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WHAT IS KEY TO CONTROLLING DIABETES? AWARENESS OR WEALTH?

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Data from the National Family Health Survey-5 (NFHS-5) indicate that more than the wealth of a person, awareness levels play a relatively superior role in diabetes incidence. But do ground realities support this conclusion drawn using data? **Sonikka Loganathan** speaks to K. Srinath Reddy and Emilija Zabiliute about the wealth-awareness-diabetes link. Edited excerpts:

Q / The NFHS-5 data indicate that 10.6% of women in the poorest 20% households were either on medication to control diabetes or have a random blood glucose level higher than 140 mg/dL (milligrams per decilitre). The corresponding figure for the richest 20% of households is 17%. With such a marginal difference, is it correct to call diabetes a rich man's disease?

A / **Emilija Zabiliute**: You're right. I think there are a lot of preconceptions, and diabetes is usually associated with surplus food. However, it doesn't really reflect the ground realities. Data show that not only the incidence of diabetes, but also the scale of suffering from chronic illnesses and, especially when it comes to complications, the impact are severe among people with low income levels too. So, in terms of both disease incidence and how people experience the disease, it's not just a rich people's disease, as our popular imagination suggests very often.

A / **K. Srinath Reddy**: Indeed, neither is it a man's disease, nor is it a rich person's disease. If you look at the global distribution of diabetes, both men and women are affected by it. And we know from global experience that, in general, diabetes, cardiovascular diseases and some other chronic diseases start first in the higher socioeconomic group, and then progressively reverse. In fact, the poorer sections become the more dominant victims over a period of time when the epidemics mature into an advanced stage.

A / **EZ**: Of course, there are a lot of changes in urban diets, but also among poorer folks. We may assume that persons who do physically intensive work will eat traditional diets, but their diets have been changing as well. Not just in India, but across the world, unhealthy food is cheaper. But there are a variety of reasons, and there is no one explanation.

Q / What are some of the factors behind diabetes among the poor beyond what we know, which is diet and exercise? And what kinds of challenges are they facing?

A / **KSR**: Diet, physical activity, also the kinds of stress levels, sleep levels, all these are

important contributors to body inflammation, which is the underlying basis of both diabetes and cardiovascular disease. The poor now consume far less fruit and vegetables. And they also have polished grain, therefore they don't get much fibre. They consume unhealthy edible oils, which stoke inflammation. Also, if we take body mass index for defining overweight and obesity, the problem is more with the total body fat, or adiposity. If it is distributed much more around the abdominal organs, it is called visceral adiposity, which is much more associated with inflammation and insulin resistance and diabetes. Unfortunately, the kind of unhealthy foods that the poor are forced to eat can lead to a fair amount of visceral adiposity. Routine health services do not really reach the poor in adequate numbers for timely diagnosis. Therefore, diabetes doesn't get detected, or is detected very late, when it has already reached the stage of complications. And even when they do access health services, they're not often treated with the same level of consideration as some of the richer and affluent sections are.

A / **EZ**: It is crucial to understand that lifestyle is not something people directly choose; this really depends on structural conditions and social processes. Food choices are not necessarily just about a person's individual choices or wishes, they depend on their economic position and social environment.

Q / How would diabetes play out differently between a lower-income person and a higher-income person, once diagnosed?

A / **EZ**: I worked with people in Delhi who had lower income levels. They could not afford medicines, so they looked for free government medication and insulin doses. But to access that, you have to make a lengthy journey. For working class people to even allocate a day to travel and spend in a hospital is tough. Women, for instance, have child care responsibilities, and it is almost impossible to go to hospital.

Q / When we look at NFHS data, we see that 17.4% of women who had completed zero years of schooling were either on medication to control diabetes or had a random blood glucose level higher than 140 mg/dL. The corresponding figure for women who completed 11 years of schooling was much lower, 8.4%. Can education be used as a proxy for awareness about the disease?

A / **KSR**: Education matters a lot. If you had asked this question about 50 years ago, or 100 years ago, in India, we would have said that the richer and more educated sections would have more diabetes. But over the last 20-25 years, it's become clear that there has been a reversal of the social gradient. When it comes to diabetes, and cardiovascular disease, education trumps even income. You may have a high income level, but if you're not well-educated, you're more likely to get diseases. If you do not have a high income level, and you're not well-educated, then you're suffering in both ways.

A / **EZ**: Knowledge is very important. However, during my research, I've never met people who didn't know what diabetes is. Even those persons who had very low literacy levels, very low formal education levels knew what diabetes was. And they actually also had a lot of knowledge on how to control it. They really creatively navigate those care ecologies that are available for them with a lot of effort and manage somehow to assemble care that is needed for them. So, very often people know about the disease, however, it's the everyday constraints and social constraints that prevent them from caring for themselves.

Q / How is diabetes manifesting among rural populations?

A / **KSR**: Let me first take you to the U.S. Rural America that has more obesity, or diabetes, or hypertension or cardiovascular disease. That was not true about 70 years ago. Health transition

takes place over time, along with developmental transition and urbanisation. Now the same phenomenon is happening in India. The rates are increasing fairly rapidly in rural India. The kind of food they're eating is ultra-processed. With labour-saving transport devices becoming available in rural parts, the physical activity levels are also getting lower.

Q / How does diabetes affect women differently?

A / **EZ**: India is so diverse that to make generalisations is quite difficult. However, there are communities where mostly women are responsible for cooking, and there is a quiet division of labour. There are also certain familial and gendered hierarchies around food-sharing and food-making. I did some research and found that it's difficult for a woman in India, especially among low-income groups, to cook food for herself separately from the family if she has diabetes, because there's a lack of resources. And that it wouldn't be socially acceptable to put so much effort on your own meals.

Q / Is this really a question of access to information about invisible diseases, rather than of wealth?

A / **KSR**: We are seeing a huge rise in diabetes in India. So, it's absolutely important for us to make people much more aware of the risk factors, to enable them to have healthier diets which are affordable, to promote greater levels of physical activity, and to educate them about what diabetes is in terms of symptoms, and complications, and motivate them to seek early self-referral.

A / **EZ**: If you are thinking about medical knowledge, I'm sure that among persons with a high degree of formal education it would be higher. But, is it knowledge about diabetes or is it about diabetes care? Also, does that knowledge actually translate into better care for these persons even if they understand what diabetes is in biological and medical terms? Among poor populations, it really would be mostly the structural issues that wouldn't allow persons to do what the doctors advise.

K. Srinath Reddy is a physician and an Honorary Distinguished Professor at the Public Health Foundation of India

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