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Dear Friends and Colleagues

It remains a great honour and privilege for me to welcome you all to this edition of our bi-annual newsletter. The latter half of the year 2018 was indeed full of events. From West Africa to East Africa, North Africa to Southern Africa, Paediatric Endocrinologists had tales to tell about their services to the profession and the community. We have witnessed a number of activities geared towards the commemoration of the World Diabetes Day in November, to the hosting of the Diabetes Youth Camps by colleagues serving various parts of our great continent of Africa. The mandate of ASPAE is to ensure that African children receive the world-class standard of care in all endocrine diseases including diabetes; and that goal can only be achieved by the collaborative efforts of our hardworking Paediatric Endocrinologists. We value teamwork and multi-disciplinary approach to care, hence we should never tire from involving all crucial stakeholders in improving the care of children with endocrine disorders. In this newsletter, we will also hear the testimonials, first hand from the patients themselves, how they benefited from the services offered by our members. It is indeed my sincere believe that Paediatric Endocrinology in Africa has evolved from just surviving to optimal care.

Looking at the year 2019, the roadmap has been drawn and the path has been cleared. ASPAE will continue with its service to the general membership and our community by hosting the 2nd ASPAE Summer School and the 9th scientific Annual ASPAE conference in Lagos, Nigeria in March 2019. ASPAE will continue our collaborative efforts with our sister organizations to contribute to the field of knowledge in the specialty of Paediatric Endocrinology.

Above all, it gives me great satisfaction to see members of ASPAE, who are also the alumnus of the Paediatric Endocrinology Training Centre for Africa, reaching great heights in their career at their local institutions. I would like to take this opportunity to specifically congratulate Prof Jerome Elusiyan who was recently appointed to the position of Professor of Paediatric Endocrinology at the Obafemi Awolowo University. As the ASPAE family, we congratulate Prof Jerome Elusiyan for this well deserved achievement.

May God bless you all and our beloved ASPAE.

Yours truly,

Dipesoema Joel MBChBBAO, B Med Sc(NUJ), MRCPI
THE EDITOR

Dear Friends and Colleagues.

I am delighted to celebrate what every one of us is doing to make Paediatric endocrinology a reality and to give services to our children. Kind of regional oriented services given by people from the region for the people in the region at the local site spreading from the cities to villages. Among the 17 United Nation Sustainable Development Goals, Goal No 3 and 4 aims at reducing premature mortality of non communicable diseases by one third through prevention, treatment and promote mental health and well being. Over the last few years we as ASPRE have been developing and running different clinics for children with non communicable diseases i.e. Diabetes, DSD Thyroid etc to keep them going and living a good quality of health hence improving their health and mental well being. So let us fight for our children let us prevent them dying from what we can prevent, let us diagnose them early and let us show case whatever we are doing to attain the SDG No 3.4. Our current issue showcase the services going on in our centre from July to Dec 2018 including the diabetes day across Africa. Let us do advocacy for our children.

Enjoy the read and God bless you all.

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Editor of the ASPRE Newsletter
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AS PAEDIATRIC ENDOCRINOLOGISTS BELOW ARE SOME OF ACTIVITIES/PROGRAMMES THAT WE ARE UNDERTAKING ACROSS AFRICA

I-HYPOGLYCEMIA
By Dr Adelle Chetcha, Cameroon

Hypoglycemia is the most common acute complication of T1DM and a major obstacle to obtaining optimal glycemic control. Hypoglycemia is defined a BG level less than 70mg/dl (3.9mmol/l) or when symptoms occur at a values close to 70mg/dl (3.9mmol/l). Severe Hypoglycemia is an event associated with neuroglycopenia leading to coma, seizure and requiring a parenteral treatment. Precipitating factors of hypoglycemia are: insulin excess, insufficient meal, exercise, sleep, alcohol consumption, long duration of diabetes (glycemic unawareness). Signs and symptoms are: tremors, sweatiness, palpitations, pallor, hunger headache, nausea, tiredness, poor concentration, blurred vision, difficulty hearing, confusion, dizziness, irritability, seizure, coma, death. The aim of the treatment is to maintain the BG level > 3.9 mmol/l (70 mg/dl), the ideal is to reach a level of 5.6mmol/l (100mg/dl). The patient with diabetes should always have on him a source of glucose (cube of sugar, banana, biscuit... etc.)

In case of severe hypoglycemia (seizure, loss of consciousness, coma), we shall use 10% dextrose: 2.5ml/kg or if available 25-30% dextrose: 1-1.5ml/kg or IM glucagon. If the patient is conscious, give a fast-acting glucose:-<15kg-1cube of sugar-15-30 kg-2 cubes of sugar- 30-60kg-3cubes>60 kg-4cubes of sugar.

II- HYPERGLYCEMIA The diabetic patient need to reach therapeutic goals: fasting BG 70-140mmol/l, 2H post meal BG<10mmol/l, bedtime BG 6.6-10mmol/l. Any results above that is considered as hyperglycemia in a diabetic patient. The causes are insulin omission/insufficiency, insulin absorption defect (lipodystrophies), illness (insulin resistance), high carbohydrate concentrated meal. Therapeutic diabetic education is essential in the prevention and management of hypo/hyperglycemia. We should adjust insulin doses depending on the type of food, exercise, glucose monitoring. Meal omission is forbidden, avoid alcohol consumption, early treatment of illnesses and adoption of good technique injection are mandatory.

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By Dr. Joshua Kapungu,

I am a general practitioner since 2015 at St. Francis Referral Hospital at Ifakara town located in Morogoro. In the monthly basis I attend only five patients and four newly diagnosed patients of Type 1 DM in a year. Since I participated in the national short clinical training on DM type 1 care in children and adolescents in 2016, it helped me a lot in improving management and diagnosis of patient with minimal symptoms of Diabetes Mellitus Type 1; of which initially I treated as infectious disease like malaria which is the most prevalent in my area. The challenges which I am facing as a general practitioner is I hardly see them in their initial diagnosis, and when they start attending the clinic they either get lost to follow up or have poor compliance to clinic due to poor road infrastructure, cost of transport and unreliable geographical location. In addition, I learned that some patients fail to have good storage of insulin which requires admission due to poor social economic status.

The good thing on seeing DM type 1 patients is when diagnosis reached, it requires frequent clinical assessment and laboratory tests to reveal associated conditions, and if the patient adhere well to insulin treatment the outcome is good.

I am delighted to share my short experience in the care of children with of Diabetes mellitus care. Bravo to all care takers, it real needs a next eye and them to be part of you and your family.

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My name is I.S. I am 14 years old girl. I’m a refugee from Central Africa now living in a camp in East Cameroon. In the beginning of 2018 a doctor in our camp discovered that I have diabetes because I was drinking too much water, and losing weight. They asked my mummy to inject me 2 times a day. Hmm why mummy? Because I was blind! Well things were very difficult and finally I started drinking too much water again and fell into coma on July 2018. I was then transferred to Yaoundé. Doctors said my weight was 19 kg for 129 cm. My blood sugar was 29 mmol! I was severely malnourished with ketoacidosis and had a cataract! I spent 2 months in a Mother and Child center as I was meant to undertake a surgery for my eyes but due to excessive cold the surgery was postponed and finally... one day I saw light! We were all happy and I saw tears of my doctor Suzanne and the smile of my mummy. Did I tell you? My mummy and I never went to school! So the doctors faced difficultés to explain how I should take insulin! They tried something with images but I don’t know if I got everything, one thing in my mind was that I don’t want to go into coma again! I went back to my camp, weight 25 kg. Hope I will see my doctors soon! We really need to open a clinic which to tackle diabetes. Bravo to the doctors and nurses. The day I was discharged.

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We set out at noon for the camp venue - St Justina's Monastery located on the rocky hills of Sharon in Abakaliki Ebonyi state Nigeria. We arrived safely after an hour’s drive from Federal teaching hospital Abakaliki, which was our meeting point. We were greeted warmly and cheerfully.

The beauty and quietness of the environment was refreshing. There were many trees that provided much needed shades from the scorching sunshine with lush green well-kept lawns. The atmosphere was cool, calm and peaceful. The monastery was founded in 1982 and occupied over 150 acres of land. It is bounded on its East side by the famous Ebonyi River which supplied water for irrigation of their farms and provided fish for the community. No doubt a good place for quiet meditation and tourism. We were shown to our lodge and later served delicious lunch prepared by the sisters. It was a vegetable sauce with meat fish and prawns served with corn pudding. Desert was freshly plucked oranges from the monastery orchard. The patients and staff were so overjoyed that everyone was quickly bonding with each other during the time of icebreaking activity. The programme for the camping was basically topic presentations by the patients themselves, presentation by the diabetes nurse, games and periodic prayer at the chapel. The topics were mainly presented by the older patients and they showed an in depth knowledge and mastery of the subjects. The topics were 1. Diabetes - what is it, 2. Blood glucose monitoring 3. Management of diabetes 4. Types
of Insulin, 5. DKA and its management 6. Sites of insulin injection. At the end the best presenter was given a prize. We learnt some slangs from the youth like “do not take too much carbohydrate it will make you go high” (High means in the context of the glucometer reading HI, denoting excessive blood sugar).

On the second day we trekked to the Ebonyi River. This was a 30 min trek that left everyone exhausted by the time we returned. The Ebonyi River was an awesome sight to behold. This river is said to be a major tributary of one of the most important rivers that make Nigeria’s geographical landmark – River Benue. There were boats at the banks of the river which everyone took turns to step in. We also tried unsuccessfully to make camp fire and roast some fish in one of the abandoned huts. The camping was an opportunity for staff to observe directly some common practices of these patients. Such as 1. How insulin dosage was done and withdrawn from the syringe. 2. How the insulin was being injected. 3. How the records of blood glucose were entered in their charts. Some grave errors were noticed and members of staff were able to give practical corrections. Patients discussed issues relating to stigma in school. Experiences of hypoglycaemic episodes and how to handle them (Storage of insulin at home).

Feeding patterns.
Children talked about their individual experiences and we noticed that they were diverse. We had opportunity to exchange ideas and offer practical solutions to some of the issues raised. The most common bad practice we noticed which gave us insight on the reasons for poor glucose control, was disparity between what is recorded and what is actually done. This disparity was noticed most commonly among the adolescent boys. Among the biggest challenge was adhering to the prescribed insulin dosage. These boys erratically increased or decreased their dosages even after being told what to do. It is important to note that we all kept a central recording of all patients’ blood sugars at
the beginning of the camp, which was used as the baseline and was across the board. After correction, admonition and counselling by members of staff, the blood glucose records showed significant improvement. Naughty behaviour noticed mainly in boys, which was craving for foods they stole from the kitchen at night. In fact our cookies and fruits were mostly gone before dawn. When confronted they denied but complained that they were hungry. We opted to resolving insulin dosage to reflect the patients needs. The camping was an opportunity to have the patients tested for at least 4 times a day and monitor their blood sugar. Some of these children ordinarily do not test their blood sugar as frequently as they should, because of lack of access to monitoring devices. By the time we left the camp on Monday 12th Nov 2018, everyone felt fulfilled and satisfied with the exercise. We arrived at the hospital in the morning to begin the walk that marked the world diabetes day celebration in Ebonyi state. The walk was made possible by collaboration of several bodies like DIAPAED club, DAN, The chief medical director Federal Teaching Hospital Abakaliki, Pharmaceutical companies like Novo, Roche and Megalife.

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As an annual tradition, the Sudan Childhood Diabetes Association (SCDA) is always busy on 14th November in preparing “our fun day” as the diabetic children call it. In adherence to this year’s IDF theme “the family role in diabetes management” we tried to expand our activities as much as possible to cover different areas in the capital Khartoum to increase the awareness among the community and involve the families in the process. The celebration started a week ahead of the WDD in three socio-cultural women centers for three days where educational community-based lectures were presented by our multi-disciplinary team about childhood diabetes, diagnosis and management, the concept of a healthy diet for all children; not only the diabetics, the important role of family and school as well as the psychological support as a crucial part in managing these kids. This event has been followed by another two-day educational sessions in our new building of dreams, the Sudan Childhood Diabetes Centre, in collaboration with Women Group and Youth Group. On 13th of November, we participated in a forum about childhood diabetes in collaboration with the Sudan Customer Protection Association. On 14th of November, we organized ourselves into three groups in three different locations; the main was in the Sudan Childhood Diabetes Centre where children and their families gathered, listened to music and danced with lots of fun activities for the children in addition to free check-up for the blood glucose levels in our free clinics as well a gallery with focused, simplified messages delivered to the families in taking care of their children. It is always a privilege to participate and join these little creatures in their special day, the day of their voice!

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DIABETES SCREENING CAMP FOR THE FAMILIES RESIDING IN DAR ES SALAAM

Dr. Rahim Damji, Dar es salaam

The Global Diabetes awareness campaign is held on 14th November every year. Regency Medical Centre conducts a free Diabetes screening and the theme for this year was “Diabetes and the family”. We invited the rest of the family members as well as screening for the global endemic disease. Numbers of activities were performed, clients’ weights, height, blood pressure pulse rate and blood glucose were measured. Teaching and counselling sessions followed thereafter...

Fig: Noel (21 years old) a child with T1DM following closely as the instructor Dr Rahim Damji is giving education to the newly diagnosed patients. Noel is a patient with T1DM since the age of 6 years, currently on insulin pump. We screened over 375 clients of all age groups and could diagnose diabetes in 22 (5.8%) individuals ranging between 40 and 65 years of age. Once the diagnosis was established, they were channeled for counselling and later to diabetes clinic further evaluation and initiation of treatment.

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Prof. Elusiyan, Jerome Boluwaji Elutayo is one among our members and has recently been promoted to the position of professor of paediatric with effect from 1st October 2018 at Obafemi Awolowo University, Ile-Ife, Nigeria. Prof. Elusiyan Jerome has contributed enormously to the building of Paediatrics and Paediatric Endocrinology not only in Nigeria but across Africa and the world. Prof. Jerome is a graduate of Obafemi Awolowo University, Ile-Ife, Nigeria, where he graduated with a degree of Bachelor of Medicine and bachelor of Surgery (MBChB). Prof Elusiyan Jerome is a member of Fellow, West African College of Physician and many more associations. He completed the sub-speciality training in Paediatric Endocrinology at the Paediatric Endocrinology Training Centre for Africa (PETCA) in Nairobi, Kenya in 2009. He is a current co-ordinator of departmental academic programmes in the teaching Hospital, the Chairman of Medical Advisory Committee of Obafemi Awolowo University teaching hospital and many other positions. He has authored over 50 publications in peer reviewed journals, conference proceedings and book chapters. As members of ASPAE, we would like to heartily congratulate Prof. Elusiyan Jerome in his new appointment. Congratulations Dr Elusiyan Jerome and May God bless you.

IMPORTANT DATES

ASPAE 2019 13th-15th March 2019, Lagos
ESPE 2019 19th-21st Sept 2019, Vienna, Austria
ISPAD 2019 30th Oct-2nd Nov 2019, Boston, USA