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Why Are Women Waiting Longer for a Diagnosis?

Advancing Early Detection and Access
to Care for Women Living with
Noncommunicable Diseases



PARTNERSHIP FOR
WOMEN'S WELLNESS



Introduction

On September 22, 2026, global health stakeholders, including clinicians and patient advocates, convened in New York City on the sidelines of the 81st session of the UN General Assembly for a roundtable focused on gendered gaps in the diagnosis and treatment of noncommunicable diseases, or NCDs. The discussion was hosted by the Partnership for Women's Wellness (PWW) and Siemens Healthineers.

Moderated by Luyanda Majija, director of PWW, the session examined where women are missed from screening to diagnosis and treatment across disease states, including breast and cervical cancer, cardiovascular disease and cardio-kidney-metabolic conditions. Participants also explored the financing, policy and innovation needed to close that gap. A central message that emerged was that women's health must move beyond its long-standing equation with reproductive health to encompass the full range of conditions that affect women throughout their lives.

Tisha Boatman, executive vice president of global external affairs and health care access at Siemens Healthineers, framed the discussion with her experience facing hurdles getting a timely diagnosis. After she found a lump in her breast with no known risk factors, it was Boatman's self-advocacy and expertise in cancer diagnostics that secured the help she needed, an outcome that many women don't get. She noted that health systems generally cover treatment for interventions, but often fail to fund screening and early diagnosis, despite clear evidence that early detection saves lives and money.

Where Women Are Missed

Speakers described how both biology and system design delay diagnosis in women. Dr. Marcello Tonelli, president of the International Society of Nephrology, explained that standard blood tests for kidney disease are often based on muscle mass, which can obscure results in women. Women diagnosed with kidney disease are also less likely to be referred for interventions that prevent loss of kidney function and complications. Tonelli stressed that these gaps are largely related to system-level and social barriers, and are therefore within the health community's power to fix.

Dr. Jessica Peña, a cardiologist and executive committee member of the International Atherosclerosis Society, described cardiovascular disease as a “pediatric disease that manifests in adulthood,” meaning the risk factors and signals show up early, but can be easily missed, making the life-course approach a critical need. She pointed to new sex-specific thresholds for diagnosing myocardial infarction and urged clinicians to use information they already have, including reproductive risk factors and opportunistic findings from mammograms and other imaging.

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Dr. Mychelle Farmer, chief medical officer of Advancing Synergy, underscored structural barriers that women face. Primary care, which should be the starting point for screening and diagnosis, is often siloed and underfunded. Farmer expressed her concerns about the persistent closure of community health centers in the U.S., leaving people in need of care destitute. She also noted that women have long been excluded from clinical research, and that young women, particularly in low- and middle-income settings, face discrimination and other steep barriers to care.

Available Does Not Always Mean Accessible



Participants emphasized that services existing on paper did not necessarily mean women could reach them. Dr. Uche Ralph-Opara, chief health officer at Project HOPE, pointed to travel time, caregiver responsibilities and lost income as costs women consider before seeking care. She urged health systems to ask women what they need, noting that women want care that is affordable, convenient and accessible.

Dr. Githinji Gitahi, group chief executive officer of Amref Health Africa, added that clinic hours often conflict with women's working hours, and that a heavy reliance on out-of-pocket spending leaves many women unable to afford care.

Several speakers called for moving beyond the long-standing equation of women's health with reproductive health. Dr. Kimberly Green, global program director for primary health care at PATH, also identified menopause as an often unnamed accelerant of risks as women age. Stigma, she said, limits both discussion of menopause and basic access to hormone replacement therapy.

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Building on What Already Works

Speakers agreed that many of the platforms and tools needed to close the gender gap already exist. Dr. Robert Newman, executive director of AMP Health, argued that HIV programs already deliver chronic care and could be expanded to manage conditions like diabetes and hypertension. He offered that for the approach to be effective, health systems needed to redefine them as chronic diseases and do away with vertical health financing models. Gitahi concurred, describing how community health workers conducting door-to-door infectious disease outreach could also screen for common risk factors like hypertension and refer women to care.

Digital and AI-enabled tools are also showing promise. Debbie Rogers, CEO of Reach Digital Health, shared how South Africa's MomConnect program messages mothers from pregnancy until their child turns two. After a survey found many mothers had not been screened for hypertension during antenatal visits, the program began telling women which screenings to request. The program reported a 140% increase in women seeking care.

Elise King, managing director of the Go Red for Women Venture Fund at American Heart Association Ventures, highlighted investments in an FDA-cleared AI tool that detects heart conditions that disproportionately affect women.

Joe Exner, CEO and chairman of the board of the Steele Foundation for Hope, described an AI-driven cervical cancer diagnostic that runs on a standard Android device and delivers results in minutes.

Financing and Measuring Progress

A critical theme that emerged was that sustainable investment. Gitahi urged governments to expand social health insurance to all populations, including women, and to use public funds for health care payments. Responding to Gitahi's remarks on the role of health financing, Vinna of the Global Fund noted that less than 4% of funds are allocated to diabetes and cancer. That share is far smaller than the toll taken by these diseases, which leaves early diagnosis for women severely underfunded.

Dr. Jeremy Veillard, manager of health policy and regulation at the World Bank Group, noted that health inequities are reinforced by socioeconomic inequalities. He outlined the bank's strategy to reach 1.5 billion beneficiaries by 2030, many of them women and people living with chronic diseases. Green pointed to Indonesia's shift toward life-course primary care at scale and called for pooling donor resources around priorities like women's health.

Measurement emerged as a prerequisite for advocacy. Christina Schrade, founder and managing director of SEEK Development, noted that no aggregated data on NCD spending for early diagnosis in women exists. This lack of data makes funding gaps difficult to demonstrate. Dr. Nigina Muntean, chief of staff at the United Nations Population Fund, underscored the scale of underdevelopment in women's health research and called for a holistic approach that treats women as whole patients. King added that the business case is strong, especially given that women make most health care decisions for their families.





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Moving the Needle on Women's Health

Progress depends on treating screening and early diagnosis as core components of health coverage. Several priorities emerged to advance early diagnosis in women's health. Recalibrating diagnostic tools and thresholds to reflect sex-specific differences can help clinicians catch disease in women sooner. Strengthening primary care as the entry point for screening, referral and coordinated care can support women across their life course. Expanding existing platforms, including HIV programs and community health worker networks, can extend NCD screening to women in low-resource settings without building new systems from scratch. Designing services around real constraints women face, such as cost, distance, work and caregiving, can turn available care into accessible care.

Participants also emphasized the value of investing in data systems that track spending and outcomes to strengthen advocacy and accountability, and scaling proven digital tools to help women know what care to request. Underpinning each priority was a shared commitment to bringing women to the table to design the services meant to serve them.

Conclusions

The roundtable reaffirmed that the delays women face in diagnosis are not inevitable.

There is an urgent need to collaborate and consolidate resources for women's care. Exner captured this spirit when he asked those in the room to help guide his foundation's planned investment in cervical cancer diagnostics: "We have capital, we need your expertise." Investing in women's health benefits governments, health systems and economies as well as patients. Closing the gender health gap, participants concluded, is a prerequisite for global health equity.

The Partnership for Women's Wellness will carry these priorities forward in its future advocacy work.



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The Partnership for Women's Wellness extends its appreciation to Siemens Healthineers, roundtable speakers and attendees for their contributions to the discussion.