle income countries, particularly among women. ^{xxxv} **In the countries targeted by this survey, the estimated prevalence of physical inactivity among women in 2008 ranged 17% in Kenya to 71.6% in the United Kingdom.** ^{xxxvi} **Physical inactivity data for Afghanistan was not available.**



Estimated physical inactivity prevalence among women (%) (2008)



Women in the ten countries surveyed were asked about a range of physical activities that increase breathing and heart rates, which are beneficial to the prevention of non-communicable diseases. Two-thirds (66%) of women report walking at least two days a week for at least 10 minutes a day. Nearly as many (59%) report performing strenuous chores like cleaning and gardening. More than one-third (36%) report exercising or playing sports at least two days a week for at least 10 minutes at a time. Riding a bicycle, either for exercise or for traveling from place to place, is far less common, with 15% of women reporting cycling for at least 10 minutes a day two days a week. And just 5% of women report not doing any of the physical activities mentioned above.

Majorities of women in most countries say they walk at least 10 minutes a day two days a week, from 52% in India and Indonesia to 95% in Russia. The exceptions are Afghanistan and Brazil, where 40% report this level of activity. Large majorities report doing strenuous household chores in Afghanistan (84%) Russia (84%), followed by Mexico (76%) the UK (73%), the US (71%) and South Africa (56%). As for exercising or playing sports, majorities of women in the US (59%), Russia (56%) and Mexico (51%) say they do this at least 10 minutes a day two days a week. Riding a bicycle is highest in Indonesia (36%) and India (27%), where bicycles are a popular mode of transportation. Notably, women in Brazil (18%) are much more likely than women in other countries to report not doing any of these physical activities.

In a typical week, do you engage in the following activities at least 2 days a week for at least 10 minutes each day?

None	0	4	5	7	18	1	7	0	2	2	5
Ride a bicycle	2	7	27	36	15	15	2	12	15	17	15
Exercise/play sports	14	24	32	42	19	51	17	56	47	59	36
Do strenuous household chores like cleaning, gardening	84	37	25	44	42	76	56	84	73	71	59
Walk	40	72	52	52	40	85	58	95	89	80	66
N	1015	1000	1000	1000	1000	1005	1000	1004	1003	1007	10034
	AFG	KEN	IND	INDO	BRA	MEX	SAF	RUS	UK	US	Total
	Low Income		Lower Middle		Upper Middle			High Income			

And there are a variety of reasons why women say they are not able to exercise regularly. At the top of the list, more than 3 in 10 (34%) say the main challenge to exercising regularly—at least two days a week for at least 10 minutes each day—is not having enough time. Half as many women report a lack of interest or motivation (17%), followed by not having a place to exercise (12%). Relatively few women say they are physically unable (7%) or that exercise is not culturally acceptable (5%).

Not having enough time—the overall top reason—is highest in South Africa (44%) and Mexico (43%), followed by Russia (37%), Brazil (36%), Kenya (36%), the UK (33%), Indonesia (31%), India (28%), the US (28%) and Afghanistan (25%). Lack of interest or motivation is highest in Kenya (24%) and the US (24%), followed by the UK (22%), Russia (20%), Brazil (18%), Afghanistan (16%), South Africa (13%), India (13%), Mexico (10%) and Indonesia (9%). Not having a place to exercise is higher in the developing countries, ranging from 11% in Mexico to 19% in Afghanistan, but much lower in the US (7%) and the UK (5%).



In Afghanistan, where there are cultural barriers to women exercising, about the same number say this prevented them from exercising (24%) as mentioned time constraints (25%). Cultural barriers are also cited in India (11%) and Indonesia (9%). Women in the US (34%) and the UK (33%) are much more likely than women in the other countries to report exercising on a regular basis, followed by Mexico (28%), Brazil (27%), South Africa (26%), Russia (25%), India (23%), Kenya (22%), Indonesia (17%), and Afghanistan (8%).

What is your main challenge to exercising regularly (at least 2 days a week for at least 10 minutes each day)?

Not applicable (I do exercise regularly)	8	22	23	17	27	28	26	25	33	34	24
Not interested or motivated	16	24	13	9	18	10	13	20	22	24	17
Not enough time	25	36	28	31	36	43	44	37	33	28	34
No place to exercise	19	13	13	18	13	11	12	13	5	7	12
Physically unable	8	3	12	15	5	4	3	5	6	5	7
Exercising is not culturally acceptable	24	1	11	9	1	0	2	0	1	1	5
Other reason	0	0	1	0	1	2	0	1	1	1	1
No answer	1	0	0	0	0	0	0	0	0	0	0
N	1015	1000	1000	1000	1000	1005	1000	1004	1003	1007	10034
	AFG	KEN	IND	IINDO	BRA	MEX	SAF	RUS	UK	US	Total
	Low Income		Lower Middle		Upper Middle			High Income			

Smoking

"We believe that health is both global and local and we strive to improve health not only in the United States but around the world. We can win against NCDs in smart ways by taxing tobacco, improving early-life nutrition to prevent obesity, and strengthening health systems."

— Ariel Pablos-Mendez, USAID, US Government

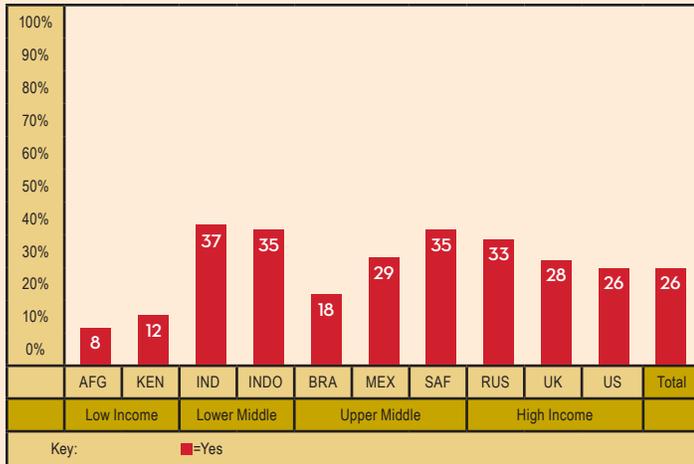
Nearly one billion people smoke worldwide and tobacco is responsible for 6 million global deaths each year.^{xxxviii} Although smoking rates are higher for men than for women in nearly every country, recent research suggests that men's smoking rates are slowly decreasing while tobacco use among women is increasing in some countries.^{xxxvix} Central and Eastern Europe, including Russia, have some of the highest female smoking rates in the world.^{xi}

In countries with high rates of smoking among men, second-hand smoke is a significant risk factor for non-smoking women. Second-hand smoke was responsible for approximately 275,000 adult female deaths in 2004.^{xli}

Tobacco use among women reported in the ten countries varied widely, though overall about one-quarter (26%) report smoking daily or at least occasionally. Roughly one-third of women in India (37%), Indonesia (35%), South Africa (35%), and Russia (33%) say they smoke daily or occasionally, as do nearly as many women in Mexico (29%), the UK (28%) and the US (26%). Notably, the rates of reported tobacco use in Brazil (18%), Kenya (12%) and Afghanistan (8%) and are markedly lower.



Do you smoke any tobacco products such as [Afghanistan: hookah, pipes, or cigarettes] [India: cigarettes, cigars, pipes, bidis, or hookah] [Indonesia: cigarettes, cigars, pipes, bidis, kretek, or hookah] [All other countries: cigarettes, cigars, pipes, or hookah] daily or even occasionally (you smoke but not every day)?



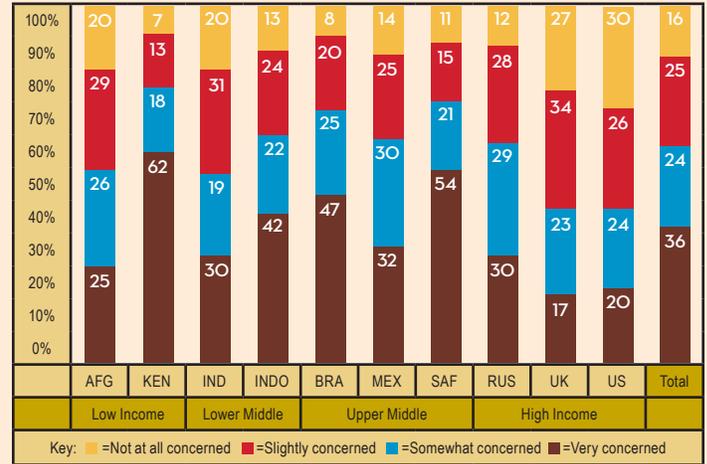
Concern for Children

In contrast to advertising of sugar-sweetened beverages, a solid majority of women in the ten countries surveyed are concerned about the impact of tobacco advertising on children. A total of 6 in 10 (60%) women are very concerned (36%) or somewhat concerned (24%) about children seeing advertisements for cigarettes or tobacco products on TV, billboards or other public places. Concern is highest in Africa, where 8 in 10 in Kenya (80%) and South Africa (75%) are concerned, including a majority in each country (62% and 54%, respectively) who say they are very concerned about children seeing advertisements for cigarettes or tobacco products on TV, billboards or other public places. A total of 7 in 10 women in Brazil (72%) say they are very or somewhat concerned, followed by 6 in 10 in Indonesia (64%), Mexico (62%) and Russia (59%), and 5 in 10 in Afghanistan (51%). Women in the US and the UK, where there are strict limits on the advertising of tobacco products, are less concerned, with 4 in 10 (44% and 40%, respectively) saying they are very or somewhat concerned.

“If we are serious about leaving the world a healthier place for our children, we must act now to prevent and control NCDs.”

— Kerida McDonald, UNICEF

How concerned are you about children seeing advertisements for cigarettes or tobacco products on TV, billboards and other public places?



CONCLUSION

NCDs are our generation’s responsibility to fix. It is on our watch that these diseases have reached crisis proportions. We must leave the world a better and healthier place for our children and future generations. We must reduce the impact of NCDs; in fact, it is essential for a sustainable world.

This study – Insights from 10,000 Women on the Impact of NCDs – provides valuable evidence that can help shape NCD policy. And influence the post-2015 dialogue and ‘The World We Want’.

We call on NGOs to access this study report and the accompanying videos, and use the women’s voices in their advocacy efforts to make change. We ask governments to review the evidence and take definite steps to reduce the burden of NCDs for women and their families everywhere.



Her Story, in Her Voice

WOMEN LIVING WITH NCDS



MICHELE'S STORY: LIVING WITH ASTHMA (BRAZIL)

My name is Michele, from Rio de Janeiro. I'm a single mother. I am a hairdresser. My life is a bit stressful, always running, a working life, family, children. I am divorced and I live with my two daughters and they are economically dependent upon me. My children are five and 15 years old. So, all their responsibilities are on me.

Last time I went to the doctor it was traumatic because I had this asthma crisis. I was very short of breath, a lot of pain in my chest. I was very desperate because I did not know what was happening. It was like I was suffocating. As if my glottis was closing down. I couldn't feel the air passing through. Then they put me on nebulizer therapy and it got better.

This season is the worst for my asthma, the transition to winter. This is when I have the most difficulties, and an asthma crisis every time. I think my profession as a beautician contributes a little to my asthma problem. Because of the chemicals, the smell. Of course, the environment in Rio de Janeiro also adds to the problem. I try to avoid allergic things as much as possible but some things are inevitable. There is no way one can forbid everything. We cannot ask everyone to be aware of our problem, right? Not everyone is aware of the problem of asthma.

If there is something I hate doing, it is spending money on medicines. One saves up for so many things and then one has to spend it on medicines. Now we do not have health insurance so I need to go to a medical appointment within SUS (universal healthcare).

I lost my mother, and then recently my uncle who had pulmonary emphysema died. It will be one month since he passed away, and I was there the whole time...I have completely abolished cigarettes from my life. Never again do I want to put a cigarette in my mouth. Because I saw very closely how he suffered and it hit me in a way that I cannot explain. It is very sad to see someone trying to breathe, trying to fight for his life, and not being able to do it. I get very emotional when it is someone I love. My uncle was like a father. It was very difficult for me.

Nowadays I totally despise cigarettes. My daughters didn't like cigarettes before and now when someone smokes they just leave the room. I worry a lot about my daughters because we should think about the future of our children. I think about their nutrition, give them healthy food to eat, and ask them to avoid smoky places because they are allergic too.



To view this video click on:

<http://arogyaworld.org/programs/capturing-the-voices-of-10000-women/videos/>

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APPENDIX

Survey Methodology

Surveys of 10,034 women age 18 to 40 were conducted in 10 countries on behalf of Arogya World by Abt SRBI and Jana. The questionnaire was designed by Abt SRBI in consultation with Arogya World. The surveys were administered in three different modes:

1. Surveys were conducted face-to-face in urban areas of Afghanistan (n=1,015) March 15-19, 2014, by an in-country market research agency under the direction of Abt SRBI. Women were selected by cluster sampling the largest city in each of five regions: Herat (West), Jalalabad (East), Kabul (Central), Kandahar (Southeast), and Mazar-e-Sharif (Northwest). Households were randomly selected within each cluster using a random walk procedure. Within each household, women were selected by a random selection procedure.
2. Surveys were conducted online by sampling online panels in Mexico (N=1,005), Russia (N=1,004), the United States (N=1,003) and the United Kingdom (N=1,007) between March 25 and April 1, 2014. The surveys were programmed and hosted by Abt SRBI. Online panels were sampled in multiple replicates in proportion to the age demographics of the panels, and quota ranges were used to limit skews by age.
3. Surveys were conducted on mobile devices by sampling online panels in Brazil (N=1,000), India (N=1,000), Indonesia (N=1,000), Kenya (N=1,000) and South Africa (N=1,000) March 5-30, 2014. The surveys were programmed and hosted by Jana. The mobile sample was sampled in multiple replicates by sending invitations to the mobile panel inviting members to participate in the survey.

Table 1: Sampling and mode

Country	Sampling	Mode
Afghanistan	In-person probability sample	Face-to-Face
Brazil	Mobile panel	Mobile
India	Mobile panel	Mobile
Indonesia	Mobile panel	Mobile
Kenya	Mobile panel	Mobile
Mexico	Online panel	Web
Russia	Online panel	Web
South Africa	Mobile panel	Mobile
UK	Online panel	Web
US	Online panel	Web

The resulting interviews in Afghanistan comprise a probability-based, representative sample of the urban populations that were sampled. The margin of sampling error is plus or minus approximately 3.1 percentage points at the 95 percent confidence interval for the full sample of 1015 interviews. Samples of online panels and mobile panels are non-probability samples because the sampling is restricted to panel members only and does not sample the universe of the target population (women age 18 to 40). Consequently, a margin of error cannot be computed for the online and mobile samples.

The sampling approach and mode may affect how representative the sample is of the target population of women age 18 to 40. In Afghanistan, as noted, the sample was drawn only from urban locations and excludes rural locations. In the remaining countries, urban and rural respondents were sampled from their respective panels but rural respondents are under-represented in the final sample of completed interviews in India, Kenya, Mexico, Russia, and South Africa. This is due to the limited availability of panel respondents in rural areas. In Brazil, Indonesia, the UK, and the US, rural respondents are represented on-par with current population estimates. Table 2 provides a comparison of current urban/rural population estimates and the completed Arogya World survey samples.



Table 2: Urban and rural distribution

Country	Population Estimate		Arogya World Survey			
	Urban (%)	Rural (%)	Urban & Suburban (%)	Rural (%)	Unknown (%)	N
Afghanistan	24	76	100	0	0	1015
Brazil	85	15	81	12	7	1000
India	31	69	64	27	10	1000
Indonesia	51	49	54	45	2	1000
Kenya	24	76	72	27	1	1000
Mexico	78	22	96	3	1	1005
Russia	74	26	94	6	0	1004
South Africa	62	38	82	11	8	1000
UK	80	20	80	16	4	1003
US	82	18	73	22	5	1007
Total			80	17	4	10034

Surveys sampled through online and mobile panels, and conducted online and by mobile devices, may also over-represent higher income women because these approaches only recruit women who have the Internet access and the technology necessary to complete the survey.

“Data will be critical in informing actions and interventions both locally and globally to mitigate the growing impact of NCDs in the years to come. We are pleased we were able to use our research know-how to implement this important survey across the globe, leveraging mobile and web technologies, key assets in health communications.”

**— Ken Gaalswyk, Vice President,
International Research, Abt SRBI**



STAKEHOLDER PERSPECTIVES

"We see the increase of NCDs, especially in developing countries, as a major global health problem. That's why Novartis is proud to collaborate with Arogya World on their 10,000 Women's study, drawing attention to the impact of NCDs on women's lives around the world.

— **Jurgen Brokatzky-Geiger, Novartis**

"The survey deciphers and translates every single letter into the real daily struggles of women for simply being women, and on what it is like to be in the developing world and deal with the devastating impact of diseases that are chronic, super expensive, and hard to treat.

We must work together to empower women to steer their families towards healthy living and influence the global community to make a difference in their lives, because when women are empowered, the whole world can prosper."

— **HRH Princess Dina Mired, King Hussein Cancer Foundation**

"It is well known that NCDs are largely preventable. But that is not being effectively translated into action at the country level. We are eager to use this study's findings to get policymakers to invest in women-centered NCD programs."

— **Kenneth Thorpe, Partnership to Fight Chronic Disease**

"If we are serious about leaving the world a healthier place for our children, we must act now to prevent and control NCDs."

— **Kerida McDonald, UNICEF**

"Every woman can be a role model and central to the NCD movement. So we must empower women as actors of change. That can only happen if men and boys live up to their responsibilities and take on their fair share of the burden of unpaid care work."

— **Daniel Seymour, UN Women**

"Women are the cornerstone of global health and development. Ensuring they have access to NCD prevention, treatment and care programs helps improve the health of families and communities."

— **Karl Hofmann, Population Services International**

"Tremendous lessons can be learned from the HIV movement, especially as we realize that policy change is a political process that can be helped by involving people living with and affected by HIV."

— **Susana Fried, UNDP**

"We must not forget that women have atypical heart attack symptoms, that there are more women in the aging global population, and that 90% of cervical cancer deaths are in developing countries. We cannot win until we become more responsive to the needs of women."

— **Rama Lakshminarayanan, WHO**

"Governments must make it easier for people to adopt healthy behavior and implement the right programs and policies designed for impact. NCDs are a shared responsibility."

— **Jeff Meer, Public Health Institute, NCD Roundtable**

"Let us use the 10,000 women's voices from this study as a mark of respect for the 10 million or more who die from NCDs each year, who no longer have a voice."

— **Sally Cowal, American Cancer Society, Task Force on NCDs and Women's Health**

"We believe that health is both global and local and we strive to improve health not only in the United States but around the world. We can win against NCDs in smart ways by taxing tobacco, improving early-life nutrition to prevent obesity, and strengthening health systems."

— **Ariel Pablos-Mendez, USAID, US Government**

"With this global study we are providing data on women's views on the human toll and economic impact of NCDs, data we believe will compel decision-makers to address these serious diseases, and help women and families lead healthier lives."

— **Nalini Saligram, Arogya World**

"In my years in global public health, I have observed that the political process is too often divorced from real life. Arogya World's study, in giving voice to 10,000 women on a subject central to their lives, begins to bridge that gap and advance the global dialogue on NCDs in a powerful way."

— **Jeff Sturchio, Rabin Martin**

Arogya World is a global health non-profit organization working to prevent non-communicable diseases (NCDs)—diabetes, heart disease, cancer and chronic lung diseases—through health education and lifestyle change. Through our programs and advocacy efforts, we help people around the world lead healthier lives.

Our mission is reflected in our name: "Arogya" in Sanskrit means to live a life without disease.



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