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Diabetes care from a gender Perspective

CARE: A HUMAN LEGACY

Since prehistoric times, caregiving has been essential for the survival of our species—not merely a daily activity but an evolutionary strategy that enabled community life, protection of the vulnerable, and sustenance of life itself. Historically, however, this role has been shaped by a strong gender division, positioning women as the primary caregivers.

From an anthropological perspective, this context invites reflection on the role of care and self-care in chronic diseases such as diabetes, while also highlighting the gender inequalities embedded in these practices. Understanding this reali- »

» ty is necessary in order to propose alternatives that foster equity.

THE BURDEN OF CARE IN DIABETES

Type 1 Diabetes: Care in Childhood and Adolescence

Because T1DM is often diagnosed in childhood or adolescence, families must immediately **reorganize** routines. Disease management requires constant attention: blood glucose monitoring day and night, insulin administration, meal planning, medical follow-up, and emotional support.

In heterosexual two-parent households, the daily responsibility for care most often falls on **mothers**, who assume the primary role in managing their child's disease (1). This not only transforms family dynamics but also affects women's professional lives. Many request reduced work hours, leaves of absence, or workplace accommodations to meet the medical and emotional needs of their children. In Spain, 85% of work-hour reductions and 92% of family-care leaves are requested by women.2 This burden, often invisible, profoundly impacts women's mental health, professional development, and overall well-being. Gender inequality extends to **employment**: while women with children younger than 12 years have significantly lower employment rates than those without, men's employment rates increase after having children (2).

During adolescence, gender differences become more pronounced. Adolescent girls with T1DM report higher levels of anxiety, depression, and eating disorders, which may hinder self-care and metabolic control (3). These differences are not only biological but also the result of social and cultural pressures that affect girls and boys differently. Thus, incorporating a gender perspective into emotional and educational support for adolescents with T1DM is fundamental.

Type 2 Diabetes: The Invisible Care

Type 2 diabetes (T2DM), more prevalent in adulthood, also displays a clear gender dimension in caregiving. Caregivers are most often women—daughters, wives, or daughters-in-law—who frequently provide unpaid care for many hours each day. **Nearly** half report high caregiving burden (4).

According to the Platform of Patient Organizations (5), 35% of women caregivers report very high daily burden, 62% report stress, 45% loss of control over life, and 40% feelings of guilt. Women dedicate an average of 7 hours per day to caregiving, compared with 3 hours among men. Sixty percent of this time involves personal care; the remaining 40% includes household and general support tasks. As a result, 31% of women caregivers rate their health as "poor" or "very poor," compared with 20% of non-caregivers and 17% of men.

DIABETES CARE IN THE FIRST PERSON

Self-management of diabetes involves complex, ongoing tasks: glucose monitoring, nutrition control, insulin or oral therapy, physical activity, symptom monitoring, health care visits, and decision-making. These responsibilities are deeply influenced by social, cultural, and family contexts, where gender roles play a decisive role.

Research shows that gender not only determines who provides care but also how individuals care for themselves (6). Social expectations and cultural mandates affect men and women differently, shaping attitudes toward health and creating structural barriers.

Women are socialized to prioritize care for others, which hinders asking for help, setting boundaries, or sharing responsibilities—even during illness. Women also more often attribute disease to emotional or stress-related causes, which affects their engagement with treatment and follow-up (7).

Men, conversely, tend to delegate more and assume less direct responsibility for their health. This does not mean they neglect diabetes care, but they often maintain greater emotional and practical distance from daily management compared with women, who are more heavily involved and less able to separate self-care from other responsibilities.

Women Caregivers: Self-Care in the Background

For adult women with diabetes (type 1, type 2, or gestational), self-care is often relegated to the background behind family, work, or social demands. Qualitative studies across Europe, the Middle East, and North America highlight recurring patterns: »

IT IS ESSENTIAL THAT HEALTH SERVICES INCORPORATE A GENDER PERSPECTIVE INTO THE EMOTIONAL AND EDUCATIONAL SUPPORT OF ADOLESCENTS WITH TYPE 1 DIABETES (T1DMM)

RECOGNIZING THE GENDER DIMENSION IN DIABETES CARE IS NOT ONLY A MATTER OF SOCIAL JUSTICE BUT ALSO OF HEALTH SYSTEM EFFECTIVENESS

- **Prioritizing others' needs:** Many women feel guilty dedicating time to their own care if they have dependent children, family members, or work demands. This may result in postponing medical visits, reducing physical activity, neglecting nutrition, or sacrificing rest.

- **Lack of time and mental energy:** The double burden of household and caregiving responsibilities leaves many women exhausted at day's end, with little energy for treatment decisions or healthy meal planning, negatively affecting health (6, 7).

- **Normalization of self-neglect:** Some women internalize that their role is to care for others, perceiving lack of self-care as "normal." This reinforces a cycle in which self-care is seen as a luxury or selfish act. A recent study found women with T2DM—particularly mothers or caregivers—often reported frustration, exhaustion, and inadequacy when unable to meet recommended self-care levels (7).

Differences in Perceived Support by Gender

In addition to the direct consequences on self-care, qualitative studies have also shown differences in the social support received by caregivers, depending on gender

- Men with diabetes in heterosexual couples often receive direct disease management support from female partners, including supervision of diet, lifestyle habits, and medical follow-up. Though sometimes perceived as intrusive, this improves adherence.

- Women with diabetes tend to receive emotional support but less direct involvement in treatment. Male partners rarely assume practical caregiving tasks.

As a result, women often manage diabetes largely alone, while men benefit from more active support networks (8).

PROPOSALS FOR MORE EQUITABLE CARE

Recognizing the gender dimension in diabetes care is not only a matter of social justice but also of health effectiveness. To build a fairer model of care, **specific measures** are needed:

In the case of T1DM care during childhood and adolescence, it is essential to provide greater institutional support to families, particularly mothers, who usually assume most of the caregiving burden. Although specific **labor policies** such as CUME (leave for the care of minors with serious illness) exist, at present they may only be requested by one parent. Policy changes are needed to allow both parents to share this leave, distributing work-hour reductions equitably (eg, 50/50), thereby encouraging joint involvement in care. In terms of education, it is crucial that all individuals responsible for caring for minors participate actively in diabetes education processes.

From the clinical setting, **both parents should** be encouraged to participate in order to prevent caregiving responsibilities from falling disproportionately on women. This requires providing resources, training, and support that promote genuine and coordinated co-responsibility. In addition, it is urgent to develop **mental health programs** for adolescents with T1DM, using a gender-based approach that considers the different social and emotional pressures affecting girls and boys.

For T2DM, it is a priority to recognize the role of caregivers within health plans, making their work visible and **providing emotional, educational, and financial support**. The creation of gender-specific support groups may help address the unique barriers faced by women and men in both self-care and caregiving. **Awareness campaigns** are also needed to foster co-responsibility within families, promoting a more equitable distribution of caregiving tasks. Finally, **labor measures** must be strengthened to facilitate work–life balance without penalizing women, such as shared leave, incentives for companies that promote equity, and publicly funded caregiving services. D

CONCLUSIONS

A gender-based analysis of diabetes care shows that women—whether as mothers, partners, or daughters—assume most of the caregiving burden in both T1DM and T2DM. Women with diabetes themselves also face a "double burden," prioritizing care for others over self-care, which significantly undermines their health.

Making this reality visible is the first step toward change. Incorporating a gender perspective into diabetes care will improve quality of life for caregivers and patients alike, and advance a more equitable, human, and sustainable health system.

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