



International
Diabetes
Federation

Advocacy guide

to the IDF Diabetes Atlas Ninth edition 2019



463
million | **PEOPLE LIVING
WITH DIABETES**





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Foreword

Professor Rhys Williams
Chair, IDF Diabetes Atlas Committee (9th edition)



Diabetes is a serious threat to global health that respects neither socioeconomic status nor national boundaries. **The latest data published in the *IDF Diabetes Atlas 9th edition* show that 463 million adults are currently living with diabetes.** Without sufficient action to address the pandemic, 578 million people will have diabetes by 2030. That number will jump to a staggering 700 million by 2045.

People living with diabetes are at risk of developing a number of serious and life-threatening complications, leading to an increased need for medical care, a reduced quality of life, and undue stress on families. **Diabetes and its complications, if not well managed, can lead to frequent hospital admissions and premature death.**

Currently, massive health inequalities persist across the globe. With diabetes, these manifest in a lack of awareness among many populations about the risk factors and symptoms of diabetes, and in a need for both increased training of health care professionals and better access to diagnostics and medicines – particularly in low- and middle-income countries. Despite being available for almost 100 years, insulin remains unaffordable and unavailable to many people with diabetes for whom it is essential.

Despite the stark realities the new data represent, there is an enduring positive message: with prompt and accurate diagnosis and access to appropriate care, **diabetes can be managed and its complications prevented.** Furthermore, type 2 diabetes can often be prevented and there is compelling evidence to suggest it can, in some circumstances, be reversed.

Effective national advocacy is required to convince those who establish health priorities and allocate budgets that **tackling diabetes is a critical and achievable goal.** The best available evidence must be used to raise awareness of diabetes, to engage stakeholders in type 2 prevention and to create national diabetes plans that are appropriate to unique local contexts. All people living with diabetes should benefit from the early detection and appropriate treatment of complications. Achieving universal health coverage (UHC) will require governments to make sure people with diabetes have uninterrupted access to essential diabetes services, medicines and devices, and that these are affordable at the point of delivery.

The *IDF Diabetes Atlas* is published as a resource for those who have to make decisions about diabetes care and prevention and for those who seek to influence such decisions. **This guide is intended as a practical tool for all diabetes advocates.** The information contained will help you to navigate the *IDF Diabetes Atlas 9th edition*, and to make convincing arguments for improving prevention and care for people at risk of, or already living with, diabetes.

Ultimately, this guide aims to stimulate governments and the private sector to take action to identify undiagnosed diabetes, take further steps to prevent type 2 diabetes in those at risk, and improve care for all people living with diabetes.

Section 1: Worldwide toll of diabetes



Diabetes is **one of the fastest growing health challenges** of the 21st century, with the number of adults living with diabetes having more than tripled over the past 20 years.

Diabetes is rising worldwide

In 2000, the global estimate of adults living with diabetes was 151 million. By 2009 it had grown by 88% to 285 million. Today, we calculate that 9.3% of adults aged 20–79 years – **a staggering 463 million people – are living with diabetes**. A further 1.1 million children and adolescents under the age of 20 live with type 1 diabetes.

A decade ago, in 2010, the global projection for diabetes in 2025 was 438 million. With over five years still to go, that prediction has already been surpassed by 25 million.

Diabetes estimations are based on the population between 20 and 79 years. Adults beyond that age are not included in the estimations. The IDF Diabetes Atlas estimations are therefore quite conservative.

The impact is huge... and set to rise even further

IDF estimates that there will be 578 million adults with diabetes by 2030, and 700 million by 2045.

Read more in *IDF Diabetes Atlas Chapter 3*

www.diabetesatlas.org/atlas/en01

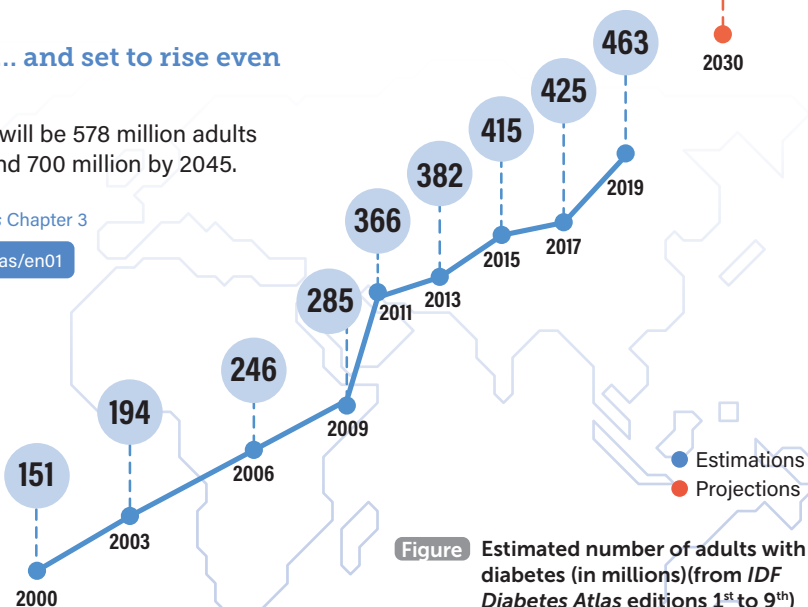


Figure Estimated number of adults with diabetes (in millions) (from *IDF Diabetes Atlas* editions 1st to 9th)

What is diabetes, and why is it on the rise?

Diabetes is a chronic disease that occurs when the pancreas is no longer able to make insulin, or when the body cannot make good use of the insulin it produces. There are three main types of diabetes:



Type 1 diabetes is caused by an autoimmune reaction in which the body's immune system attacks the insulin-producing beta cells of the pancreas. As a result, the body produces very little or no insulin.



Type 2 diabetes is the most common type of diabetes. Initially, hyperglycaemia (high blood glucose levels) is the result of the inability of the body's cells to respond fully to insulin, a situation termed 'insulin resistance'.



Gestational diabetes (GDM) is characterised by high blood glucose levels during pregnancy. It may occur at any time during pregnancy (although most likely after week 24) and usually disappears after the pregnancy.

Read more in *IDF Diabetes Atlas Chapter 1*

www.diabetesatlas.org/atlas/en02

An impact across generations

Women who experience GDM face an increased risk of developing type 2 diabetes later in life. In addition, babies born to mothers with GDM also have a higher lifetime risk of obesity and developing type 2 diabetes themselves.

This contributes to an **intergenerational cycle of obesity and diabetes** that seriously impacts the health of the entire population, and the generations to come.

The increasing prevalence of diabetes worldwide is driven by a **complex interplay of socioeconomic, demographic, environmental and genetic factors**. The continued rise is largely due to an upsurge in type 2 diabetes and related risk factors, which include rising levels of obesity, unhealthy diets and widespread physical inactivity. However, levels of childhood-onset type 1 diabetes are also on the rise.

What is impaired glucose tolerance?

Impaired glucose tolerance (IGT) is a condition of raised blood glucose levels above the normal range, but below the recommended diabetes diagnostic threshold. The terms 'prediabetes' and 'non-diabetic hyperglycaemia' are sometimes used as alternatives.

IGT is important because it:

- indicates a risk of developing type 2 diabetes in the future;
- denotes an already heightened risk of cardiovascular diseases;
- offers the opportunity for interventions that can lead to the prevention of type 2 diabetes.

The estimated number of adults with IGT, and therefore at increased risk of developing type 2 diabetes, is 374 million. It is predicted to rise to 454 million by 2030 and to 548 million by 2045.

Societal causes

Growing urbanisation and changing lifestyle habits (e.g. higher calorie intake, increasing consumption of processed foods, sedentary lifestyles) are contributory factors for the increasing prevalence of type 2 diabetes at a societal level. While global prevalence of diabetes in urban areas is 10.8%, in rural areas it is lower, at 7.2%. However, this gap is closing, with rural prevalence on the rise.



Advocacy tips: **Know the evidence**

To become an effective diabetes advocate, you must have a good understanding of what diabetes is, its current extent, its evolution in the past 20 years and anticipated future projections. Whatever form of advocacy you are undertaking, you need to use the latest available evidence to make the case for better diabetes awareness, education, prevention, and care.

Make sure you have read and understood the latest diabetes estimates and projections, as well as the most commonly used diabetes-related terms. Familiarity with these essential data and concepts – including a grasp of the extent of diabetes in your country and region – will enable you to understand and communicate the importance of diabetes in your local or national context.

Here are some tips to start or continue your advocacy work:

- ✓ If you have not already done so, carry out **your own reading and research**, so you fully understand the differences between the various types of diabetes and the challenges they pose in your own country.
- ✓ Use the latest *IDF Diabetes Atlas* and website, to locate **global and regional data**.
- ✓ Check out the IDF Atlas Regional Factsheets, for a precise idea of the main diabetes priorities and **challenges in each region**.
- ✓ Download up-to-date **graphics, slides and other resources** from the IDF Atlas website to help you share the global 'big picture' of diabetes.
- ✓ If you encounter words or terms you are not familiar with, you can consult the helpful **diabetes glossary** on the IDF Diabetes Atlas website.

 www.diabetesatlas.org/upload/resources

 www.diabetesatlas.org/glossary

Section 2:

Individual, social and economic impacts

Osarenkhoe Ethel Chima-Nwogwugwu (Nigeria). Diabetes advocate living with type 2 diabetes

Diabetes increases the risk of health complications

Diabetes has the potential to cause numerous debilitating health complications that can lower quality of life and lead to early death. Most often, complications are the result of an unmanaged or poorly managed diabetes. However, people with appropriate diabetes management are also at risk of developing complications.

Half of the 463 million adults living with diabetes today are unaware that they have the condition, and are therefore at high risk of developing serious diabetes-related complications.

Diabetes increases the risk of early death

IDF estimates that approximately 4.2 million adults will die as a result of diabetes and its complications in 2019. This is equivalent to **one death every eight seconds**.

Globally, 11.3% of deaths are due to diabetes. Almost half of these deaths are in people under 60 years of age.

Acute diabetes complications

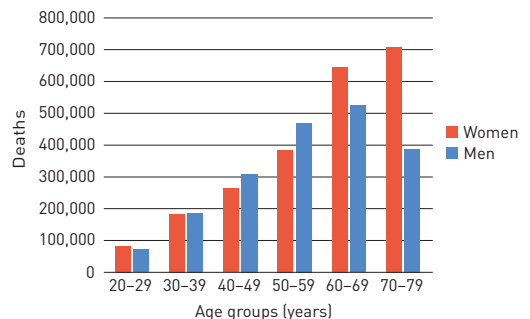
Acute, or short-term, diabetes complications, resulting from extremes of blood glucose levels, are common in type 1 diabetes and can also occur, when certain medications are used, in type 2 and other forms of diabetes. These can lead to permanent illness or even death.

Understanding acute diabetes complications

Lack of access to insulin, misdiagnosis or delayed diagnosis of type 1 diabetes can result in *diabetic ketoacidosis* (DKA), a common cause of death in children and young people with diabetes. Additionally, *hypoglycaemia* (low blood glucose) is common in type 1 diabetes (and in type 2 diabetes when insulin or sulphonylurea medicines are used).

A specific effect of high blood glucose levels – *hyperglycaemic hyperosmolar state* (HHS) – can also occur in people with type 2 diabetes. Overall death rates with HHS are estimated at 5–20%: 10 times higher than for DKA.

Figure Number of deaths due to diabetes in adults (20–79 years) by age and sex in 2019



CHRONIC COMPLICATIONS OF DIABETES

Chronic, or long-term, complications of diabetes may already be present in people with type 2 diabetes by the time they are diagnosed. They can also appear soon after the onset of type 1 diabetes. Early detection and appropriate treatment are essential to prevent disability and death.



Diabetic eye disease

In most countries, *diabetic retinopathy* continues to be the leading cause of blindness in the working age population. Diabetic retinopathy prevalence increases with duration of diabetes in both type 1 and type 2 diabetes, and is associated with deteriorating glycaemic control and the presence of hypertension.



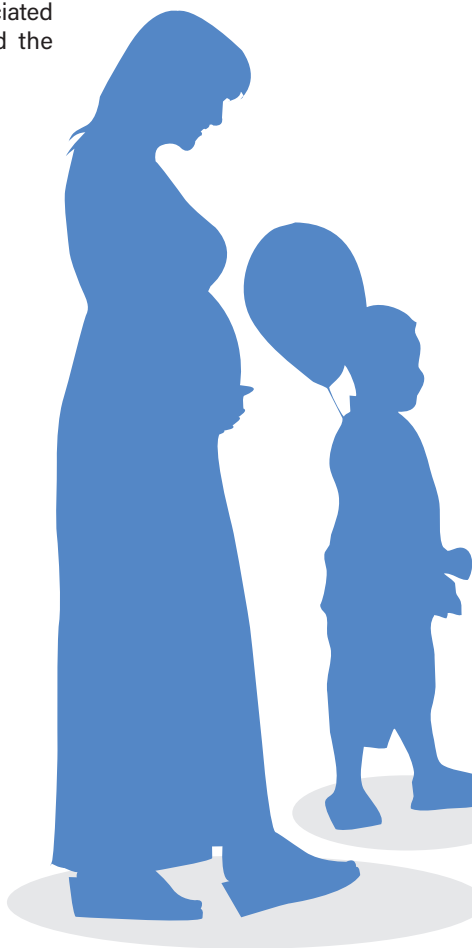
Diabetes and oral health

Diabetes and poor oral health negatively affect each other in a two-way relationship. Gum disease raises blood glucose levels, and may contribute to the development of type 2 diabetes or to poorer control of blood glucose in existing diabetes. Diabetes negatively affects all soft and hard tissues surrounding the teeth. Poor oral health and missing teeth can lead to poorer diet and quality of life in people with diabetes.



Diabetes-related complications of pregnancy

An estimated 15.8% (20.4 million) of live births were affected by *hyperglycaemia* in pregnancy in 2019. *Gestational diabetes mellitus* (GDM) is associated with multiple adverse pregnancy outcomes for both the mother and the baby, as explained on page 3.





Diabetes and cardiovascular diseases

Cardiovascular diseases account for, from one-third, to half of all, diabetes-related deaths. Diabetes and elevated blood glucose are associated with an approximate doubling of cardiovascular diseases risk.



Diabetic kidney disease

Diabetes, *hypertension* (high blood pressure), or a combination of both, cause 80% of *end-stage kidney disease* globally. Both diabetes and *chronic kidney disease* are also strongly associated with *cardiovascular diseases*.



Nerve and/or vascular damage and diabetic foot complications

Diabetic foot and lower limb complications affect between 40 and 60 million people with diabetes globally. Currently, less than one-third of physicians recognise the signs of *diabetes-related peripheral neuropathy*. The resulting missed diagnoses contribute greatly to its high rates of morbidity and mortality.

Read more in *IDF Diabetes Atlas* Chapter 5



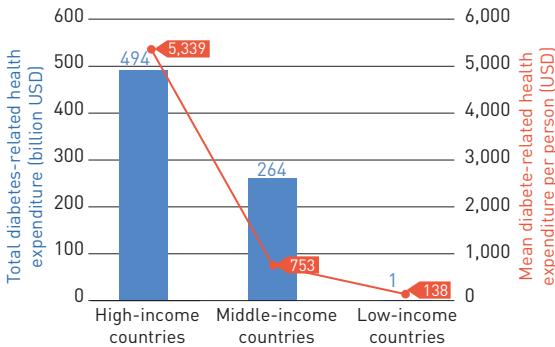
www.diabetesatlas.org/atlas/en03



Economic and social impact

Diabetes also imposes a significant economic impact on countries, health systems and – when healthcare must be funded ‘out-of-pocket’ – on people with diabetes and their families.

Figure Diabetes-related health expenditure (20–79 years) by income group in 2019



Direct costs

IDF estimates the **annual global health expenditure on diabetes at USD 760 billion**. It is projected that these direct costs will reach USD 825 billion by 2030 and USD 845 billion by 2045.

The costs of treating complications account for over 50% of the direct health costs of diabetes. For example, management of diabetic ketoacidosis (DKA) is a considerable part of the cost to a country’s health system: treatment of a single DKA episode in the United Kingdom costs an estimated GBP 1,387 (around USD 1,750).

Indirect costs

Premature death, disability and other health complications due to diabetes are also associated with a negative economic impact for countries. It is estimated that these **‘indirect costs’ of diabetes add an additional 35% to the annual global health expenditures** associated with the condition.

Sources of indirect costs include labour-force drop out, mortality, absenteeism and presenteeism (reduced productivity when at work). Of these, the first two dominate the global picture comprising 49% and 46% of all indirect costs, respectively.

Intangible costs

For people living with diabetes, concerns about managing the condition and fears of future complications and their potential impact on quality of life, are significant contributors to the intangible costs of diabetes. **These include worry, anxiety, discomfort, pain, loss of independence** and a host of other crucially important features of living with diabetes.

Read more in *IDF Diabetes Atlas* Chapter 3

www.diabetesatlas.org/atlas/en04



Advocacy tips: Establishing partnerships and identifying key advocacy priorities

After doing your initial research about diabetes, it is time to establish partnerships to increase your chances of successfully changing minds, health policies and corresponding budgets.

Voices are more influential when they speak together – and **advocates are more efficient when they work jointly**. We recommend you start exploring alliances within the diabetes community, by talking to other people living with diabetes and their carers, healthcare professionals, and your local or national diabetes association. Further, search for allies in organisations working on some of the diabetes-related complications you have read about in this section, for example, cardiovascular disease and kidney disease. You can also search for collaborators in networks of young or older people, organisations of scientists and healthcare professionals, and other civil society groups.

When looking for advocacy partners, ask yourself if there are certain sectors of society – the private sector, academia, civil society, etc. – that are likely to wield greater influence or credibility to your advocacy activities.

One of the purposes of joining forces with other stakeholders is to pinpoint **unifying advocacy priorities** that you can work towards together. Here are some issues that affect most countries to a greater or lesser extent, and require urgent action:

- Undiagnosed diabetes
- Lack of access to diabetes care, medicines and supplies
- Increasing rates of type 2 diabetes, including among young people
- Lack of diabetes education
- Discrimination against people with diabetes

To better understand the most urgent diabetes priorities in your country, visit the **Diabetes Data Portal** on the *IDF Diabetes Atlas* website to view **IDF Country Diabetes Reports** and print or download a report of your country's estimations.

Once you have agreed on advocacy priorities with your partners, you can prepare your key messages using the relevant evidence/data you have found in the *IDF Diabetes Atlas*. When putting together your arguments, think about what type of evidence is most likely to be compelling and credible among those you must convince. For example, when addressing policy-makers **use the evidence on the economic impact of diabetes** you have read about in this section.

Diabetes data portal



www.diabetesatlas.org/dataportal

All *IDF Diabetes Atlas* editions and other resources



www.diabetesatlas.org/upload/resources

Section 3: Demographic and geographic outline

Narsimha Raji Dichpally (India).
Diabetes advocate and carer for
his father with type 2 diabetes

Diabetes is a truly **global challenge, affecting all ages, continents and communities**. While information on the impact of social, economic and political determinants on diabetes is scarce – particularly in low- and middle-income countries – it is clear that the condition is influenced by a complex interaction of behavioural, genetic and socioeconomic factors, many of which are outside our individual control.

Age profile of diabetes

Working age

Three in four people living with diabetes (352 million people) are of working age (between 20 and 64 years old). This number is expected to increase to 417 million by 2030 and to 486 million by 2045.

This generates a growing human impact and will also drive a serious and expanding strain on productivity and economic growth in the coming decades.

Older people

In 2019, **the estimated number of people over 65 years of age with diabetes is 111 million**. One in five adults in this age group is estimated to have diabetes.

It is projected that by 2030 the number of people over 65 with diabetes will further increase to 195 million. By 2045, it will reach 276 million. These data point to substantial increases in the diabetes population of ageing societies in the next 25 years, as well as the inevitable public health and economic challenges this will bring.

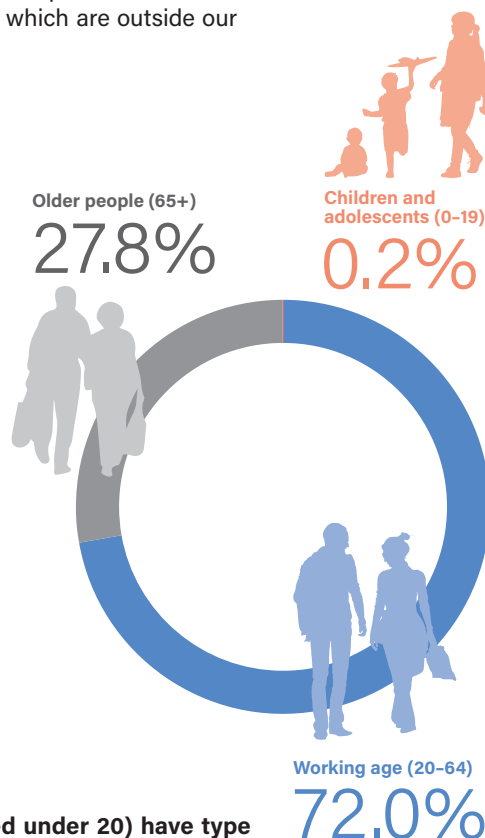
Children and adolescents

An estimated **1.1 million children and adolescents (aged under 20) have type 1 diabetes**. There is some evidence that type 2 diabetes among children and adolescents is increasing in some counties, but it is not currently possible to estimate the numbers due to a lack of data.

Read more in *IDF Diabetes Atlas Chapter 3*



www.diabetesatlas.org/atlas/en05



Understanding prevalence vs age-adjusted comparative prevalence

'Age-adjustment' is a statistical process used to present rates of disease when populations with different age structures are compared.

In preparing the *IDF Diabetes Atlas*, age-adjusted comparative diabetes prevalence is calculated and adjusted to take into account current and future age structure of the world population. The resulting 'age-adjusted' diabetes prevalence provides a more accurate picture of the comparative proportions of a population affected by diabetes.

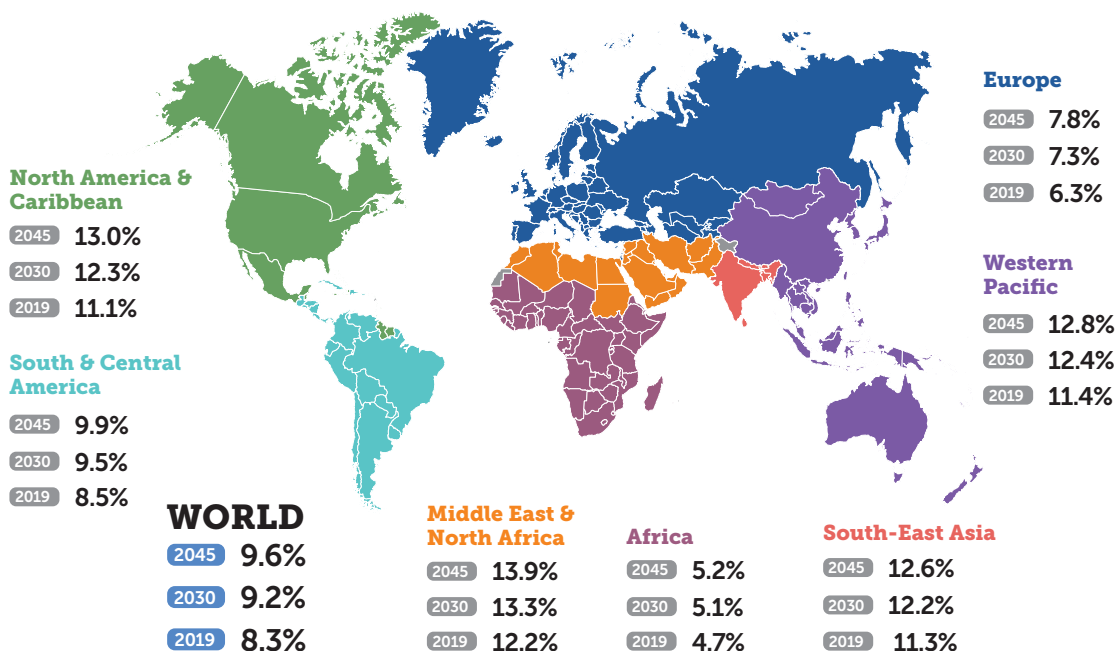
Geographical profile

Diabetes prevalence

The IDF Middle East and North Africa (MENA) Region has the highest age-adjusted prevalence of diabetes in adults in 2019, 2030 and 2045 (12.2%, 13.3% and 13.9%, respectively).

The IDF Africa (AFR) Region has the lowest age-adjusted prevalence in 2019, 2030 and 2045 (4.7%, 5.1% and 5.2%), which can be partly attributed to lower levels of urbanisation, under-nutrition and lower levels of overweight and obesity. However, the number of people with diabetes in this Region is expected to increase in 143% by 2045 – the largest percentage increase of all regions over that period.

Map Prevalence of diabetes in adults (20–79 years) in IDF Regions, by age-adjusted comparative diabetes prevalence



For confidence intervals, see full *IDF Diabetes Atlas*, Table 3.4.

Related deaths

The Region with the highest estimated number of diabetes-related adult deaths is the IDF Western Pacific (WP) Region, where 1.3 million deaths are due to diabetes each year. This is followed by the IDF South-East Asia (SEA) Region, with 1.2 million deaths. The Region with the lowest number of diabetes-related deaths is the IDF South and Central America (SACA) Region (0.2 million).

Read more in *IDF Diabetes Atlas* Chapter 4

www.diabetesatlas.org/atlas/en06

Countries with the highest numbers of people with diabetes

In 2019, the countries with the largest numbers of adults with diabetes are China, India and the United States of America, and are anticipated to remain so until 2030. It is projected that the number of people with diabetes in Pakistan will exceed that in the United States of America by 2045, moving the country to third place.

Table Top 10 countries or territories for number of adults (20–79 years) with diabetes

Rank	2019		2030		2045	
	Country or territory	No. of people with diabetes (millions)	Country or territory	No. of people with diabetes (millions)	Country or territory	No. of people with diabetes (millions)
1	China	116.4	China	140.5	China	147.2
2	India	77.0	India	101.0	India	134.2
3	United States of America	31.0	United States of America	34.4	Pakistan	37.1
4	Pakistan	19.4	Pakistan	26.2	United States of America	36.0
5	Brazil	16.8	Brazil	21.5	Brazil	26.0
6	Mexico	12.8	Mexico	17.2	Mexico	22.3
7	Indonesia	10.7	Indonesia	13.7	Egypt	16.9
8	Germany	9.5	Egypt	11.9	Indonesia	16.6
9	Egypt	8.9	Bangladesh	11.4	Bangladesh	15.0
10	Bangladesh	8.4	Germany	10.1	Turkey	10.4

For confidence intervals, see full IDF Diabetes Atlas, Table 3.5.

Low- and middle-income countries

The highest prevalence of diabetes in adults occurs in high-income countries, with an estimated 10.4% of the population having diabetes. The diabetes prevalence is 4% in low-income countries, and 9.5% in middle-income countries.

Over the next 25 years, diabetes prevalence is expected to increase in all countries, with the greatest increase expected in middle-income countries. If current trends continue, the largest increases will take place as economies transition from low- to middle-income status.

Understanding non-communicable diseases

A non-communicable disease (NCD) is one that is not infectious and does not transmit from one person to another. **NCDs kill 41 million people each year**, equivalent to 71% of all deaths.

NCDs are driven by rapid urbanisation, globalisation of unhealthy lifestyles and population ageing. Sometimes referred to as 'chronic diseases', NCDs tend to be long-term and have a combination of genetic, physiological, environmental and behavioural causes.

Addressing the modifiable behavioural risk factors, such as consumption of tobacco products, physical inactivity, harmful use of alcohol, and unhealthy diets, can improve the outcomes of all NCDs, including type 2 diabetes.

Global inequalities

Inequalities in access to quality healthcare persist, particularly in low- and -middle-income countries. Diabetes is often undiagnosed or inadequately treated, with people unable to access the essential medicines and devices they need.



Undiagnosed diabetes

While found everywhere, **low-income countries have the highest proportion of undiagnosed diabetes**, at 66.8% (two in three people with diabetes). This is due to a combination of limited access to healthcare services, inadequate training among healthcare professionals and lack of awareness of the symptoms among the general population.



Misdiagnosis

In many less-resourced countries, health worker awareness about type 1 diabetes is low and glucose testing facilities are limited, meaning the disease is often mistaken for malaria, pneumonia or various other conditions. If the diagnosis of type 1 diabetes is delayed or missed, the risk of serious complications and mortality rises. If missed entirely, the person will likely die. **This may be the most common reason for the death for children with type 1 diabetes globally.**



Children and adolescents

In countries with limited access to insulin and inadequate health service provision, children and adolescents with type 1 diabetes, even when correctly diagnosed, face serious complications and often premature death.



Hyperglycaemia in pregnancy

Nine out of 10 live births affected by hyperglycaemia in pregnancy are seen in low- and middle-income countries, where access to antenatal care may be limited.



Access to insulin

Worldwide, many people with type 1 diabetes cannot access the insulin they need to survive. Additionally, it is estimated that one in two people with type 2 diabetes do not have access to the insulin they have been prescribed. **Populations from low-income settings suffer the most from lack of availability to diabetes medicines.** For example, 86% (four in five) of people with type 2 diabetes in Africa do not have access to the insulin they need.



Mortality

Ninety percent of all diabetes-related premature deaths and 87% of all diabetes-related deaths happen in low- and middle-income countries. This can be attributed to the lowest rates of diabetes diagnosis and the difficulties in accessing diabetes care in these settings, when compared to high-income countries.

Understanding the Sustainable Development Goals

The Sustainable Development Goals (SDGs) provide a roadmap for addressing global challenges, including health, poverty, inequality, climate, peace and justice. Although there is an SDG focused on health (SDG3: *Ensure healthy lives and promote wellbeing for all at all ages*), **most SDGs and targets are interconnected.** For example, SDG11, target 7: *Provide universal access to safe, inclusive and accessible, green and public spaces*, also becomes relevant to ensuring that populations have access to affordable opportunities for physical activity. Additionally, SDG2, target 1: *End hunger and ensure access by all people, in particular the poor and people in vulnerable situations, including infants, to safe, nutritious and sufficient food all year round*, is also applicable in campaigning for affordable healthy food. **Partnerships across sectors are key to achieving the SDGs.**



Advocacy tips: Bringing international diabetes commitments to the national level

Diabetes disproportionately affects low- and middle-income countries, where four in five (79%) adults with diabetes live. It poses a **significant challenge for sustainable development**, and requires political willingness to be addressed. Although diabetes did not attract much political attention in the past, this has improved in the last 15 years with the adoption of the following international commitments.

2006

UN 61/225 Resolution on Diabetes

Diabetes recognised as a chronic, debilitating and costly disease that poses a severe risk for families, UN Member States and the entire world.

Governments encouraged for the first time to develop national policies for diabetes prevention, treatment and care.

2013

WHO Global Monitoring Framework

Overarching goal of reducing premature mortality from NCDs by 25% by 2025.

Nine diabetes-related global targets to be achieved by 2025, including:

- 0% increase in diabetes and obesity prevalence.
- Reducing insufficient physical activity by 10%.
- 80% coverage with essential medicines and technologies.
- At least 50% of eligible people receiving drug therapy and counselling (including glycaemic control) to prevent heart attacks and strokes.

2015

UN Sustainable Development Goals

Adoption of a new development framework with 17 Goals, to be achieved by 2030.

Several diabetes-related targets:

- Reduce premature mortality due to NCDs by 30%.
- Achieve universal health coverage (UHC).
- End malnutrition in all its forms, including overweight and obesity.

2011

First UN High-Level Meeting on NCDs

Unanimous adoption of the Political Declaration on NCDs prevention and control, including a set of commitments firmly positioning diabetes and other NCDs on the international political agenda.

2014

Second UN High-Level Meeting on NCDs

Governments unanimously agreed on four time-bound commitments:

- By 2015: consider setting national NCD targets for 2025 and consider developing national multisectoral policies and plans to achieve the 2025 national targets.
- By 2016: reduce risk factors for NCDs and consider strengthening health systems to address NCDs through people-centred primary healthcare and UHC.

2017

WHO Global Conference on NCDs

Re-commitment by governments to intensify action to protect people from the harms of NCDs.

As a diabetes advocate, it is important that you **bring these international commitments to the national sphere**, by using them to underpin your requests to governments. Check the WHO NCD country profiles, to see how well your country is doing against each of the targets.

If you want to learn if your country is on track for the 0% increase in diabetes target, look at your country profile in the *Global Nutrition Report 2018*. If you see that your country's progress towards the objectives is insufficient, **hold your government accountable by requesting stronger and more effective actions to address the existing gaps.**

If you want to be updated about the latest diabetes-related international meetings and opportunities for global advocacy, **follow IDF on social media** and regularly check out the IDF advocacy webpage. If you have diabetes or are a carer of a person with diabetes, you can also **join the Blue Circle Voices**, the IDF global network of advocates. If you want to learn more about IDF advocacy work, contact IDF at advocacy@idf.org

2018

Third UN High-Level Meeting on NCDs

Scale up the implementation of the commitments made in 2011 and 2014 for the prevention and control of NCDs, and 30 other broad-based NCD-related commitments.

2019

High Level Meeting on Universal Health Coverage

Scale up national efforts towards UHC, including further implementing a range of actions to promote active and healthy lifestyles.

idf.org/our-activities/advocacy-awareness.html

idf.org/our-network/blue-circle-voices.html

who.int/nmh/publications/ncd-profiles-2018/en

globalnutritionreport.org

 IntDiabetesFed

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 international-diabetes-federation

 intdiabetesfed

Section 4: Proven and effective actions

Verónica Emilia Tapia Abril
(Ecuador). Diabetes advocate living
with latent autoimmune diabetes

Improved education at the population-level, strong health systems, and effective policy frameworks are key to adequately address the primary risk factors of type 2 diabetes (such as poor eating habits, obesity and inadequate physical activity) and the high numbers of people living with undiagnosed diabetes.

Medication and lifestyle changes

Living with diabetes

Although recent evidence suggests that remission of type 2 diabetes may be possible, **both type 1 and type 2 diabetes should currently be regarded as lifelong conditions** that require continuous self-management.

People with type 1 diabetes need daily injections of insulin to control their blood glucose levels. If they do not have access to insulin, they will die. Regular blood glucose monitoring and a healthy lifestyle are also required to effectively manage type 1 diabetes.

Priorities in type 2 diabetes management include a healthy diet, regular physical activity and maintaining a healthy body weight. Oral medicines and insulin may also be prescribed to help control blood glucose levels.

People at risk of diabetes



Type 1 diabetes

No effective and safe intervention currently exists to prevent type 1 diabetes. However, there is some evidence that a high growth rate in children is a possible risk factor, indicating that a healthy lifestyle preventing over-eating and sedentarism is recommended.



Type 2 diabetes

Healthy diet and a physically active lifestyle are the most important preventive factors for people at risk of type 2 diabetes. Clinical trials conducted over the past two decades clearly show that the prevention or delay of type 2 diabetes is possible through lifestyle modifications or administration of some pharmacological agents.



Diabetes in pregnancy

Hyperglycaemia in pregnancy (HIP) can be classified as either gestational diabetes mellitus (GDM) or diabetes in pregnancy (DIP). Both can lead to increased risk of subsequent diabetes in the mother and pre-disposition during the life of the unborn child. Frequent check-ups are recommended for mothers-to-be as part of regular antenatal appointments.



Impaired glucose tolerance and impaired fasting glucose

Impaired glucose tolerance (IGT) and impaired fasting glucose (IFG) are conditions where blood glucose levels are above the normal range and below the recommended diabetes diagnostic threshold. The terms 'prediabetes', 'non-diabetic hyperglycaemia', 'intermediate hyperglycaemia' are also used as alternatives.

Read more in *IDF Diabetes Atlas Chapter 3*

www.diabetesatlas.org/atlas/en07



Patricia Gómez Medel (Mexico).
Diabetes educator and carer to
daughter with type 1 diabetes

Universal health coverage

Universal health coverage (UHC), as proposed by the World Health Organization (WHO), aims to ensure that all people obtain the essential health services they need without suffering financial hardship when paying for them. The shared global commitment, as per the SDGs and the 2019 *UN Political Declaration on UHC*, is to achieve UHC by 2030.

Health systems must ensure that diabetes is included in the services provided as part of the UHC package of essential services, and each country needs to align these services with its technical and financial resources.

The entry point for diabetes care should be at the primary healthcare level, which provides both preventive and curative services within communities and close to individuals throughout their lifespan, ensuring effective health monitoring, diagnosis and care. This also ensures that all aspects of the individuals receive care, and not just their diabetes.

Diabetes care is multi-dimensional, as a result of the complex interactions between environmental, lifestyle, clinical and genetic factors. **Each person has a unique profile of risk factors and complications**, and access to continuing care, education and medication strongly influence the clinical course. An integrated partnership between health professionals and people living with diabetes should safeguard the health and well-being of all patients and their families.

Primary healthcare staff should be trained to recognize the symptoms of diabetes, perform and interpret diagnostic tests and provide quality treatment and care. With regard to the issue of access to medicines, **the WHO Model Essential Medicines Lists prioritize metformin, gliclazide and human insulin over newer and more expensive treatments**. IDF also considers glucometers, needles and test strips as essential supplies for people with diabetes.

Read more in *IDF Diabetes Atlas Chapter 6*

www.diabetesatlas.org/atlas/en08

National policies and strategies

Diabetes is one of the four main NCDs highlighted in SDG 3 and is reflected in the targets of the WHO *Global Monitoring Framework* and the *Global Action Plan for the Prevention and Control of NCDs 2013–2020*. These frameworks establish targets and recommended strategies, and are useful in guiding governments' responses to NCDs. **There are some promising NCDs 'best buys' recommended by WHO and backed by robust evidence**. One of these is the imposition of taxes on sugar-sweetened beverages, which can lower the consumption and help prevent obesity and new type 2 diabetes cases. Further evidence for the efficacy of this intervention is needed, but many countries around the world are adopting such taxes.

This is often combined with other public health measures, such as placing detailed labelling on food packaging. Another 'best buy' recommended by WHO is the development and implementation of education and awareness campaigns (including on media) to foster physical activity in the community. Such campaigns have proved to be cost-effective in the fight against sedentary lifestyles.

The solutions that work in one place may not be as effective in another, so policies and prevention programmes must be tailored for each country and coordinated across all sectors involved.



Pei Yan Heng (Singapore). Volunteer at children's diabetes camps living with type 2 diabetes



Advocacy tips: Setting objectives that 'join the dots'

Once you have gathered evidence, established partnerships, identified priorities and assessed your country's progress against international commitments, it is time to **set your advocacy goal and objectives**.

Your overall long-term advocacy goal should aim high, be ambitious and aspirational, and seek to create realistic, lasting change (for example, "improve the health outcomes of people living with diabetes in my community"). Your goal should rely on the achievement of several **shorter-term objectives that must be 'SMART'**: specific, measurable, achievable, realistic and time-bound (as in "secure funding for the development of an education campaign on healthy eating and physical activity by World Diabetes Day next year.")

As you design your advocacy objectives, look out for the needs and opportunities that are most likely to lead to impactful results in the short-term. Effective advocacy is incremental and **achieving small, visible advocacy victories is a sure way to motivate you and your partners to be more ambitious and driven in the future.**

When advocating for improved approaches to diabetes in your country, city or community, you must consider the **interconnectedness** of what happens at the level of the individual, within the health system and within society. Ideally, your **objectives should be achievable through the implementation of effective and proven actions**, such as the ones described in this section. For more information about recommended interventions to prevent and control diabetes, check the latest *IDF Diabetes Atlas* and the 'best buys' proposed by WHO.

Engage with existing plans and priorities

One of the easiest ways to become an advocate is by supporting an objective already set by a diabetes association.

Look out for opportunities to influence and participate in official processes that may be relevant for achieving your objective. For example, if your government is working in the development of a national diabetes plan, investigate how you can engage in the process and do not hesitate in offering your expertise.

Section 5:

IDF call for a multisectoral response to diabetes

The mission of the International Diabetes Federation (IDF) is to promote diabetes care, prevention and a cure worldwide. IDF is committed to tackle diabetes at all levels – from programmes at community level to worldwide awareness and advocacy initiatives.

The 9th edition of the *IDF Diabetes Atlas* has provided background for the following IDF recommendations:

1 Prioritise diabetes care and control

National governments, civil society organisations, the private sector and other members of the global diabetes community should play their part in developing **multi-sectoral initiatives for the early detection of all types of diabetes and its complications**. These initiatives should include measures to increase awareness of the symptoms of diabetes and its complications among the health workforce and the general population.

Governments should dedicate **sufficient funds** to guarantee appropriate care for all, notably to train an adequate number of health workers and ensure the availability and affordability of essential diabetes medication, with insulin as a priority. Increased resources must be mobilised to tackle the psychosocial impact of diabetes in individuals and families, and to mitigate the economic impact of diabetes at all levels.

Governments and industry must implement further concrete and sustainable responses to address differential pricing and other barriers to universal access to insulin.

2 Develop and implement national plans and strategies to reduce the impact of diabetes

National Diabetes Programmes are a tried and tested strategy for **an effective and coherent approach to diabetes prevention and management**. A multi-sectoral approach is key to improve health services devoted to diabetes care and to reduce the barriers to accessing diabetes medicines and technologies, such as equipment and supplies. These are a crucial investment in the long-term health and well-being of populations.





Erum Ghafoor (Pakistan).
Consultant diabetes educator
living with type 2 diabetes

3 Extend health promotion programmes to reduce the impact of diabetes and its complications

Governments and all actors in the global diabetes community should collaborate in the development of **multi-sectoral and locally-tailored education and lifestyle programmes** to promote healthy dietary choices and increased physical activity. Programmes should use a community-wide approach to raise awareness of modifiable risk factors of diabetes and its complications, which will have benefits above and beyond diabetes – for example, on cardiovascular diseases, obesity, some cancers, mental health and a number of other aspects of human health and well-being.



4 Promote high-quality research on diabetes

A significant number of countries do not have high quality data on diabetes prevalence, related complications and mortality. Governments and research funding agencies should make funds available to promote high-quality research on the occurrence and the impact of diabetes, to **improve our understanding of the measures required** to address the global rise in the prevalence of both type 1 and type 2 diabetes.

An increased number of high-quality studies will improve the coverage and accuracy of estimates and predictions in future *IDF Diabetes Atlas* editions and other compendia of this kind, which are essential for a comprehensive global diabetes monitoring. Additional national and regional databases of diabetes occurrence and care should also be developed and properly maintained to ensure their quality and the utility of the data they contain.

Read more in *IDF Diabetes Atlas* Chapter 6

www.diabetesatlas.org/atlas/en09



Advocacy tips: Identifying and reaching out to your target audience



Primary decision-makers Bodies, organisations and individuals with the authority to generate change. This includes ministries (especially ministries of health), parliamentarians, funding agencies, non-governmental organisations that implement/support diabetes programmes, and business communities and leaders.



Influencers Second-level audience that advises and influences the primary decision-makers. This includes opinion leaders (press, technical specialists, authors, religious leaders), well-known celebrities and public figures, prominent doctors or health and scientific commentators, and civil society (including diabetes organisations, support groups and peer-to-peer patient networks).

Primary decision-makers are typically hard to reach, but you can often access and influence them through secondary audiences.

Reach out to both groups, cultivate ongoing relationships and keep them informed about your priorities, progress and future plans, to ensure the success of your advocacy work.

Once you have defined your key audiences, you will be fully prepared to **deliver your evidence-based recommendations**, such as the ones outlined in this section. Depending on your target audience, you may need to tailor your messages and the evidence used.

World Diabetes Day (WDD) offers an excellent advocacy opportunity to reach out to decision-makers and influencers. Celebrated every year on November 14, WDD is the leading global diabetes awareness and advocacy campaign, officially recognised by the UN and led by IDF. On the WDD website you can find resources to support the campaign, which you can translate as needed and use in your outreach to key audiences.

The biggest factor influencing the effectiveness of your advocacy will be to dedicate **sufficient time and attention to appropriately mapping your target audiences**. The most robust and evidence-based messaging about diabetes will have little impact unless it is actively directed towards the right stakeholders. Your main target audiences as a diabetes advocate typically fall into two main categories:

When mapping your target audiences, think if you or any of your partners has a high-level contact you could use to reach primary decision-makers. Also, do some research to find out if any opinion leader or public figure in your community/country is personally affected by diabetes, and invite them to join your advocacy efforts or act as spokesperson.

Your recommendations should always be as concise as possible and clearly state what you expect your audience to do. Whenever possible, you should **draw on real-life stories** and experiences of people living with diabetes – including your own, if you are living with diabetes.

The recommendations will need to be delivered in a credible manner, through different channels, and often repeatedly. Depending on your target audiences you might initially choose direct communication approaches such as emails or social media campaigns. **Consider the following advocacy entry points →**




Primary decision-makers Ultimately, your aim should be to establish face-to-face meetings with relevant local, regional and national policy-makers, to discuss the current diabetes policies and your recommendations for improvement. When meeting a decision-maker in person, bring with you accessible printed materials with your evidence-based recommendations. If face-to-face meetings are not possible, contact policy-makers via letter or email. On the IDF Advocacy webpage you can find several templates of letters to policy-makers, that you can tailor and translate into your national language



Influencers

Share with them the latest *IDF Diabetes Atlas*, and your national estimates and projections, to convince them about the necessity for change. If you are contacting press, reach out to the main health-focused news outlets in your country and to the journalists writing about health-related topics in general media.

 idf.org/images/HLM_letter_to_policymakers.docx

 worlddiabetesday.org

 twitter.com/wdd



**International
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