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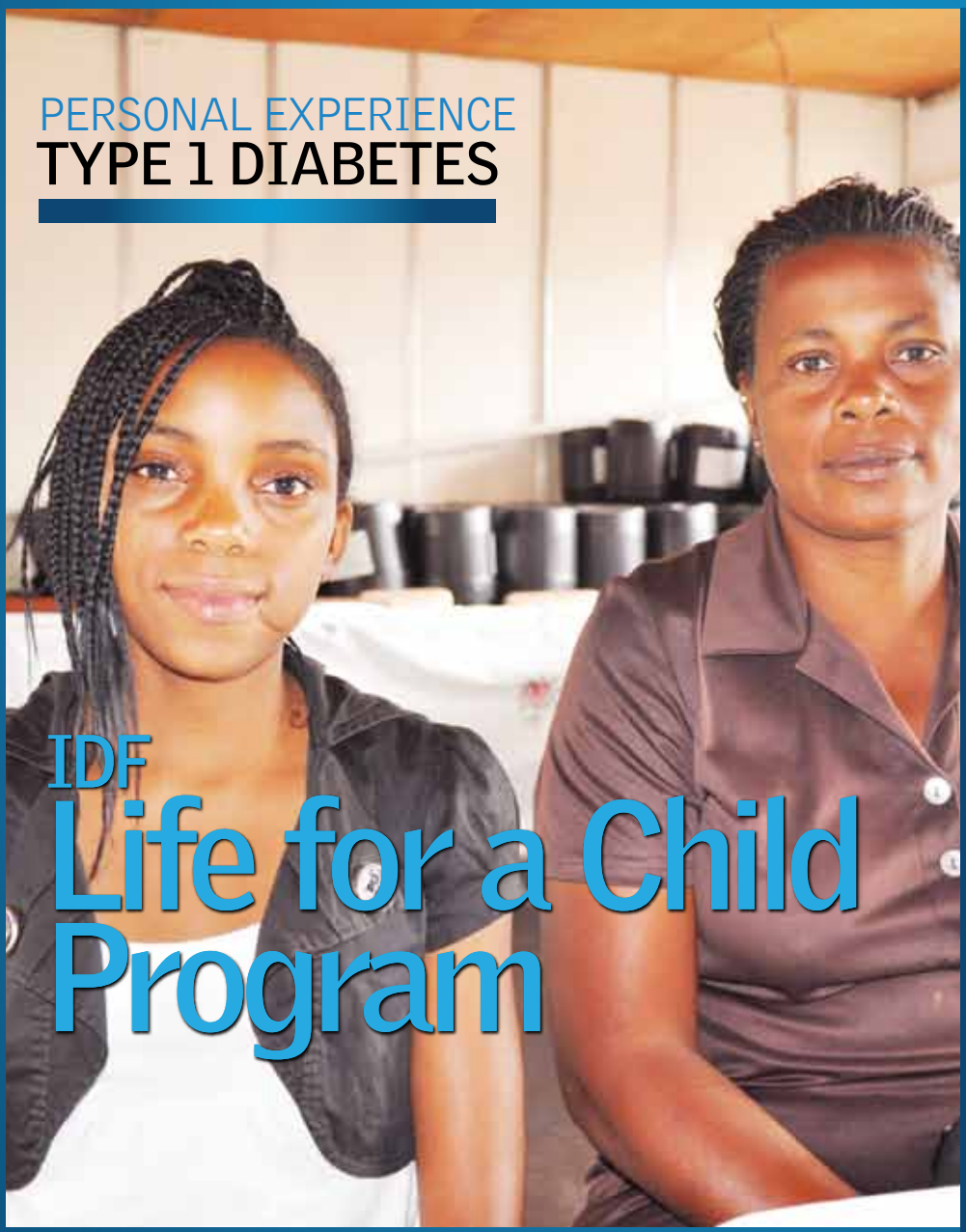
SPECIAL CONGRESS EDITION

IDF Africa newsletter

International Diabetes Federation



PERSONAL EXPERIENCE
TYPE 1 DIABETES

IDF Life for a Child Program

unite for diabetes

Dear Colleagues,

I Welcome you all to the Second Issue of the IDF Africa Region (IAR) Newsletter, July 2012. This comes at the moment when IDF Africa Region is gathering momentum to showcase the activities that have been taking place in the region during the triennium 2010 – 2012, at the Inaugural African Diabetes Congress, with its exciting satellite events. During this triennium, we have been focused on the theme Diabetes in Africa: Facing the Future with Hope for all Ages. Indeed, standing in 2010, and looking through 2012, I see a bright future, full of hope, for people with diabetes in Africa. This has been a deliberate act of management, and has required the efforts of all the stakeholders in Diabetes in Africa. We are in the process of frog-leaping into the better future tomorrow, and it cannot be changed.

But IDF Africa Region is in the real world; it still has a difficult terrain, and needs our generation to change the mindset of all the actors; if we are going to sustain the momentum. This has been echoed in all our Regional Meetings; at the African Leadership Forum, East African Diabetes Summit and at the Sommet African Francphone due Diabete, underscoring its importance in the development of the Africa Region.

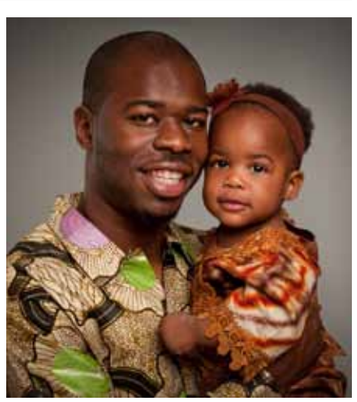
The Africa Diabetes Care Initiative has proudly delivered and the African Children with diabetes gathering at Ngurdoto Mountain Lodge, with their counterparts from Europe will be telling the world that the wind of change has come and no one can stop it: Diabetes in Africa must have both Quality and Quantity; no More no Less. The Expert Diabetes Educators trained in Conversation Maps, I am sure will take up this challenge as they will be gathered in Arusha as well.

The African Foot Care Project aiming at the prevention of lower limb amputation will be launched at the African Diabetes Congress in Arusha. It is a paradigm shift in the approach to foot care in Africa, combining both technology and the art of African culture of collectivity to prevent lower limb amputation in persons affected by diabetes.

I wish you an enjoyable reading, and a fruitful Congress.

Dr. Silver K Bahendeka | Consultant Physician, Diabetes and Endocrinology
Chair, IDF Africa Region

The IDF Diabetes Atlas 2011 estimates that there are 36,100 children < 15 years with type 1 diabetes in the IDF African region (essentially sub-Saharan Africa). One would expect a slightly higher number for youth 15-25 years.



IDF LIFE FOR A CHILD PROGRAM

Dr Graham Ogle, FRACP, General Manager – IDF Life for a Child Program, Director, Health and Social Services, HOPE worldwide (Australia)
Ms Robyn N Short, BAT, BHealth, Program Manager - IDF Life for a Child Program

CHILDREN & YOUTH IN NEED

In developing countries, children and youth with diabetes have an uncertain future. Some are unable to access or afford insulin and other critical components of care, and so die quickly from ketoacidosis or hypoglycaemia. Others develop serious and debilitating complications in young adulthood, crippling their chances of further education, employment and relationships.

Misdiagnosis is an unfortunate reality, as the presenting symptoms and clinical findings may be diagnosed as a more common illness such as pneumonia, gastroenteritis, malaria or typhoid, with death ensuing from ketoacidotic coma.

Aside from insulin, experienced medical care and thorough ongoing diabetes education are critical, along with monitoring of blood glucose. These aspects of care are unavailable for many children and youth with diabetes in Africa, particularly in regional areas.

The IDF Diabetes Atlas 2011 estimates that there are 36,100 children < 15 years with type 1 diabetes in the IDF African region (essentially sub-Saharan Africa). One would expect a slightly higher number for youth 15-25 years. However this data is based on limited studies, some of which are not recent. We suspect the numbers are smaller, but increasing.

The challenge for the African – and the global – diabetes community is to assist these children and youth now, whilst working towards comprehensive and sustainable solutions for each country.

IDF LIFE FOR A CHILD PROGRAM

Now in its eleventh year, the International Diabetes Federation Life for a Child Program (LFAC) supports over 9,000 children and youth with diabetes in 39 developing countries, and is run in partnership with Australian Diabetes Council and HOPE worldwide (Australia).

The Program operates by identifying and strengthening existing diabetes services so that they can provide the best possible health care, given local circumstances, for children and youth with diabetes. Depending on local needs, and resources available to LFAC, support includes insulin, syringes, meters and strips, HbA1c testing, education materials, health professional training, capacity building and vocational training.

US$1.6 million in donated supplies was distributed last financial year, along with US$499,750 of precisely targeted cash support.

LFAC IN AFRICA

LFAC began work in Africa in 2004, with Dr Marguerite de Clerck at Clinique Pour Jeunes Diabetiques in Kinshasa. Organisations in a further twelve sub-Saharan countries, as well as Sudan and Morocco, have since signed Memorandums of Understanding (MOU), and over 5,000 children and youth <26 years now receive assistance. LFAC works closely with African experts such as Prof. Jean-Claude Mbanya and Drs. Kaushik Ramaiya, Silver Bahendeka and Alieu Gaye. A brief summary:

Democratic Republic of the Congo
Partners: Catholic Health Services and Association Vaincre le Diabète au Congo. Insulin, syringes, and other supplies have been provided for children and youth in Kinshasa and regional areas. Dedicated funds support clinic renovations, and safe deliveries for young pregnant mothers. Recently, support has been extended to Association of Diabetics of Congo in Goma.

Eritrea
Partner: Eritrean National Diabetic Association. LFAC has sent in insulin, syringes, blood glucose test strips and educational materials for the 500+ children and youth with diabetes in the country.

Ethiopia
Partner: Ethiopian Diabetes Association. LFAC is assisting with insulin, syringes and test strips, particularly for adolescents, and care is spreading to various regional centres through the efforts of the EDA and Government Health Services.

Ghana
Partner: Komfo Anokye Teaching Hospital. An MOU has been signed, educational resources sent in, and other supplies will soon be sent to support the establishment of a paediatric diabetes clinic.

Kenya
Partners: Kenyatta National Hospital and Diabetes Kenya. LFAC commenced support in 2011; this will be expanded in 2012-3.

Liberia
Partners: Ganta United Memorial Hospital and IRC, Liberia. Ganta approached LFAC for support in late 2010, and insulin, meters and strips have all been provided. An MOU has been signed with IRC to extend support to new children's diabetes clinics in two main hospitals in the capital Monrovia.

Mali
Partners: Santé Diabète, Association Malienne de Lutte contre le Diab te. Children and youth are now able to access care in most parts of the country.

Nigeria
Partners: Lagos University Teaching Hospital, Obafemi Awolowo University/Teaching Hospital Complex and others. LFAC's support in Nigeria is steadily expanding and assisting with much-needed development of children's diabetes services throughout the country.

Rwanda
Partner: Association Rwandaise des Diabetiques. ARD joined the Program in 2004 with 25 children; now there are over 600, receiving care nationwide with cooperation from the Rwandan Ministry of Health. ARD receives additional guidance from the University of Pittsburgh (USA), Dr. Deborah Edidin, and the cycling Team Type 1.

Tanzania
Partner: Tanzania Diabetes Association. TDA has coordinated LFAC care since 2005 and, in association with the Department of Health, nine adolescent clinics were established in 2010 providing access to care and supplies for youth in urban and regional areas.

Togo
Partners: Association Togolaise du Diabete (ATD) and Togoverein. Insulin, meters, strips and syringes for 50 children/youth.

Uganda
Partners: Uganda Diabetes Association and Ugandan Government. LFAC support is being provided to assist care in three provincial hospitals.

Zimbabwe
Partner: Zimbabwe Diabetes Association.
In tandem with Government health services, ZDA distributes insulin and syringes to children and adolescents with diabetes in nearly all provinces of Zimbabwe.
Since starting in 2007 the number of youth receiving support has grown from 33 to 400. and in Northern Africa

Sudan
Partners: University of Gezira, and Sudanese Childhood Diabetes Association (Khartoum). Support of meters, test strips, syringes, and educational materials for children cared for at Gezira, and insulin for Khartoum and other regions.

Morocco
Partner: Association Badil.
LFAC supports 35 children/ youth cared for at Hôpital d'enfant Rabat, providing funds for meters and strips.

FURTHER INITIATIVES
These include:
- Website with diverse education resources in major world languages (www.idf.org/lifeforachild/diabetes-education-resources)
- Translation, production and printing of new education materials
- Custom-built web-based clinical database
- Production and distribution of diabetes symptoms posters
- Support of registers to determine incidence and prevalence
- Establishment of mentoring relationships with developed country centres
- Epidemiological research

DO YOU NEED HELP?

LFAC welcomes requests for support from centres/ Associations in new countries or countries where the Program is already assisting. Please contact lifeforachild@idf.org

INNOVATIVE PRODUCTS, AFFORDABLE FOR THE GENERAL PUBLIC

The ABEM is a youth organization of medical students.
In partnership with Handicap International and the Ministry of Health and Figtht against HIV/AIDS, our association is conducting diabetes awareness sessions targeting the youths both in schools and universities since 4 years.
Our association is domiciled in the University Hospital of Kamenge. Our aim is to establish a framework in Burundi awareness and study for health promotion.
The diabetes is the third cause of hospitalization in Burundi particularly in the Hospital University in which we practice.
It is in this context, our medical association made a partnership with the Handicap international.
We work on two original activities in November 2011:
- Budding Geniuses is an innovative game developed by ABEM that aims at assessing the knowledge of students on diabetes after awareness sessions have been conducted in the respective school
ABEM managed to bring together several schools in Bujumbura city and engaged them in a contest. During the budding geniuses' game, schools are grouped into pools A, B, C...
and taken through a series of Question and answer sessions on various topics on diabetes.
The first school to press the button is given the opportunity to answer the questions.
Plays off games are done until we emerge with the best club (school) which is awarded prizes.
This has greatly increased the students' participation and enhanced learning.

- In partnership with Handicap International and with support of the Ministry of Health and fight against HIV/ AIDS, we organized a campaign to detect risk factors for diabetes on a large public square in Bujumbura (Palace of Arts and Culture).
This campaign to detect risk factors Diabetes allowed any resident to see if risk of developing type 2 diabetes and begin to adopt a healthier lifestyle.
The first day was not quite satisfactory as where people were not sufficiently informed in advance on activity.
Mobilization strategy was to invite media so they can inform people on this campaign to detect risk factors Diabetes in news editions. The third day we have seen the number of participants increase; we expected to get 400 people a day but the expected number was doubled, about 1000 people per day.
We use simple ways like questions on family history , a blood pressure measuring the voltage pressure, a scale measuring weight, a meter ribbon around taking size or circumference Abdominal, 3000 people have been sensitized on the risk of becoming diabetic
They have been classified according to their risk factors on diabetes.
This activity was a success because we believe that we make a positive impact not only on the lives of people with diabetes, but also on people at risk of developing the disease.
Balance, blood pressure are accessible; not expensive and thus the detection of risk factors of diabetes is simple.

Pasteur MBERIMBERE
Member of ABEM,
an association of University Medical Students in Bujumbura, Burundi

DIABETE DE LA FEMME ET DE L'ENFANT EN COTE D'IVOIRE ET LES DEFIS DE ASFED (Association pour la Sante de la Femme et de l'Enfant Diabétiques)

ASFED (Association pour la santé de la Femme et de l'Enfant Diabétiques) créée en 2011 et basée en Côte D'Ivoire.
Je m'appelle Toure SALIMATA connu sous le pseudonyme de MASSAL , je suis styliste modéliste (désigner) connue du monde de la mode en Côte D'Ivoire et diabétique depuis 2007.
C'est lorsque j'étais enceinte de mon premier fils en septembre 2010 qu'il m'est venu l'idée de créer une association qui prendra en compte les populations vulnérables telles les enfants et les femmes diabétiques car le suivie de la grossesse chez la femme enceinte représentait un énorme cout et elle ne bénéficiait pas de prise en charge aussi je constatait que lors des consultations, certaines patientes n'étaient pas au rendez vous pour cause elles n'arrivaient pas à faire face au coût énorme des soins et ceci leur portait préjudice elle et le bébé.
Face à cela, j'ai fais comprendre aux femmes qu'il serait judicieux de ce constituer en association car aucune autre association n'avait pris la défense des femmes et enfants diabétiques auparavant et ensemble on pouvait faire changer les choses aussi attirer l'attention des politiques sur notre sort.
Par la suite mon pays a traversé une crise poste électoral qui l'a mis dans un chao pendant 4 mois et moi j'ai perdu mon bébé mort-né à la naissance précisément le 11 Avril 2011 et c'est là que j'ai véritablement réalisé qu'il fallait des actions et surtout de la part des diabétiques eux même.
Mon Association s'occupe du bien-être socio médical de la femme enceinte diabétique et également de l'enfant diabétique car l'enfant diabétique tout comme la femme enceinte diabétique sont tous deux insulinodépendant. Ici en Cote D'Ivoire ni l'enfant, ni la femme enceinte ne bénéficient de prise en charge et les soins coûtent encore chers.
L'Association ne bénéficie pas de subvention de l'Etat ni d'aide extérieur cependant depuis la création, en Juin 2011, en moins d'un an nous avons réussi à mener une série d'action qui sont entre autre :
Le 25 Aout 2011 nous avons fait une conférence de presse sur le Sommet de l'ONU sur les Maladies Non Transmissibles et notre espoir de voir nos dirigeants s'engager davantage dans la lutte contre le diabète
Ensuite, nous avons pris une part active dans la célébration de la journée Mondiale du diabète le 14 Novembre dernier
Après la journée Mondiale je me suis rendu à Dubai aux Amirates Arabes Unis pour le compte de l'Association dans le cadre du Congrès International de Diabète sans le soutien de l'Etat ni de la Fédération Internationale
Par la suite, nous avons monté le projet de LA JOURNEE DE L'ENFANT DIABETIQUE le premier en Côte D'Ivoire probablement en Afrique et dans le monde et la cérémonie a eu lieu le 05 MAI 2012 et comme doléances à l'endroit de nos autorités, nous avons souhaité :
- Un centre de soins intensifs pour les enfants diabétiques
- Une prise en charge des femmes enceintes et enfants diabétiques
- Aide aux parents des enfants diabétiques dans la prise en charge de la scolarité des enfants diabétiques car beaucoup d'enfants ne fréquentent plus l'école car la famille est appauvrie par la maladie de leur enfant
- Aide à la production de spots de sensibilisation

Suite à cela, le gouvernement a réagit en promettant la création très prochaine d'un centre pour enfants diabétiques.
Et j'avoue que cela a été une belle expérience que nous voulions renouveler chaque année à la même période car des gens en Côte D'Ivoire étaient étonnés de savoir qu'il y a des enfants qui souffrent de diabétique et que la maladie gagnait du terrain de plus à cette occasion, l'association a fait des Dons de lecteurs de glycémies aux enfants malades, l'association a

offert également des lecteurs à un centre de soin d'un quartier très défavorisé, elle a apporté un soutient financier à un jeune diabétique dans la réalisation de son microprojet et les enfants ont fait des témoignages écrits ou ils décrivent au quotidien leur maladie. Ces actions ont été possibles grâce à General Médical et Dianox des représentants de laboratoire.

Il ya un manque de communication sur le diabète chez nous, la priorité du ministère de la santé est la lutte contre le sida mais les choses vont changer car notre association a en vue d'autres actions qu'elle veut mener et étant donner que je suis créatrice de mode, de par mon image je suis en train de mobiliser quelques acteurs de la culture.

Déjà j'ai rallié à notre cause une association de cinéastes Ivoirien dénommée Ivoire filme et communication, avec eux nous avons réalisé un documentaire sur une femme diabétique qui a donné naissance à des jumelles prématurées, témoignage diffusé le jour de la cérémonie de la JOURNEE DE L'ENFANT DIABETIQUE.

-Pour nos prochaines actions, nous envisageons avec le père d'une petite diabétique de 5ans artiste chanteur rappeur, mobiliser un collectif de rappeur, composer une chanson de sensibilisation

-Aussi élaborer des spots de sensibilisations et d'éducations

Nous avons réalisé une enquête sur le coût du suivie de la femme enceinte diabétique qui s'élève à environ 14450 ET 24450 FCFA /MOIS rien que le traitement du diabète et cela à fait également réagit le gouvernement et on espère que les mesures vont suivre rapidement.

Aussi pour la prochaine Journée Mondiale du Diabète, nous envisageons une vaste campagne de sensibilisation et de dépistage dénommée « Quinzaine de Prévention » ciblé dans une région de la Côte D'Ivoire touché par la crise, pour l'instant, nous ne disposons Pas de moyens financiers.

Aussi nous avons besoin d'aide pour finir les travaux d'un centre de santé qui pourra disposer d'un centre d'écoute pour les diabétiques.

Dans nos actions, la personnalité politique qui nous soutien est la Présidente de la Commission Nationale des Droits de l'Homme elle a été la marraine des enfants pour cette première édition de la Journée de L'Enfant Diabétique et n'ayant pas pu être présente ce jour là, elle envisage nous recevoir très bientôt.

Nous aurions souhaité être à Arusha pour pouvoir partager toutes cette expérience mais l'association ne dispose pas de suffisamment de moyens pour effectuer le voyage.

Nous adressons nos sincères remerciements au Programme National de Lutte contre les Maladies Non Transmissibles, tous nos bénévoles.

En Afrique il nous faut un ambassadeur quelqu'un qui par ses actions porte très haut le combat contre le diabète

Nous espérions que vous auriez bonne réception de notre journal et que le sommet va dégager de bonne perspective pour la lutte contre le diabète

TOUS UNIS CONTRE LE DIABETE DE LA MERE ET DE L'ENFANT

Pour l'association, la Présidente
Mlle TOURE Salimata
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When people hear the word "diabetes", they first think of a painful Death. When I hear the word "diabetes" what I think of is water. Why? Because I suffered from a rare condition call a frightening, weak, helpless, delirious and confused experience. I believe I started experiencing early symptoms of Diabetes in 2007. At that time, I was full of life and never experienced all these many diabetics' symptoms such as migraine headaches, vomiting, lack of energy, weight loss, overheating, and male sexual problems;

I became so slim that family and friends started avoiding me, thinking I had AIDS. I was subjected to a laughing stock, I became so frustrated that I stay indoors and most people that called me on phone will advise me to patiently wait for death. It was so humiliating, frustrating and added much pains to my then existing pains. All these and more were because of lack of awareness and health enhancement. People should be educated about diabetics especially in our localities.

In most African villages, many local health care centers do not have access to insulin, it is sad to say that. It took many years to dictate what was wrong with me. Africa is a place where diagnosis machines lie; Results were coming in different forms including malaria and hepatitis. Diabetes is a chronic condition and diabetics have to inject themselves with insulin daily for the rest of their lives as their bodies are unable to produce enough hormones which means that insulin is as important as life
One symptom I experienced on a daily basis for approximately two years (before my diagnosis) was extreme thirst unlike any thirst I had ever experienced before! I felt as if I could go into a panic state if I did not get something to drink quickly, as I would become light-headed and felt dizzy. I could not go fifteen minutes without drinking some type of liquid. As a result of all of the liquid I was consuming, I was constantly urinating.

The rate of which young diabetics are increasing is alarming. The majority of the poor patients cannot afford this. "Even in relatively sophisticated cities, the number of diabetes sufferers with amputated feet due to late diagnosis and poor treatment is distressing high. This epidemic is responsible for so much suffering and loss of life, yet so little is being done to tackle it. Doing nothing in the face of the epidemic will place significant stress on the economic development of many countries and jeopardize the Millennium Development Goals.

In Nigeria, pharmacies and all major hospitals, at times go without essential diabetic medicines and these has kept many Nigerian diabetics battling to raise money to buy essential drugs as well as buying nutritious food which is also very expensive. The high cost of medicines means that the majorities of the poor often go untreated or have no regular treatment.

Insulin chews about 20 percent of monthly household income in Nigeria, a monthly minimum treatment for diabetics costs between US$130-150 excluding examinations and follow-up health care. A diabetic patient in Nigeria now needs more than $165 for needles and insulin a month. The majority of the poor patients cannot afford this.

BIOGRAPHY

Prince Ikenna Anthony Nwaturuocha is the fifth Child of Six Children from the Ancient Royal Dynasty of His Royal Majesty King Nwaturuocha from Nguru Mbaise Imo State of Nigeria. As a Diabetic patient /Advocate and philanthropist. Prince Nwaturuocha is the President / Founder of Greenleaf Diabetics Patients Foundation, an Organization committed to supporting patients and providing opportunities for them to get best available Education, Care/drugs and treatment in Nigeria. Prince is a Graduate of Federal University of Technology Owerri Imo State and a Graduate of Center for African Family Studies (CAFES) Nairobi Kenya. He has Diploma in Science Laboratory Technology with specialty on comprehensive monitoring and evaluation, presently a student of Amaigbo School of public Health. He is the Nigerian Youth Representative at the International Diabetes Federation, Former Speaker African Youths Parliaments, Member Young Diabetes online Forum, Member International Students Conference Committee on None Governmental Organizations & United Nations Millennium Development Goals, ISCA , Member Youth Sub Committee of the 14th International Conference on STDs in Africa, ICASA . Speaker at the Global Consultation on SRH needs & Rights of Young People in Addis's Abba Ethiopia. An International Youth Foundation, IYF Award Winner 2005, Youth Action Network Ambassador 2006, Staying Alive Foundation Award Winner 2009.Past President United African Youths, Former Vice President African Youths for Peace, Member National Youth Network on Health , Member Youth at the World Bank; Member United Nations Council of Youths affiliated to the UN Non Governmental Liaison Services UNGLS ,Member African Civil Society Coalition, Task force member of Global Youth Coalition on Health GYCH, National Secretary Mbaise Youths Assembly ,Nigerian National coordinator Cytometry for Life. Co-Founder Juvenile Diabetes Rehabilitation Center.

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CDiC Project:

Kenya Diabetes Management and Information (DMI) Centre's Experience

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DMI works in partnership with the ministries of health and other stakeholders to fulfil its mission of developing, documenting and delivering comprehensive programmes for creating public awareness in, and for prevention, diagnosis and management of diabetes in Kenya.

Diabetes in children is often diagnosed late and the quality of life and chances of living a full life to adulthood is compromised by poor management. Inadequate information on diabetes and an inconsistent supply of insulin, among other factors, contribute to poor management. In response to the challenges faced by children with Type 1 diabetes in Kenya, DMI initiated a five-year World Diabetes Foundation-funded project in 2008. The project was aimed at improving the management of diabetes and quality of life of children with Type 1 diabetes. This project was incorporated into the CDiC Project in 2011. Children from disadvantaged backgrounds with poorly controlled Type 1 diabetes, aged 18 years and below, registered and attending a health facility, identified from selected centres countrywide are enrolled on the project. Each child receives a glucometer, diary, improvised insulin storage container and monthly supplies of insulin, glucometer strips, lancets, syringes and needles at no cost. Parents and children are re-educated on diabetes management and counselled on living with diabetes either during monthly review sessions at DMI; home visits; parent's forums at DMI or three-day residential diabetes youth camps. Demographic data, random blood sugar and HbA1c are recorded at time of enrolment. Families record daily blood sugars while measurements of HbA1c, heights and weights are repeated at six-monthly intervals at DMI. By May 2012, 214 children were enrolled on the Project.

A constant supply of insulin improved the management of Type 1 diabetes: reduction in HbA1c and hospital admissions; and improved growth parameters1.

Youth camp participants demonstrated increased knowledge on diabetes self-management and a willingness to live positively with diabetes2. Some feedback from April 2012 camp participants:

"I have learned that I should not pity myself but live a normal life and also I should be responsible and control my life. Therefore I intend to live like any other child, be responsible of myself and control my life"

"The most important thing I have learned is how to accept that I am diabetic. I want to change my life and start managing my sugar levels and diet"

"I have learned how to store my insulin and where to inject. I intend to be keeping my insulin in the right place and also be injecting my insulin in the stomach without supervision. I have decided to take control and take the right amount of food and what is good for my health"

Despite these benefits, inadequate follow up of children due to poor linkage and communication with clinicians at base clinics presents a challenge to making long-lasting changes to management of diabetes in these children.

Parent's forums for counselling and education of parents and guardians on diabetes and its management provide an opportunity to obtain feedback on parent's experiences and the challenges of bringing up a child with Type 1 diabetes. These forums enable parents share experiences and learn from each other. Some learning points identified by parents attending forums in 2012:

"We are not alone in this condition. I have to encourage my child that it is not the end of life and loneliness but life is full of endurance and courage. To face the future with confidence"

"Setting my son free. Discussing his condition together and not treating him special"

"That I am not alone. I should face the challenges with a lot of courage and determination. I will make sure wherever I go in gatherings, I have shared my experience with diabetes, especially in children, and how to cope with the condition... creating awareness"

Parents identified challenges of adolescence; transition from parent to self-care, dealing with emotions; lack of information and diabetes management skills; stigmatization and lack of diabetes awareness especially in rural areas and schools among their areas of concern. Parents suggested age-appropriate or stage of diabetes acceptance-appropriate discussion groups; and decentralisation of the forums to local centres as modifications to make the forums more beneficial to them. It is anticipated that some of these concerns will be addressed once the Project is rolled out to other centres in Kenya.

Acknowledgements
Project supported by Novo Nordisk and World Diabetes Foundation. Youth camps sponsorship by Safaricom Foundation and Johnson and Johnsons.

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The First African Diabetes Congress

The First African Diabetes Congress is organized by the International Diabetes Federation (IDF) Africa Region, with anticipated participation by members of the Pan-African Diabetes Study Group (PADSG), Pan-African Diabetes Educators Group (PADEG), Pan-African Association for Foot Care (PAAFC) and all those working in the area of diabetes and other non-communicable diseases (NCDs).

The First African Diabetes Congress is a comprehensive, multidisciplinary forum with a stellar faculty of leaders in diabetes and other Non-Communicable Diseases (NCDs). The Congress will bring together more than 500 key stakeholders and leaders to discuss ambitions, priorities and actions for change in diabetes and NCDs within the Africa Region. The First African Diabetes Congress is regarded as a highly influential event that will raise attention to the health care delivery in diabetes and other NCDs in the Africa Region. The main focus will be on the prevention of complications and improved quality of life of people living with diabetes and other non-communicable diseases. This is an area of important research priority and fostered debate especially on the long-term implications for diabetes care and health policies. The signature design of this congress includes state-of-the art review lectures and symposia by leading world experts followed by debates aimed to solving controversies and generating consensus. There will be up to 25 hours of continuing medical education with presentations from leading diabetes experts on cutting-edge clinical research in diabetes treatment and management. The sessions will include the latest information on the management of diabetes and its complications, practical tips and proven strategies for improving patient care, and translation of the latest diabetes research into clinical practice.

Specific themes of the First African Diabetes Congress include:

Diabetes foot care, eye complications, gestational diabetes, diabetes and co-morbidities (TB, HIV/AIDS, Depression), role of intrauterine growth in the development of diabetes and other NCDs

Quality of care and access to essential medicines

Strengthening health systems to cope with both acute and chronic diseases in poor resource settings

Current approaches to diabetes research, education and management

Latest research findings on interventional therapies for type 2 diabetes and their relevance to the diabetes epidemic in the Africa Region

Impact of interventional therapies on cardiovascular risk in diabetic patients

Public engagement activities to increase knowledge, create awareness and community action for diabetes

Conventional paradigms versus novel ideas on the aetiology of diabetes and obesity: a forum for debate leading scientists in the field of diabetes

Oral and poster presentations

International Diabetes Federation
unite for diabetes

CHANGING DIABETES IN CHILDREN, CHANGING LIVES, CHANGING DESTINY

Jean Claude N. KATTE (MD)
Regional Hospital Bafoussam,
Changing Diabetes in Children, Cameroon.

The changing diabetes in children program in Cameroon started in mid-year 2010 in the centre region with the creation of the first clinic in Yaounde. The CDiC clinic at the Regional Hospital Bafoussam in the West region was then created 8 months later. Prior to the creation of the diabetes clinic, the management of children with type 1 diabetes was anarchic and poorly understood and conducted in small and underserved hospitals and private clinics around the region. Treatment was expensive and only wealthy families could afford.

The creation of the clinic on the 14th April, 2011 marked the dawn of a new era of hope in the lives of both children and parents of children with type 1 diabetes in the West region. Till date, 27 children regularly receive education and treatment at the diabetes clinic in the Regional Hospital in Bafoussam.

The impact of the CDiC clinic can be observed in multiple areas running through the training of health professionals, vast educational campaigns, and holiday camps for children with diabetes, free treatment and much more.

The CDiC program has brought a wide spread knowledge about diabetes and especially about diabetes in children which was not known to exist amongst the native population. Many vast campaigns have been carried out using the television, radio and written press to educate the population on the existence of diabetes in children and that this disease can be controlled. At the clinic, we have seen a considerable number of children coming for screening for diabetes meaning awareness on the existence of childhood diabetes have increased. So far, one diabetes awareness camp has been organized for the children in the region were the children were thoroughly educated on insulin treatment and how to use their glucose meters. This was proven to be very fruitful.

CDiC program has trained several Medical Officers in the district hospitals in the region to identify children with diabetes, administer an initial treatment in the case of an emergency, and thereafter refer to the diabetes clinic.

The impact of the program has also been seen in the financial burden of the disease in the different households. Insulin is expensive in our setting and when parents were asked if the free insulin received at the clinic helped households financially at the end of the month, the answer was a satisfactory yes. The money saved at the end of the month could help these parents to better provide for feeding, treat effectively any concurrent infection and thereby improving the quality of life.

Finally, the CDiC program has generally improved the follow-up and the overall glucose blood control of the children currently registered at the clinic. The importance and impact of this program cannot be over-emphasized. I wish to end with a word of Thanks to all the actors and sponsors of this program for changing diabetes in the children of the west region in Cameroon, changing their lives and giving them hope and destiny.

Children with diabetes in Ghana.

Type 1 diabetes is one of the most frequent chronic diseases in children and in Africa it represents a major challenge in terms of diagnosis and treatment. Type 1 Diabetes Mellitus (T1DM) is a growing concern worldwide but in Ghana this is not the trend. It is believed in Ghana that diabetes among children is rare. Type 1 diabetes is still not seen in the hospitals and clinics in Ghana. So it is still thought of as a rare disease even among doctors and other health care workers. The true burden of diabetes in Ghana is not known. Some paucity of work has been done mainly in Type 2 diabetes, there are still no data in Ghana reflecting the national scale. This is the case in many parts of Africa. Moreover, much of the available data is not population-based and is of limited value for making generalizations about diabetes in children in Africa.

Pediatric Diabetes Clinic in Ghana.

Following my training from PETCA, Nairobi, Kenya we have established Pediatric Diabetes and Endocrine Clinic at Komfo Anokye Teaching Hospital (KATH), Kumasi, the first of its kind in Ghana. The clinic has ten active children with diabetes. Children with diabetes and other endocrine diseases now have supervised care. The children with diabetes in Ghana are not being diagnosed in hospitals and health facilities. They are, more likely, being seen and treated as infectious diseases. KATH has an adult Diabetes Clinic which was established in 1992. The clinic has since recorded a total of 15,326 patients with diabetes. For this period only eighty children have been registered and we do not have up to twenty children actively attending the diabetes clinic. So the question is where are the children with diabetes in Ghana?

If children with type 1 diabetes are not diagnosed and properly managed they eventually develop diabetes ketoacidosis (DKA). In Ghana DKA can easily be misdiagnosed and mistreated as cerebral malaria or meningitis. If this happens, mortality is almost 100% and unfortunately, such mortality will still be registered as due to cerebral malaria or meningitis and not diabetes. Many of the hospitals and clinics, especially at the district levels, do not check blood glucose of severely ill children and so missing those who have diabetes.

Most of the children with type 1 diabetes in Ghana are from poor socioeconomic background. The families are not able to buy glucose meters and strips for home monitoring of blood glucose. So far it is only one family, out of ten, that has been able to buy glucose meter and glucose strips. They are also not able to afford the cost of HbA1C and other laboratory investigations. So glycemic control in these children is difficult. What I do is that for those who stay in towns and villages where there are hospitals and clinics that have laboratories that test blood glucose, I give them letters in a pleading tone so that the laboratory technicians will test their blood in the mornings and evenings. This trend is not effective as some of them live far away from the hospitals. Even those who are able to follow, it is erratic because they have to go and check in the morning between 6am and 7am and in the evening 6pm and 7pm. This periods are outside the normal working hours and the technicians are not usually available to do their blood glucose for them. Work starts at 8 am and children are supposed to be at school by 8 am

Ghana has health insurance system (NHIS). Under this system a patient pays a premium which is renewable every year. A patient has to register to benefit from the NHIS. Under the NHIS the fixed dose insulin is free and that is what we use for all our pediatric patients. Unfortunately, most of the investigations that children with diabetes have to do are not covered by the health insurance. Many of the pediatric patients are not able to do them.

The aims of the Clinic

Service Provision: Our major aim is to provide supervised care to children with diabetes and other endocrine diseases. We aim to create a clinic of excellence services.

Follow up of Patients

We aim at 100% follow up so those who fail to come for review at the appointment dates are later called on phone to come.

Education: is part of our activities in the hospital. Currently, I take the medical students on lectures in pediatric endocrinology and diabetes. I take them in tutorials and on the wards.

I do periodic presentation at the department level to stimulate interest in pediatric endocrinology among doctors in the department. I intend to do cases presentations of the various conditions that we see in the clinic to the department.

Outreach programs: I am already involved in outreach work in pediatric diabetes and endocrinology. I go to a local FM station periodically to educate the general public on pediatric diabetes. I go to churches and other hospitals to educate doctors and the other health workers on how to recognize diabetes in children and to refer them to the pediatric diabetes clinic.

Setting of Satellite clinics in the Regions and Districts

We plan to set up satellite clinics in the regional and the district hospitals so that children with diabetes may not have to travel always to Kumasi. I will oversee such clinics and I will consult with the local clinicians or health workers from time to time. Such clinics will also be a concentration and referral points for children with other endocrine disease that for reasons of limited resources cannot be managed at the district hospitals.

Research: is part of the clinic. We have started creating data base. The only limiting factor is that many endocrine patients are not able to do their investigations as the hormones are not under national health insurance and the patients are not able to afford the cost.

Challenges

We have so many challenges

Human resources

We have one pediatric diabetes/ endocrine nurse. She has no formal training. She is being trained on the job but she will need formal training so that she can properly participate and organize the clinic. We need pediatric dietician, pediatric psychologist. In the meantime, we will do with the adult dietician and psychologist.

Laboratory Support from KATH is inadequate as far as the endocrine clinic is concerned. Almost all the investigations are done in private laboratories as most of them are not done in KATH laboratory.

Blood glucose monitoring at home

Many of the children with diabetes are not able to do home monitoring of blood glucose at home because they can not afford the cost of glucose strips and meters

NHIS: All the hormonal investigations are not covered by the NHIS and they are expensive considering the income levels of the parents of the patients. Almost all the patients are not able to do their investigations. Many of them do not return because of the cost of laboratory investigations. We need investigation to confirm diagnosis and also to follow treatment response.

A 11 year old boy, David, with diabetes. He weighed 15kg < 3rd percentile , height = 144< 3rd percentile cm. Was seen in September, 2011 with random blood glucose of 37 mmol/dl. He came to hospital alone, was not accompanied by an adult. Was conscious no urine ketones. No home supervision, no monitoring of blood glucose, and had defaulted for the past 3 years.

Could not do any investigation but we stabilized his blood glucose and put him on insulin. He later on got febrile illness in November, 2011and was admitted to a district hospital where he died after some few days of admission.

International Diabetes Federation

DIABETES AND ITS COMPLICATIONS:

A PERSONAL AND CARETAKER EXPERIENCE MANAGING TYPE 1 DIABETES.

By John Petter and his mother Stellah Petter.

My name is John Petter from Tanzania, East Africa. I am 19yrs old and have lived with Type 1 diabetes for 5 yrs since being diagnosed in 2007. I have faced many challenges, and continue to do so as a diabetic patient, personally, within my family and in the wider society around me.

Let me start to talk about my personal challenges. After being diagnosed as a diabetic, my caretaker, my mother, did not have sufficient knowledge of all the aspects related to the control of my diabetes. Therefore at times I felt weak and control of my diabetes was poor. It also became evident that I needed spectacles because of my deteriorating eyesight.
My extended family found it unacceptable and not normal for a young child to develop diabetes. Whispers and gossip spread around the neighborhood that I was HIV Positive. Others cast aspersions at my mother by saying that she was sacrificing offerings (superstitions or local beliefs) in order to gain more income and profit for her business. All of which was totally untrue and brought about by lack of knowledge, awareness and understanding of Type 1 diabetes in a young person.
In the wider society many people treated me as if I was disabled because of my slender appearance. At Secondary school, studying for my le 'O' levels, some of my fellow students and friends shunned me and didn't want to be friends because they were concerned about the 'transmission' of diabetes similar to that of Tuberculosis. Once again this was caused by lack of proper education on diabetes.
Staff at the school, teachers and nurses, also had poor knowledge of my condition. When shown my medical report they felt very sad because their past experiences led them to believe that diabetics died. Before going to school I normally took my insulin but at times when I felt unwell during the day I spoke to the nurses who either gave me Panadol tablets or sent me home. The Headmistress of the school informed the staff that I was not allowed to do any physical work for fear of injury. Even during sports or games sessions I was not permitted to perform in a sports competition. As a result fellow students labeled me 'a weak boy who cannot do anything'. This experience has affected me to the point that I do not like to explain or share that I am a diabetic because I'm afraid of discrimination and humiliation.

Caretaker experience of managing Type 1 Diabetes:
My name is Stellah Petter, mother of John. After John was diagnosed with Type 1 diabetes the relatives of his father blamed me as the source of John's health problems. His father rejected him and considered John as 'worthless' in the sense that if he continued financially supporting and meeting his needs he would be throwing his money away since John's life would be short.
In 2008 I started to attend the diabetic clinic at Muhimbili National Hospital, Dar es Salaam, where under the Tanzanian Diabetic Association (TDA) we received training and education on all aspects of diabetes management such as foot care and insulin dosage. We also received a free diabetes testing machine (glucometer) May God bless them.

THE IMPROVEMENT OF DIABETES EDUCATION BY USING THE CONVERSATION MAP DURING HEALTHCARE PROFESSIONALS TRAININGS IN CONGO-BRAZZAVILLE.

AUTHORS: C. L. ELENGA-BONGO[1 2], E. BOUENIZABILA[2 3], F. MPASSI-NDOULOU[2]

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Background
Diabaction-Congo and partners ,in agreement with the government of Congo have built since 2008 a decentralized model of diabetes care, which has improved diabetes management and diagnostic . Knowing that education is proved to be the cornerstone of diabetes management and that in these trained centers different ways of diabetes education have been successfully used.
After the introduction of the Conversation Map (CM) in Africa in 2009, which aim is the improvement of diabetes education in Africa. The new challenge of Diabaction-Congo was to bring the new tools in diabetes centers, to improve and standardize diabetes education in Congo.
- Lack of specialized diabetes centers and trained healthcare professionals : one (1) Specialized Diabetology-Endocrinology service in the Teaching Hospital of Brazzaville, one (1) specialized ambulatory center in Brazzaville (Diabcare Center of Diabaction) and one (1) non-specialized Unit of Diabetology in Pointe-Noire (2nd city)

What we do : project and results
The Project conducted by Diabaction and partners exists since 2008 according to the 2006 WHO Afro diabetes strategy, consisting in the reinforcement of peripheral centers in the system of diabetes care, because of the lack of specialists.
There are three levels with different package of activities in the Congolese healthcare system: Primary (peripheral), secondary and tertiary (high level) .
Since 2008 in Congo, diabetes is included in the Minimum Package of Activities in the peripheral centers, where actually are conducted different activities leading to diagnosis, management and prevention of diabetes.

With the support of Diabaction/WDF project, in total: 2 ambulatory specialized diabetes centers (Diabcare) were created in Brazzaville and Pointe-Noire (2 more are in creation in Gamboma and Dolisie) 11 regions of Congo have been trained to management of diabetes, 350 healthcare professionals, 15 peripheral hospitals have been reinforced,150 peripheral diabetes centers "pilots" created and 25 " satellites " diabetes centers.
The peripheral centers are linked to the highest level within the framework of reference of diabetic patients. The highest level is represented by the Teaching University Hospital of Brazzaville, and also (since October 2010) the General Hospital Adolphe Sice of Pointe-Noire and Two Specialized ambulatory centers in Brazzaville and Pointe-Noire.

Introduction of the Map tools
After the first CM expert-trainers training in December 2009 (Johannesburg, South-Africa), the challenge was to bring the new tools to the trained centers for patients sessions.
The existing model of diabetes care in Congo was a favorable environment to the introduction of the Conversation Map tools to improve diabetes education. Healthcare professional trainings were conducted in two (2) steps.

Step 1: The CM training was automatically included in the diabetes management trainings in all regions.
From January 2010 to April 2010, the Map conversation trainings concerned Brazzaville: Teaching Hospital (3 nurses) Ambulatory Specialized Center of Brazzaville (1 educator) and 7 " satellite "diabetes centers .
From July 2010 to July 2010, the map tools were presented during the trainings in diabetes management in 3 regions (Cuvette-Centrale, Niari, Plateaux)
September 2010 the training of trainers was held in Pointe-Noire concerning the General Hospital Adolphe Sice (3 nurses), 3 " satellite " centers (5 healthcare professionals).
From March to June 2011, the training concerned three (3) regions (Lekoumou,Likouala and Sangha) and three (3) main centers were given the tools, both for health care providers and patients with diabetes.

Step 2: Trainings organized with the support of IDF. These trainings were organized according to the suggested budget. Two (2) trainings were organized.
- 17th September 2011 in Pointe-Noire, the training concerned ten (10) from General Hospital Adolphe SICE, 4 " satellite " diabetes centers and three (3)main private clinics.
- 21st September 2011 in Brazzaville, the training were organized for eight (8) diabetes centers

After the trainings each center received the different maps for patients sessions.
Diabetes education for patients
In these different centers the Map Conversation tools have been used from May 2010 for patients with diabetes and the global view is: the tools being very interactive are accepted by the trainers and the Patients.

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Conclusion:
The Conversation Map tools have improved education in the diabetes care in Congo by making it more interactive and standardized. The existing model of diabetes care created by Diabaction-Congo and partners in agreement with the government facilitated the introduction of the Conversation Map tools. IDF support was very important to concretize trainers trainings and to support the new vision of education in Africa.
The results of different sessions conducted for patients with diabetes in Congo let us think ,that actually the Conversation Map is the main diabetes education tool used in all centers.

THE DYNAMICS OF DIABETIC CARE IN A DEVELOPING WORLD

The role of religion in diabetic care cannot and must not be underestimated as it plays a major role in the attitude of individuals and the community to diabetic care. In view of this, community diabetology should be encouraged with individual communities coming up with programs that put into consideration religious beliefs perculiar to such community.

According to the international Diabetes Federation diabetic Atlas; Diabetes Mellitus is one of the most common non-communicable diseases (N.C.D) globally.
D.M, is the fourth leading cause of death in most high-income countries and now there is substantial evidence showing that it is epidemic in many economically developing and newly industrialized countries.

Africa, a multicultural, religious and ethnically diverse continent had traditionally been dominated by infectious diseases but with rapid urbanization, NCD's are quickly becoming a priority for health in this continent; with an estimate of about 14.7 million Adults being diabetic in 2011 and a projection of 28.0 million by year 2030.

According to I.D.F, financial estimate of Africa indicate that at least USD2.8billion was spent on health care due to diabetes alone in 2011 and this is expected to rise by 61% in 2030.
It is however imperative, based on the facts above as health care givers and stakeholders to firstly understudy Africa with its peculiarities and strategize a befitting and appropriate health care system that put into consideration and accommodates the African mindset.
This health care system must understand Afric's multicultural settings,religious inclinations and embrace its ethnic diversity.

FACTORS AFFECTING DIABETIC CARE AND POSSIBLE SOLUTIONS
Africa, a developing continent is characterized by multiple factors that has plunged the continent into an era of economic and social setbacks and this has slowed down the rate of health care delivery in the continent.
Factors influencing African health care delivery noteworthy include:

1) RELIGION

Vast majority of Africans anchor their belief to A Supreme Being who is held in the highest esteem with instructions and guidance being handed over through HIS representatives to the followers. These representatives are called clergy. African religious setting is multifaceted and has been a great influence on lifestyle and philosophy. Some believe diseases and ailments serve as a punishment for wrongdoing or an attack.

The role of religion in diabetic care cannot and must not be underestimated as it plays a major role in the attitude of individuals and the community to diabetic care. In view of this, community diabetology should be encouraged with individual communities coming up with programs that put into consideration religious beliefs perculiar to such community. Diabetic education and enlightenment should also be integrated into all religious institutions.

Community Diabetic Awareness

2) EDUCATION
According to UNESCO Africa fact sheet:
176 million Adults are unable to read to write.
47million youth (age 15-24) are illiterates.
21millions adolescents are out of school and 32 million primary aged children are not in school.

The fact above reflects a continent with poor educational foundation for both the adults and the youths (future leaders). Education is paramount to information dissemination and economic Growth
International design of diabetic care and education should be revisited with the inclusion of more flexible and grass root friendly Programs. To an average uneducated African, "the absence of disease is Health" as against the W.H.O Definition of Health and this mentality coupled with cultural and religious belief system on disease affect preventive medicine in Africa.

To a large extent, people don't tend to complain until they start noticing complications; this added to the silent nature of D.M results in the highly complicated D.M found at hospitals.

3) CULTURE

African culture is varied and diverse. With the introduction of westernization, Africa's age long culture and traditions are being substituted for western styles. This with urbanization has to a greater extent made Diabetic Care progressive in Africa i.e. through the media, internet, community research and community screening.

In light of these remarkable progress; styles, trends and culture that promotes preventive care in diabetic health care should be considered in Africa Free Community Diabetic Screening Conducted by Students Of Olabisi Onabanjo University Teaching Hospital,Sagamu,Ogun State,Nigeria

4) POVERTY

According to a UN report- Half of the population of Africa lives below a dollar a day.
32 of the world's 38 heavily indebted poor countries are in Africa (World Bank). Slums are homes to about 72% of urban citizens.
These alarming facts reflects a continent where half of its population can't boast of good feeding habits, good social status and most importantly access to quality health.
Procurement of drugs and the ability to afford healthy diets are difficult by people who live below a dollar a day.
Hence, diabetic care should involve Philanthropists, Non-Governmental organizations, Societies, Governments and pharmaceutical companies who through serious effort and commitment would empower the continent economically.

Also, I.D.F through its national bodies in Africa and affiliates should engage government into subsidizing drugs to make them affordable, available and extremely cheap such that majority of the African populace can have access to it and afford it. This will make life easier for those suffering extreme hardship in Africa.

Finally, it is imperative I point our attention to a silent but serious issue in Africa: Medical ethics and trado medical ethics.

Africa, unlike many developed continents where rules and regulations guide healthcare delivery system is faced with a challenge. The trado medicals (groups of people that use herbs in treating medical conditions) are generally not well structured and not aligned with the medical professionals. This has for a long time been a major issue of contention with people being deceived in the ability of a single drug to cure all ailments in existence. 'Gbogbonise' – A drug for all ailments as it is called, has been largely marketed and sold amongst the uneducated in the community,with even a small fragment of the educated patronising them giving false hopes of a permanent cure to D.M and this has accounted for high percentage of late presentation at the hospitals.

To forestall these activities, it is important to involve, train, and educate the tradomedicals on diabetic care and this I strongly believe, will go a long way in stopping the menace constituted by late presentations at clinics.
In addition, a structure can be put in place by the African government and leaders for the tradomedicals which will spell out the ethics of their profession and limit the unprofessionalism demonstrated in the community.

Various Tradomedical Schemes At Marketing Drugs in Nigeria

In conclusion, the peculiarity of the African continent requires calls for a more radical and strategic approach in diabetic care with health care givers, researchers, government, and NGO's understanding the challenges posed by the factors and putting these into consideration in developing a plan in diabetic health care delivery for the continent.

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unite for diabetes

THE EASD/IDF/ ADA MEETING

November is a special month for all of us working to make meaningful change in our struggle towards changing the face of diabetes. For the Ethiopian Diabetes Association November 2011 proved to be an extraordinary month. Starting from Day one of November, we had successive trainings and of course the celebration of the World Diabetes Day, November 14, the birthday of one of the greatest human beings.

We started November 1 with the opening of the 6th joint EASD/ IDF/ADA/ postgraduate course in Addis Ababa, the capital of Ethiopia.

All of us at the association worked very hard since we were given the task of the organization of this important event. At first, we thought that there will be an independent even organizer body but we were told that we had to do it. Hence, with only four office workers and three volunteers we accepted the whole responsibility. Of course, nothing would have been possible without the strong support of Dr. Ahmed Reja, the president of the association. He was counted like five people. Professor Solomon Tesfaye handled issues with the faculty and was instrumental in the organization of events with authorities.

As soon as the office received the names of delegates, we wrote letter of invitation to each one of them. All of us were busy arranging visas for those who do not have Ethiopian Embassies in their countries and when they arrived, it was us, the office that received guests. We were also responsible for preparing conference materials. Hence, we had to work until 2:00 P.M for three consecutive days.

Our hard work paid off since we were able to entertain guest from 17 African Countries and health care professionals from all regions of Ethiopia. According to our data, there were 250 delegates, 92 delegates from 17 African Countries 134 HCPs from the host country Ethiopia, and 25 Faculty members. The training was one of a kind which brought the big names of diabetes in the world with their African counterparts. It was also a podium to discuss issues in the African context with standard protocols.

The second day was so unique since we were able to hold a dinner party at the grand palace, more than 300 people attended this ceremony which was so colorful with the attendance of the Deputy Prime Minister and Minister for Foreign Affairs Mr. Hailemariam Desalegn. None of the office workers have got a chance to visit the palace before, so for many of the participants it was a once in a life time experience.

This training was very much supported by the authorities especially the Ministry of Foreign Affairs and the Main Department for Immigration and Nationality Affairs.

Dr. Ahmed Reja and Professor Solomon Tesfaye gave a press release and it was front page news on the Ethiopian Herald - the major government newspaper. The opening ceremony which was accompanied by the speech of the Deputy Prime Minister and Minister for Foreign Affairs Mr. Hailemariam Desalegn was the first news on the National TV.

This training helped to lift the profile of the association and gave us the strength to continue working hard with hopeful minds the rest of the year.

RWANDA DIABETES ASSOCIATION AND LIFE FOR A CHILD, HAND IN HAND STRIVING FOR BETTER FUTURE OF YOUTH WITH DIABETES.

Since 2003 the program of the International Diabetes Federation “Life for A Child” (LFAC) in partnership with (ARD) Rwanda Diabetes Association had provided for children and young adults up to 25 years living with diabetes mainly by supplying free Insulin, Needles, Glucose meters, Test strips, education and care .

LFAC patients and ARD educators LFAC/ARD program undertakes quarterly and annual physical examination for complications of diabetes and performs specialized laboratory tests such as HbA1c (a blood test that measures blood sugar control over a 3 month period), and Urine tests for microalbuminuria and creatinine (to detect early kidney complications). These are done on a specialized machine. These evaluations allow us to improve care and to detect early complications, Improved care can delay or prevent short- term and long-term complications as well as preventing hospitalization. Since the beginning of LFAC/ARD in Rwanda in 2003 with 3 children, the number increased to 30 in 2006, 301 in 2009, 390 in 2010. In December 2011 the number was 634 including children and young adults who died, today we count approximately 690. Considering the rising number of children registered with LFAC/ARD since Rwanda joined the program, we assume that children were dying because of lacking of follow-ups and insulin which we already known were very scarce during the time before the LFAC/ARD program in Rwanda.
582 out of the 634 currently registered children and young adults are active in the program, the remainder do not regularly show up during the visits done by ARD every 3 months; this is due to inability to afford transport or lack of information on the part of parents or patients. 38 young adults have dropped out of the program because they have passed the age limit (25 years), 16 children and young adults have died during last three years, 2 of whom died of long-term complications, 12 short- term complications like hypoglycemia and 2 because of another cause not related to diabetes. Many children in the program presented with a number of severe psychological problems as well, which remains a big challenge to be handled; for example recently a patient committed suicide.

LFAC/ARD program works with 22 hospitals in four regions of our country, we visit them every three months for testing, insulin adjustment and education in order to improve the well-being of persons with diabetes, youth especially. Approximately every month ARD sends Insulin, syringes, needles and test strips to children and young adults living with diabetes through the 22 hospitals it works with.

During the last three years the LFAC/ARD program has registered almost 50% of the whole number of children and young adults with diabetes perhaps because of the intensified communication and education through hospital visits, meeting with hospital and clinic staff and through Radio and television appearances by ARD staff.

It is unknown to date why 336 of the program’s youth with diabetes were born in the 90s, the time of the war and genocide against Tutsi in Rwanda.

The registered number in the program of youth with diabetes has doubled within one year

The number of children and youth with diabetes registered in 2011 was quite large compared to the years before which was due to an educational and counseling initiative by ARD on radio and at hospitals. Its partnership with MOH, TT1 (Team Type 1, a cycling team from the U.S.) and University of Pittsburgh played a big role in conveying the information about LFAC/ARD program so that many children came from far away to seek for help.

The number of youth with diabetes that died before we started the program is not known, but 16 children and young adults died during the last three years, a rate that has no comparison in the past, 2 deaths were due to long-term complications, 12 died due to short-term complications like hypoglycemia and 2 deaths had causes not related to diabetes.

This year, many incidents occurred during the first months of 2012. These incidents, especially hypoglycemia, led to unexpected deaths. We noticed that the parents of the children often don’t take diabetes seriously and don’t take the appropriate measures; these incidents pose a real danger for the youth in the program.

Another issue is that 38 young adults dropped out of the program by the end of 2011. Many of those children dropped out of school early because of poverty, which is often exacerbated by the cost of long term diabetes management. Another problem is the lack of knowledge on the part of primary and secondary school authorities in how to address diabetes-related problems or emergencies in schools. By setting up an education center the ARD is trying to provide these children under training in different professions. Securing their financial situation will enable them to buy their medicines after the program.

Rwanda Diabetes association and Life For A Child together with partners have taken a lot of initiatives to resolve the problems said above:

- Education

Many diabetics are in a difficult situation in Rwanda because of their own or their community’s ignorance of diabetes. This is a problem LFAC has been experiencing throughout the time it has been operating in Rwanda.
There is consequently an urgency to educate patients, their families and their communities s in order to avoid problems such as hypo and hyperglycemia.
ARD has started to educate the children’s parents but needs additional funds and support to further pursue it effectively and successfully.

- Preparing for the life after the program

As indicated above, we would have failed if the children cannot survive after the program; many youth with diabetes in Rwanda have no means to survive after they quit the program.
ARD has set up an Education center to prepare them for life after the program, 39 young diabetics have graduated so far.
LFAC/ARD youth in a class room at Mwulire diabetes Center
The results are generally positive as the children profit from the experience they gain. Even if not all of them instantly find jobs where they can apply the professional skills acquired in the center, they certainly have better knowledge and experience in diabetes care.

- Investigate missing children

Another issue raised above is the children who are missing during the quarterly visits or who don’t show up at the clinic regularly. As we are not sure whether they are deceased or face other problems, it is necessary to look for them in their home areas in order to gain information about their whereabouts. The negotiations are undergone about that with the police and the Ministry of health on a better way to make it.

- Establish Diabetes centers in the country

Our experience is that most children and youth with diabetes from Kigali have better skills in diabetes self-management compared to those living in the countryside because they have access to an ongoing education and treatment in ARD clinic. We are confident that many of the LFAC/ARD members’ lives would improve considerably if we had the means to open more centers around the country. There are two centers opened at the initiative of ARD so far, one in the East and one in the West.

Kigali main center of ARD; medical clinic, diet center and administration
The main challenges remain the means and knowledge to achieve efficiently the activities undertaken with numerous priorities that ARD has to deal with such as cover the entire area of Rwanda, train and educate.

We thank our partners who always respond to our call for help; Including IDF (through Life For A Child), Team Type 1, Pittsburgh University, The Rwandan Ministry of Health and ARD staff

By Crispin GISHOMA
ARD Cordinator

IMPLICATION DE LA JEUNESSE BURUNDAISE DANS LE MOUVEMENT DE LUTTE CONTRE LE DIABÈTE : RÔLE DE L'ASSOCIATION BURUNDAISE DES ETUDIANTS EN MÉDECINE (ABEM)

Par Adélard KAKUNZE

Au Burundi, petit pays de l'Afrique de l'Est de 8 511 618 habitants dont 45,9% de moins de 15ans, la situation du diabète tend à prendre une allure inquiétante. Bien qu'aucune étude d'envergure nationale n'ait été menée jusqu'à ce jour, le diabète est la 3ème cause d'hospitalisation dans le plus grand hôpital du pays derrière le paludisme et le VIH/Sida. Quelques études ponctuelles sur de petits échantillons montrent une prévalence du diabète comprise entre 7 et 15%, tandis qu'elle est estimée à 2,87% à Bujumbura la capitale (Source Programme national de lutte contre le diabète/Ministère de la santé et de la lutte contre le Sida). Au niveau mondial, toutes les statistiques du diabète pour les années à venir converger toutes vers une évidence : l'augmentation significative du nombre de diabétiques dans les années à venir !

Mais qui seront ces diabétiques de demain ?

Au Burundi, il y a une croyance qui veut que le diabète soit une maladie des personnes âgées et surtout aisées. Se basant sur cette croyance, les jeunes sont exclus ou s'excluent eux-mêmes des campagnes de sensibilisation sur le diabète. En 2009 ; une enquête effectuée par l'ABEM auprès de 777 élèves (entre 12 et 20ans) de 10 écoles secondaires de Bujumbura a révélé que le niveau de connaissances sur le diabète de ces jeunes était insuffisant voire nul.

L'un des principaux facteurs entraînant l'accroissement incessant de la prévalence du diabète dans le monde et au Burundi en particulier étant la méconnaissance des caractéristiques de la maladie, l'ABEM et Handicap International ont décidé d'intervenir ensemble dans le cadre du projet DEAR (Diabetes in East Africa Region) pour que la jeunesse burundaise, Burundi de demain ne soit pas la pépinière des diabétiques de demain.

C'est ainsi que le projet de sensibilisation pour la prévention et l'adoption d'un mode de vie compatible avec la lutte contre le diabète chez les jeunes scolarisés est lancée dès 2009. Ce projet visait la création et l'animation de clubs de lutte contre le diabète dans 20 écoles secondaires de 3 provinces du Burundi.

Le souci majeur de l'ABEM était dans un premier temps d'éduquer les élèves membres de ces clubs sur le diabète. C'est ainsi qu'une équipe dynamique de 45 pairs éducateurs de l'ABEM a été mise sur pied, formée sur le diabète et sur les techniques d'enseignement.

Avec l'aide des professeurs-encadreurs de ces clubs, ces pairs éducateurs ont sillonné les 20 écoles durant 4 ans pour éduquer, former et sensibiliser ces jeunes sur le diabète et surtout sur sa prévention par l'adoption d'un mode de vie sain.

Pour enseigner le diabète à un tel public de jeunes, il a fallu innover pour les inciter à se sentir concerné et impliqué dans la lutte contre le diabète.

L'une des innovations dont l'ABEM est fière est l'organisation de concours de connaissance sur le diabète, concours type génies en herbe. Ces concours génies en herbe regroupait plusieurs écoles représentés par deux élèves provenant du club de la dite école. Ce jeu Génies en Herbe (inspiré du jeu Questions pour un champion sur TV5) consistait à rassembler ces élèves et à leur poser des séries de questions sur le diabète comme par exemple « Dans cette liste qu'est-ce qui ne constitue pas un facteur de risque du diabète? 1) Tabac, 2) stress, 3) l'histoire familiale du diabète, 4) méningite ».

Le jeu étant basé sur la rapidité, la 1ère école à allumer la lampe à leur disposition, recevait le droit de répondre à la question. Si elle échouait, ce droit était accordé à une autre école. Les écoles, au départ nombreuses, s'éliminaient au fur et à mesure qu'elles marquaient des points jusqu'à ce qu'il ne reste que deux écoles qui disputaient la finale. Des prix intéressants comme un téléviseur, une chaine Hi-fi pour le club, étaient remis aux écoles championnes.

Ces jeux organisés dans les trois provinces couvertes par le projet ont permis une participation massive des jeunes des écoles concernées mais aussi des autres écoles. Cela a aussi créé une soif ardente pour ces jeunes d'acquérir des connaissances sur le diabète pour se mesurer aux autres. En marge de ces jeux, des compétitions artistiques sur la prévention du diabète étaient aussi organisées comme des poèmes, des chants, slams, sketches, dessins et les meilleures réalisations étaient primées.

L'autre innovation a été d'effectuer des séances pratiques sur les thèmes comme l'alimentation équilibrée et la pratique d'activités sportives dans la prévention du diabète. La séance sur l'alimentation équilibrée a été une occasion d'impliquer des femmes venant d'organisations communautaires féminines qui ayant reçues une formation sur le thème, se devaient d'enseigner à ces élèves comment préparer l'assiette multicolore du diabétique depuis l'achat des aliments au marché jusqu'à la cuisson.

A la fin du projet, force nous a été de constater un vrai mouvement d'aller de l'avant de ces clubs qui ont commencé à initier leur propre activités comme la sensibilisation dans d'autres écoles non concernées par notre projet ou encore l'organisation de compétitions sportives entre les différentes écoles ; suivies de séances de sensibilisation. Nous sommes fiers d'avoir initié conscientisé la jeunesse burundaise sur le diabète et d'avoir initié ce mouvement de lutte contre le diabète dans la jeunesse, mouvement qui nous l'espérons va grandir et démentir les statistiques alarmantes de la prévalence du diabète dans les années à venir.

Encadré :

L'Association Burundaise des Etudiants en Médecine a été créée en 2002 avec comme idéal de servir la société et les étudiants en médecine du Burundi en offrant à ceux-ci l'opportunité d'utiliser leurs connaissances pour aider cette société mais aussi en leur offrant un cadre d'échange professionnel tant au niveau local qu'international. Elle est depuis 2008 membre de la Fédération Internationale des Associations des Etudiants en Médecine et travaille depuis 2009 avec Handicap International sur le projet DEAR (Diabetes in East Africa Region).

International Diabetes Federation
unite for diabetes

UGANDA DIABETES ASSOCIATION

Uganda Diabetes Association was founded in 1982 and inaugurated in 1983 under chairmanship of Professor Kiryabwire (RIP). Its member came from Medical workers, Diabetes patients and civil society and the entire community and well wishers. The Association continued growing increasing in number of members. However some ups and down weakened the association and members had to re arranged themselves and organized and streamlined the whole thing and improved.

Now it has its committee members on the national Executive headed by Professor M.A. Otim and Branches also have theirs too.

VISION

To create awareness to the people of Uganda on Diabetes and to serve people with Diabetes in the most excellent way.

MISSION

To create as many centers of Health Education and treatment as possible and as near as possible to the community.

CORE VALUE

Uganda Diabetes Association respects and works within the guideline of International Diabetes Federation- the mother organization.

Aims and objectives

To create awareness on prevention, treatment and identifying Diabetes through mass Education
To treat people with Diabetes
To train Health workers on Diabetes Management.
To encourage Research in Diabetes
Association will be an advocate of Diabetes patients

ACTIVITIES OF U.D.A

1-Creating Branches throughout the country. Giving them support of materials to use, glucometers for blood monitoring and training to the Health workers of the place. They form their own Executives. This has assisted Diabetic patients in assessing care nearer to them. Avoiding long distances leading to poor adherence

2- Community out reach has been started. Village health team(VHT'S) are taught to check on the patients ,Know their needs, problems , check their sugar levels and Blood pressures and advice them accordingly. When found with big problems Health workers are contacted and advice is given accordingly

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3- Training of health workers to manage Diabetes especially in new branches that have been opened.

4- Training of VHT'S (Village Health Team) for patients support

Strengthening the Association by recruiting more people from different areas like churches, Schools and local councils through Health Education.

5- Conducting Researches on Diabetes.

6- Conducting Workshops, seminars, scientific conferences and Trainings.

7- Annual General Meeting with all branches to discuss about the association

8- We join IDF in celebrating World Diabetes Day on 14th /November every year.

9- Children's camp is celebrated every year

10-Together with Uganda Heart foundation and Uganda Cancer Society we have joint together forming Uganda Non-Communicable Disease alliance and having joint activities like community sensitization.

11- Women have formed groups and have started income generating activities like making necklaces, Floor mats, bags etc.

SOURCES OF INCOME

Membership Contributions
Ministry of Health
Pharmaceuticals
Co-operate Bodies
Well wishers

CONSTRAINTS

1-Financial constraints. Our sources of income are not reliable therefore there is not enough money for activities
2-Most members are not active
3-Association has no good income to perform some activities like proper outreaches
4- Inadequate supply of Drugs to patients who are very poor.

By

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