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 Francophone de 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 Ngurudo 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. However, this data is based on limited studies, so the numbers are smaller, but 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 26 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, educational materials, health professional training, capacity building and vocational training.

US$1.6 million in donated supplies was distributed last financial year, along with US$483,730 of precisely targeted cash support.

**LFAC in Africa**

LFAC began work in Africa in 2004, with Dr Marguerite de Clerck at Clinique Pour jeunes Diabétiques 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 12-25 years now receive assistance. LFAC works closely with African experts such as Prof Jean-Claude Mbanya and Drs. Kaushik Ramaiya, Silver Bahendeke and Alieu Gaye. A brief summary.

**Democratic Republic of the Congo**

Partners: Catholic Health Services and Association Vaincre le Diabete 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 supplies, including insulin, syringes and test strips, educational materials for the 900+ 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 2012; this will be expanded in 2013.

**Liberia**

Partners: Ganta United Memorial Hospital and IRC Liberia. Ganta approached LFAC for support in late 2010, and insulin, meters and strips were 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.

**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

**Kenya**
Partners: University of Nairobi, and Kenya Childhood Diabetes Association (Kenyatta). Support of meters, test strips, syringes, and educational materials for children cared for at Gezira, and insulin for Khatmout and other regions.

**Morocco**
Partner: Association Badil. LFAC supports 33 children/ youth who are cared for at Hospital 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/lifeforchild/diabetes-education-resources)
- Translation, production and printing of new educational 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 on topics in diabetes

Please contact lifeforchild@idf.org

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**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 Khatmout and other regions.

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**Innovative Products, Affordable for the General Public**

The 1st Educ-Aid is a youth organization of medical challenges. In partnership with Handicap International and the Ministry of Health and Fight against HIV/AIDS, our organization is conducting diabetes awareness sessions targeting the youths both in schools and in hospitals.

Our association is domiciled in the University Hospital of Khamis. Our aim is to establish a framework in Burundi awareness and study for diabetes. The diabetes is the third cause of hospitalization in Burundi, particularly in the hospital University in Bujumbura. In this context, our medical association made a partnership with Handicap International.

We work on two original activities in November 2011:
- **Budding Geniuses**: an innovative game developed by ABEM that aims at assisting the knowledge of students on diabetes after awareness sessions have been conducted in the respective schools. ABEM managed to bring together about 20 students in Bujumbura; we engaged them in a contest : sharing the budding genius's game, collecting prizes into pools, A, B, C... and taken through a series of **Question and answer sessions**

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**SDF** (Association for the sake of the Female and of the Enfant Diabétiques) is a youth organization domiciled in the University Hospital of Bujumbura.

**FURTHER INITIATIVES**
- Play-off finals are done under the supervision of a student club (which is aAWL competition.

This has greatly increased their social 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 (Place of Arts and Culture). This campaign to detect risk factors Diabetes allowed us to reach some of developing type 2 diabetes and bring it to adopt a healthier lifestyle.

The first day was only satisfactory as people were not yet sufficiently involved in advance on activity mobilization strategy to wide media so they can inform others on how to detect risk factors. Diabetes in news editions. The third day was the most successful as a large number of participants increased; we reached an average of 500 people a day but the expected number was around 1000 people per day.

We used simple ways like questions on family history, a simple test-press measuring the blood pressure, a scale measuring weight, a table ribbon around taking size or circumference Abdominal, yes people have been sensitized on the risk of insulin-dependent diabetes. 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 the people at risk of developing the disease. The blood pressure is accessible, not expensive and easy to determine. Risk factors of diabetes are simple.

Pastor AMIRIMBERE
President of ABEM, an association of university medical students in Bujumbura, Burundi.

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**Diabète de la Femme et de l’Enfant en Cote d’Ivoire et les Défis de ASFED** (Association pour la Sante de la Femme et de l’Enfant Diabetiques)

**Un centre de soins intensifs pour les enfants diabétiques**

- Une prise en charge des femmes enceintes et enfant 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 réagi 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 diabète et que la maladie gagnait du terrain plus à cette occasion, l’association a fait des Dons de lecteurs de gîmes aux enfants malades, l’association a...
un documentaire sur une actrice et réalisatrice ivoirienne dénommée "Ivoire". J'ai pu rassembler plusieurs acteurs de cinéma pour le projet. Je travaille aussi à mobiliser la population pour une meilleure prise en charge du diabète. Nous avons mis en place des campagnes de sensibilisation et de dépistage. Les actions qu'elle souhaite mener ont été possibles grâce à des subventions provenant notamment du ministère de la santé.

Je réalise des microprojets et tente de constituer une association pour soutenir les patients et leur famille. Nous avons organisé des ateliers d'éducation et des séances de consultation avec des professionnels de santé. Nous avons aussi élaboré des spots publicitaires et composé des chansons de sensibilisation.

Aussi, nous avons collaboré avec des artistes pour organiser des concerts et des spectacles pour sensibiliser la population. Nous espérons que cela booste la prise de conscience de l'importance du diabète.

Pour l'association, la participation de la femme enceinte au projet est importante. Nous avons réalisé des enquêtes sur le coût du diabète de la mère et du nourrisson. Nous avons aussi réalisé des mini-projets et offert des kits de soins aux patients. Nous espérons que cela permettra de mieux gérer les situations de crise et d'offrir une perspective pour la lutte contre le diabète.

Nous adressons nos sincères remerciements au Programme International de Lutte contre les Maladies Non Transmissibles, tous nos bénévoles. Nous espérons que vous auriez bonne réception de notre journal et que le sommet va dégager de bonnes perspectives pour l'avenir.

Pour l'association, la perspective pour la lutte contre le diabète est encourageante. Nous avons réalisé des efforts importants pour améliorer la prise en charge du diabète en Afrique. Nous espérons que la conférence au Sommet de l'IDF en 2011 aura une forte influence de bonne réception des pays africains.

Les événements que nous avons organisés ont suscité l'intérêt du public et ont permis de sensibiliser davantage sur les risques associés au diabète. Nous espérons que le sommet de l'IDF en 2011 aura une grande influence sur les pays africains dans leur prise de décision à ce sujet.

Nous espérons que les dirigeants de pays africains auront une bonne réception de notre déclaration de sommet et qu'ils prendront des mesures pour améliorer la prise en charge du diabète en Afrique. Nous espérons que le sommet de l'IDF en 2011 aura une grande influence sur les pays africains dans leur prise de décision à ce sujet.

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Nous espérons que les dirigeants de pays africains auront une bonne réception de notre déclaration de sommet et qu'ils prennent des mesures pour améliorer la prise en charge du diabète en Afrique. Nous espérons que le sommet de l'IDF en 2011 aura une grande influence sur les pays africains dans leur prise de décision à ce sujet.
Children from disadvantaged backgrounds with poorly controlled Type 1 diabetes, aged 10 years and below, registered and attending a school facility identified by a 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 2011, 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 parameters. Youth camp participants demonstrated increased knowledge on diabetes self-management and a willingness to live positively with diabetes. 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 should 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 present 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. 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.”

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“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 at solving controversies and generating consensus. There will be up to 25 hours of clinical 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 comorbidities (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 in the aetiology of diabetes and obesity: a forum for debate among leading scientists in the field of diabetes
- Oral and poster presentations
CHANGING DIABETES IN CHILDREN, CHANGING LIVES, CHANGING DESTINY

Jean Claude N. KATTE (MD)
Regional Hospital Bafoussam, 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 anachronistic 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 clinic. 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. There was a diabetes awareness camp organized for the children in the region where the children were thoroughly educated on insulin treatment and how to use their glucose meters. This was proven to be very fruitful.

The CDiC program has trained several Medical Officers in the district hospitals in the region to treat 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, they said that the household 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 improve 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.

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 has increased. So far, one diabetes awareness camp has been organized for the children in the region where the children were thoroughly educated on 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 no longer fear being diagnosed in hospitals and health facilities. They are more likely, being seen and treated for non diabetic 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 ketoacidosis (DKA). In Ghana DKA can easily be misdiagnosed and mistreated as cerebral malaria, hypoglycaemia, severe sepsis and ultimately death. In fact, this happens, mortality is almost 50% and unfortunately, such mortality will still be regarded as a neurological phenomena or meningitis and not diabetes. Many of the hospitals and clinics, especially at the district level, are not in the habit of 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 socio-economic 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 meters 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 no 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 between 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 8am.

Ghana has health insurance system (NHI). Under this system a patient pays a premium which is renewable every year. A patient has to register to benefit from the NHI. Under the NHI 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 afford these.

The aims of the Clinic

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

Follow up of Patients

We aim at follow up with 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 limited factor which 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.

We have so many challenges

Human resources

We have one pediatric diabetes/ endocrinologist and he 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.

NHI: All the hormonal investigations are not covered by the NHI 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 follow treatment response.

A 11 year old boy, David, with diabetes. He weighed 15kg < 3rd percentile, height = 144 cm, 3rd percentile. He had come 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 get febrile illness in November, 2012 and was admitted to a district hospital where he died after some days of admission.
**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 for reading. My extended family found it unacceptable that my mother took away John’s life so the staff told him to go to the Headmistress of the school and take the insulin to her. The Headmistress of the school informed me that I was not allowed to 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 am afraid of discrimination and humiliation.

**Caregiver 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 him as the source of his health problems. His father rejected him and considered John as ‘worthless’ in the sense that he continued financially supporting and meeting his needs to be throwing his money away since John’s life would be short. In 2007 I started to attend the diabetic clinic at Muhimbi 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). My God blessed them.

**Diabetes and its Complications:**

1. General Hospital Adolphe SICE, Pointe-Noire
2. Diabaction-Congo, Diabaction Center, Brazzaville
3. Teaching Hospital of Brazzaville

**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 in that the centers trained 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 training healthcare professionals: one (1) specialized Diabetology Endocrinology service in the Teaching Hospital of Brazzaville, one (1) specialized ambulatory center in Brazzaville (Diabaction Center of Diabaction and one (1) non-specialized Unit of Diabetology in Pointe-Noire (2nd city)

**What we do:**

Project conducted by Diabaction and partners exists since 2006 according to the 2006-WHO African 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, secondary, and tertiary level.

*Since 2006 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. (Diabact) were created in Brazzaville and Pointe-Noire, 2 more are in creation in Gamboma and Dolisie, 12 regions of Congo have been trained to management of diabetes, 300 healthcare professionals, 35 peripheral hospitals have been reinforced. 35 peripheral diabetes centers “pilots” created and 25 “satellite” 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:**

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:**

Trainings organized with the support of IDF. These trainings were organized according to the suggested budget. Two (2) trainings were organized - 27th September 2011 in Pointe Noire, the training concerned 50 (30) from General Hospital Adolphe SICE, 4 “satellite” centers diabetes centers and 3 (3) main private clinics.

**Step 2:**

Trainings were organized to bring the new tools to the centers for patients sessions. In these different centers the Map tools have been used from May 2010 for patients with diabetes and the global vision is the tools being very interactive are accessible by the trainers and the Patients.

**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 peculiar to such community.

African, 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 found at hospitals. According to IDF, financial statements on health care due to diabetes alone in 2011 and a projection of 28.8 million by year 2020. According to LF, financial estimate of Africa indicate that at least USD 28 billion was spent on health care due to diabetes 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 understand 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 Africa’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

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 WHO definition of health this mentality coupled with cultural and religious belief system on disease affect preventive health care can be considered in Africa Free Community Diabetic Screening Conducted by Students Of Olabisi Osnahan University Teaching Hospital, Sagamu,Ogun State,Nigeria

2) CULTURE

African culture is varied and diverse. With the introduction of westernization, Africa’s long culture and traditions are being substituted for western styles. This with urbanization has to a greater extent made diabetic care progressive in Africa. Information dissemination and community research 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. 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.

REFERENCES

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/ARD 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. We thought that there will be an independent even organizer body without the strong support of Dr. Ahmed Reja, the president of the association. He was counted like five people. Professor Solomon Testaye handled with care 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 PM for three consecutive days.

Our hard work paid off since we were able to attract participants from 17 African Countries and health care professionals from all regions of Ethiopia. According to our data, there were 250 delegates, 90 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, and 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 of Integration and Nationality Affairs.

Dr. Ahmed Reja and Professor Solomon Testaye gave a press release and it was front page news on the Ethiopian national 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 useful minds the rest of the year.

Ethiopian Diabetes Federation “Life for A Child” (LFAC) program undertakes quarterly and annual physical examination for complications of diabetes and performs specialized laboratory tests such as Hb A1c (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 1LFAC/ARD in Rwanda in 2003 with 3 children, the number of children increased to 30 in 2006, 301 in 2009, 390 in 2010. In December 2011 the number was 642 including 501 from Kigali and 201 in the West. 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 counselling initiative by ARD on radio and at hospitals. Its partnership with MOH, T1 (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 help.

During the last three years the LFAC/ARD program has registered almost 93% 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 center, they certainly have better knowledge and experience in diabetes care.

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, who are often the 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 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 diabetes are in a difficult situation in Rwanda because of their own or their community’s ignorance of diabetes. This ignorance is also experienced throughout the time it has been operating in Rwanda.
- There is consequently an urgency to educate patients, their families and their communities 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 reach this goal effectively and successfully.
- Preparing for the life after the program is needed. 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 started an education center to prepare them for life after the program, 39 young diabetics have graduated so far. LFAC/ARD youth in a classroom of diabetes.

The results are generally positive as the health profits from the experience they gain. Even if not all of them instantly find jobs where they can apply the professional skills acquired in

THE EASD/IDF/ARD MEETING

IDF Africa Newsletter 16
IMPLICATION DE LA JEUNESSE BURUNDAISE DANS LE MOUVEMENT DE LUTTE CONTRE LE DIABÈTE : RÔLE DE L’ASSOCIATION BURUNDAISE DES ÉTUDIANTS EN MÉDECINE (ABEM)

Par Adélard KAKUNZE

Au Burundi, petit pays de l’Afrique de l’Est de 8 511 668 habitants dont 45.9% de moins de 15 ans, 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 le 3ème cause d’hospitalisation dans le plus grand hôpital du pays derrière le paludisme et le VIH/Sida. Quelques études ponctuelles sur des petits échantillons montrent une prévalence du diabète comprise entre 7 et 11%, tandis qu’elle est estimée à 2,8% 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 convergent 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 772 élèves (entre 12 et 20 ans) 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 l’Handicap International ont décidé d’intervenir ensemble dans le cadre du projet DEAR (Diabetes in East Africa Region) pour que la jeunesse burundaise, Burundaise de demain ne soit pas la peinture 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 lancé 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-encadrants 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.


L’autre innovation a été d’effectuer des séances pratiques sur les thèmes de l’éducation équilibrée et la pratique d’activités sportives dans la prévention du diabète. La séance sur l’éducation équilibrée a été un occasion d’impliquer des femmes venant d’organisations communautaires féminines qui ayant reçu une formation sur le thème, se devaient d’enseigner à ces élèves comment préparer l’assiette multisollec 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 imiter 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 conscienti la jeunesse burundaise sur le diabète et d’avoir initier ce mouvement de lutte contre le diabète dans la jeunesse, mouvement qui nous l’esperons va grandir et démocratiser les statistiques alarmantes de la prévalence du diabète dans les années à venir.