Comment

No-one should have to die of untreated diabetes. Although this disease is only one among a host of health problems that afflict the poorest countries, it is one for which effective and potentially inexpensive remedies are available. Sustainable, locally-appropriate, and cost-effective strategies are what we need, and affordable insulin is a necessary part of any solution. Philanthropic initiatives, such as that of Novo Nordisk, are immensely welcome, but equity pricing needs to extend to the private pharmacies where most patients still have to buy their insulin.2 On a wider perspective, the marketing policy of the pharmaceutical industry has escalated the costs of diabetes for diminishing benefit, thereby exacerbating existing inequalities. Africa’s problem is indeed our problem too.

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I declare that I have no conflict of interest.

1 Pendsey S. Where are all the girls with diabetes? Diabetes Voice 1998; 11: 4–5.

Diabetes care in Africa

Infectious diseases still constitute the major contributors to mortality and morbidity in Africa. However, Africa also faces the emergence of chronic diseases, including cardiovascular diseases, diabetes, and cancers. The prevalence of diabetes will increase with improved access to highly active antiretroviral therapy, which is associated with a four-fold increase in the risk of diabetes.1 Diabetes, thought to be rare in Africa, is now common, but many of the issues are unresolved.

A MEDLINE search last July, with the MeSH terms diabetes mellitus and Africa, yielded 0·7% of all entries on diabetes mellitus. This dearth of publications on diabetes in Africa could be due not only to insufficient local research but also to the difficulties that African investigators face in publication in peer-reviewed scientific journals. Less than 1% of continuing multicentre clinical trials on diabetes registered with the European (EudraCT) or the US (clinicaltrials.gov) databases are based in Africa; and the small number of African trials are based almost exclusively in South Africa. This lack of research and published data biases any overview of diabetes care in the African continent.

The burden of diabetes in Africa remains difficult to estimate, despite some local data. Because of the rapidly changing population structure and the profile of diabetes risk factors, the suggested 0·8–4·0% prevalence is an underestimate of the real burden of diabetes in most African countries.7 Our work shows that diabetes prevalence has increased more than ten-fold over a decade (figure). Between 1990 and 2025, the number of people with diabetes in Africa will increase by more than 180% (from 3 million to 8 million).3 This trend and data from migrant studies suggest that an epidemic is looming.4

Risk factors for diabetes in Africa are similar to those in other regions. But the magnitude, distribution, and trends associated with such risk factors, and their perception by the population, have not been fully studied. Diabetes is more frequent in urban than in rural areas.5 The contribution of each subtype of diabetes to the estimated burden of diabetes in Africa is not fully known.

Health systems in many countries in the region are geared towards the management of infectious diseases, and therefore do not have clearly defined policies for the care and management of chronic diseases such as...
diabetes. Where logistics for diabetes care exist, diagnosis and treatment can be poor because of scarce or inadequate equipment or facilities. This situation is worsened by the scarcity of health-care workers, especially of people trained in diabetes care, and of free medication such as insulin.

Many Africans live below the poverty line and the cost of diabetes management is prohibitive to most, because few African countries have a reimbursable national health service. In Sudan, each family with a diabetic child spends 65% of its income on health care for that child. Worse still, essential drugs for diabetes, such as insulin, are not always available.

Because many diabetic patients in Africa expect that the disease can be cured—not just controlled—they turn preferentially to traditional healers who promise cures, rather than to conventional modern medicine. These obstacles to adequate diabetes care result in a high and increasing burden of acute and chronic complications.

The overall picture of diabetes in Africa may not be all bleak. Despite limited resources, long-term outcomes in some African populations are similar to those of their US counterparts, which suggests that good outcomes are achievable.

Knowledge and awareness about diabetes care are still poor, but are improving and need to be consolidated. Diabetes associations operate in several countries and some national governments have set up diabetes care programmes in their health systems. The adoption of an Africa Declaration on Diabetes at the 19th World Diabetes Congress, to be held in Cape Town in December, 2006, is expected to serve as a springboard for coordinated actions to address the burden of diabetes in Africa.

Policymakers need to be informed and convinced of the urgent need for measures aimed at primary prevention of diabetes, which have been shown to be easily applicable and beneficial especially in the African setting with scant resources. Primary prevention measures will go a long way to reduce the burden of acute and chronic complications of diabetes.

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Challenging the future: the Global Prevention Alliance

Even before the WHO Global Strategy on Diet, Physical Activity and Health1 gained hard-won approval from health ministers in 2004, the epidemics of obesity and related chronic diseases presented the most daunting challenges for public health in the 21st century. With more than 1·5 billion adults already overweight and the prevalence of diabetes forecast to double to 366 million by 2030,2,3 five major international medical non-governmental organisations realised that no single group could hope to tackle a public-health challenge of this complexity and scale. In February, 2005, these organisations agreed to join forces as the Global Alliance for the Prevention of Obesity and Related Chronic Diseases, known as the Global Prevention Alliance.

The Alliance is convened by the International Association for the Study of Obesity and its International Obesity Taskforce, with four others: the World Heart Federation, the International Diabetes Federation, the International