NON-COMMUNICABLE DISEASES:
ON THE AGENDA
IN DEVELOPING COUNTRIES

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TAKING ON THE CHALLENGE OF NON-COMMUNICABLE DISEASES

The correlation of infection and disease was recognised a few hundred years before Christ. Although people did not know about germs in detail, they observed some way of transmission. Based on that understanding also the Bible gives us information to prevent infectious diseases. A major step of prevention, the vaccination, began in the 19th century. During the 20th century, sanitation measures and the development of antibiotics and other anti-infective substances contributed as further milestones to save a lot of lives.

With the global economical development, we changed and still change more and more our food production, shift productivity to industrial products, create new infrastructures, modes of transport, change our ecological environment.

A certain status of income and wealth leads to a lifestyle of comfort, reduced physical activity and an increase of consumption of less healthy foods, more alcohol, and tobacco. Suddenly we have to face an epidemic of NCDs like angina, asthma and comorbidity. Non-infectious (non-communicable) diseases are inversely correlated to wealth. It means that the number of deaths in less wealthy countries caused by NCDs increased.

In industrialised countries, cardiovascular diseases and cancer are the top two causes of death. The world health statistics of the last decade show that the number of deaths in less wealthy countries caused by NCDs increased.

Will the economical changes lead to a slow shift from less infectious diseases to more non-infectious (non-communicable) diseases? Will we be trapped in a “disease” jam without any solution for our health systems? No, of course not. The case studies vividly described in this issue encourage us. With the strength based on our faith, the ability to understand and utilise the spirit in us, we can take on the challenge of NCDs as we have done and still work on infectious diseases. We trust in Jesus. He had the ability to cure people. He was the Lord’s son. I cannot remember anyone in history afterwards who could be compared with him. We also need to follow the Lord’s words.

We should know better and take the advice from the Bible. The key is our spiritual life and how we transform our life. The apostle Paul gives three responsibilities to that: Ephesians 4:22-24 (NIV). 22: that, in reference to your former manner of life, you lay aside the old self, which is being corrupted in accordance with the lusts of deceit; 23: and that you be renewed in the spirit of your mind; 24: and put on the new self, which in the likeness of God has been created in righteousness and holiness of the truth. It is all about the transformation of our thinking being ready and able to experience the spirit, the knowledge, and take action towards changing our life.

Being inspired by Jesus is also an important motivator and driver for our care. NCDs are mainly chronic diseases. There is no short treatment and cure. Modern medicines reduce the suffering, assist us to manage the symptoms, to increase the life expectancy. The examples of palliative care (p11), provision and use of morphine (p14) for patients in pain, these are the case studies and outstanding achievements described in this edition of Contact magazine, showing impact of care on the life of sick people.

Insulin is a hormone regulating our blood sugar. In diabetic patients, the body is not able to produce it. Being a protein, insulin cannot be swallowed. It is more difficult to produce than “small molecule” medicines and it needs to be injected. That makes the medicine more expensive, the number of manufacturers is smaller and its availability in poor countries is reduced. Pricing and other costs are obstacles. The stories from Chad (p17) make it clear enough that the need is high. If the reported project that CHAK (p19) is engaged in succeeds, it is worth to be extended to more countries and areas of the world. It could be a role model for other rather expensive but essential medicines.

Not necessarily linked to changes in economies and lifestyle are psychiatric diseases. From my own experience twenty years back when I worked in a regional hospital in the North of Namibia, we saw a lot of psychiatric diseases. At that same time, we had one eye specialist from Rwanda serving a population of 650,000 people. When you read how many patients with eye problems are served in Bethesda hospital in Benin (p21) and through ASSOMESCA in Central African Republic (p23), how untreated psychiatric diseases affect the lives of patients in Chad (p18), then you can imagine the huge impact the access to treatment and health care has. The individual will be able to read, can study, has strength to work, actively shares daily life with the community. Psychiatric disorders and eye diseases have existed for a long time. Nowadays as NCDs are more in focus, we are more likely not to forget them.

Medicines are well developed products. The basis for the right to sell and use them is scientific evidence derived from clinical trials. Their efficacy and potential sometimes can be seen through the words we use, e.g. palliative. Cancer is a disease characterised by tumour cells growing without control. These tumours damage the body, impair body functions, and cause pain. Anti cancer medicines interfere with the uncontrolled growing cancer cells. Unfortunately they also affect healthy growing cells. As pharmaceutical and medical personnel we should be aware of that. Careful handling by adhering to specific safety procedures is a prerequisite not to harm yourself and others. The EPN Board chairman gives us an overview of the international regulations we should follow (p8).

This issue contains powerful medicine for your inspiration. Even if the overall topic is non-communicable diseases, I think you will be infected by the stories.

Andreas Wiegand is Programme officer product development and strategic communication at the Ecumenical Pharmaceutical Network.

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NON-COMMUNICABLE DISEASES, A NEW GLOBAL GOAL IN PUBLIC HEALTH

For centuries, microbials have been the biggest threat to public health. Then came the vaccines, the miracle cures, and the gradual improvements in standards of living and hygiene that helped eliminate infectious diseases. The battle to control non-communicable diseases (NCD) is a different kind of fight.

The burden of non-communicable diseases is now the predominant public health challenge in the WHO European Region. The new WHO estimates presented in the Global status report on non-communicable diseases 2010, launched in Moscow, Russian Federation, in April 2011 at the WHO Global Forum, illustrate its dimensions. Among the six regions of WHO, those for Europe and the Americas share the dubious honour of having the highest proportions of deaths from NCDs and injuries. Furthermore, in relation to the risk factors for NCDs such as cancer and diabetes, the European Region has the highest overall smoking rate, the highest per capita consumption of alcohol, the highest proportion of dietary-energy intake from fat, the highest rate of raised cholesterol, and the second highest rate of overweight and obesity.

The situation of NCDs shows that the rate of obesity has nearly doubled worldwide since 1980. The grocery shelves and school lunches are full of the cheapest foods which are usually the worst for our health, cities do not have special routes that encourage people to walk or cycle, not enough free public spots where people would enjoy physical exercise and where children have safe places to play. Diabetes, which is closely associated with obesity and urbanization, is already consuming nearly 15% of the national health budgets in some countries. Prevalence is skyrocketing in rich and poor countries alike. Clearly, NCDs are becoming a global concern.

Tobacco use

Tobacco use is one of the biggest public health threats the world has ever faced. The consequences of tobacco use kill more than five million people a year – an average of one person every six seconds – and account for one in 10 adult deaths. Up to half of current smokers will eventually die of a tobacco-related disease.

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In 2010, around 43 million children under five were overweight. Once considered a high-income country problem, overweight and obesity are now on the rise in low- and middle-income countries, particularly in urban settings. Close to 35 million overweight children are living in developing countries and 8 million in developed countries.

The Parma Declaration on Environment and Health, adopted by WHO European Member States at the Fifth Ministerial Conference on Environment and Health, Parma, Italy, on 10–12 March 2010, underscores the importance of providing safe environments conducive to physical activity, and commits countries to working towards the achievement of targets to that effect. This action to promote public awareness about diet is also referred to as a “best buy”.

Improving dietary habits is a societal, not just an individual problem. Specific recommendations for a healthy diet include: eating more fruit, vegetables, legumes, nuts and grains; cutting down on salt, sugar and fats. It is also advisable to choose unsaturated fats, instead of saturated fats and to move towards the elimination of trans-fatty acids.

An unhealthy diet is one of the major risk factors for a range of chronic diseases, including tobacco advertising, and are regulating who can buy and use tobacco products, and where people can smoke.

Fig. 1 illustrates that the prevalence estimates (for both sexes) in the majority of the South-Eastern European Countries (with the exception of Israel, the Republic of Moldova and Slovenia) are higher than the WHO European average. The male:female ratio varies among the countries; Bosnia and Herzegovina, Croatia, Serbia and Slovenia have narrower sex ratios than the other countries. The general (sometimes drastic) rise in the prevalence of female smoking across the WHO European Region is alarming. Therefore, efforts should continue not only to sustain the downward trend of smoking among males seen in some of the countries in the Region, but also to focus more attention on reversing the levels of smoking among females.

The Global Strategy on Diet, Physical Activity and Health, and the European Charter on Counteracting Obesity, both stress the importance of physical activity for tackling obesity. The Parma Declaration on Environment and Health, adopted by WHO European Member States at the Fifth Ministerial Conference on Environment and Health, Parma, Italy, on 10–12 March 2010, underscores the importance of providing safe environments conducive to physical activity, and commits countries to working towards the achievement of targets to that effect. This action to promote public awareness about diet is also referred to as a “best buy”.

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cardiovascular diseases, cancer, diabetes and other conditions linked to obesity. Therefore it demands a population-based, multi-sectoral, multi-disciplinary, and culturally relevant approach.

Physical inactivity
Unhealthy diets and physical inactivity are key risk factors for the major non-communicable diseases such as cardiovascular diseases, cancer, and diabetes.

Regular and adequate levels of physical activity in adults are necessary. Physical activity is defined as any bodily movement produced by skeletal muscles, that requires energy expenditure. Physical inactivity has been identified as the fourth leading risk factor for global mortality, causing an estimated 3.2 million deaths each year globally.

Regular moderate intensity physical activity – such as walking, cycling, or participating in sports – has significant benefits for health. For instance, it can reduce the risk of cardiovascular diseases, diabetes, colon and breast cancer, and depression. Moreover adequate levels of physical activity will decrease the risk of a hip or vertebral fracture and help control weight.

Harmful use of alcohol
In many parts of the world, drinking alcoholic beverages is a common feature of social gatherings. Nevertheless, the consumption of alcohol carries a risk of adverse health and social consequences related to its intoxicating, toxic and dependence-producing properties.

In addition to the chronic diseases that may develop in those who drink large amounts of alcohol over a number of years, alcohol use is also associated with an increased risk of acute health conditions, such as injuries, including from traffic accidents.

The harmful use of alcohol is a global problem which compromises both individual and social development. It results in 2.5 million deaths each year. It also causes harm far beyond the physical and psychological health of the drinker. It harms the well-being and health of people around the drinker. An intoxicated person can harm others or put them at risk of traffic accidents or violent behaviour, or negatively affect co-workers, relatives, friends or strangers.

Thus, the impact of the harmful use of alcohol reaches deep into society.

Harmful drinking is a major determinant for neuropsychiatric disorders, such as alcohol use disorders and epilepsy and other non-communicable diseases such as cardiovascular diseases, cirrhosis of the liver and various cancers. The harmful use of alcohol is also associated with several infectious diseases like tuberculosis and sexually transmitted infections (STIs), including HIV. This is because alcohol consumption weakens the immune system and has a negative effect on patients' adherence to antiretroviral treatment.

A significant proportion of the disease burden attributable to harmful drinking arises from unintentional and intentional injuries, including those due to road traffic accidents, violence, and suicides. Fatal injuries attributable to alcohol consumption tend to occur in relatively younger age groups.

Conclusion

The Global status report on non-communicable diseases 2010 identifies the following aims for immediate action:

1. To protect people from tobacco smoke, warn about the dangers of tobacco, enforce bans on tobacco advertising, and raise taxes on tobacco;

2. To restrict access to retail alcohol, enforce bans on alcohol advertising and raise taxes on alcohol;

3. To reduce salt intake in the population, replace trans-fat with polyunsaturated fat and to promote public awareness about the dangers of unhealthy diet;

4. To promote physical activity and healthy diet through the mass media.

Decision making on, or even the implementation of, many of the identified priority actions appears very simple. In practice, this is not the case, since action is often required by non-health sectors and stakeholders that may be seen to impinge on their interests.

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Recommendations made by the representatives of FBOs on the Global Strategy addressing the challenge of non-communicable diseases

1. Increase FBOs’ participation in the implementation of the WHO 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of NCDs; Global Strategy on Diet, Physical Activity and Health; and the Global Strategy to Reduce the Harmful Use of Alcohol;

2. Advocate for the development, implementation, monitoring and evaluation of strategies addressing NCDs engaging the whole of government, the private sector, FBOs and civil society;

3. Encourage research on prevention, treatment and management of NCDs based on the capacity of church and church-related institutions;

4. Force existing essential medicine procurement mechanisms and develop new solutions to provide access to affordable NCD medicines and technologies;

5. Develop and implement comprehensive programmes on NCDs prevention and treatment for church leaders, church-related health and educational institutions, including the development of the curriculum for young generation on prevention of NCDs and healthy lifestyle.

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OVERVIEW

Once considered a high-income country problem, overweight and obesity are now on the rise in low- and middle-income countries, particularly in urban settings.
Non-communicable diseases (NCDs), such as cardiovascular diseases and cancer, are rising and in focus not only at the WHO in Geneva but in quite some health institutions and facilities worldwide too. Especially in Low Income Countries (LICs), NCD cases are increasing, often dramatically. The question of safe treatment of cancer and the right handling of cytostatic medicines arises.

Diagnosis and treatment of cancers are not easy and are becoming a real challenge for already weak health systems. There are not only budgetary constraints, but also a lack of adequate training of staff in the pharmaceutical sector and staff responsible for treatment. Cancer treatment is complex and should be restricted to specific hospitals, where modern diagnostic and laboratory equipment as well as proper knowledge about handling of medicines can be guaranteed. But with the increase of cancer, the demand for proper treatment is great even in non-specific hospitals in the least developed countries.

Access to affordable treatment of cancer has therefore to be added to our agendas and should be part of the discussions in terms of reaching the health-related millennium development goals. This includes standards of safe treatment and the right handling of cytostatic medicines.

Challenges of handling cancer medicines

The handling of these substances can be dangerous: Cytostatic medicines are "CMR" classified because they can be carcinogenic, mutagenic and reprotoxic. CMR classification makes up the first and most toxic category of substance classes into which hazardous chemicals can be subdivided, according to EU legislation. Carcinogenic chemicals can cause or promote cancers. Mutagenic chemicals can cause genetic mutations. Reprotoxic chemicals can damage the reproductive process. A study in the United States determined that in the US alone about 5.5 million health workers are at risk (Witch Polo 2004). Logistical staff in the drug supply chain management are at risk in case of improper packaging, leakage or damage. Pharmaceutical staff and nurses are at risk when handling these medicines, or preparing the medicine without proper protection (preparation of syringe or infusion, crushing tablets,...). the physician can be at risk when administering the medicine - and, ultimately, the patient might be in danger in case of improper administration. If the product is not administered completely intravenously and minimal quantities of the toxic substance reach the skin, this can cause severe skin irritations up to skin ulcers, e.g. with epirubicin or vincristine. Other consequences may not be immediately visible and only years or even decades later, cancer may break out.

In the US as well as in European countries, strict safety regulations are implemented. The preparation of these medicines should only be done under laminar air flow systems or in an insulator to avoid particles in the surrounding area. The use of gloves and a face mask are required. Facilities like that are hardly available in most regional or district hospitals in resource limited settings.

Another question is of course how to deal with the waste of such medications. How to dispose used ampoules of cytostatic medicines? Un-trained cleaning staff might just deal with them like a discarded newspaper. This would put cleaning staff at an enormous risk.

Quality of medicines

The quality of the product itself is also very crucial. The production of intravenous cytostatic medicines requires high standards for clean rooms (special air filtered environment to avoid contamination with germs) and safety measures to prevent contamination of the environment and the manufacturing personnel. The primary packaging, e.g. ampoules, vials should be free of cytotoxic medicine on the outside. Thus the production is more expensive. The procurement should only be done from good and reliable sources. These need to be selected carefully and should be fully audited. Cytostatic medicines are available as generics by now and prices have fallen considerably.

Need for awareness

There is definitely an increased need for access to chemotherapy in resource limited settings. But at the same time we need critical awareness, clear policies and standards that will prevent illness and complications for all staff and patients dealing with such medications. The pharmaceutical department of DIFAEM - German Institute of Medical Mission in Tübingen, Germany has put in place standard operating procedures for the procurement and shipping for chemotherapy. Experience in the supply of such medications in Eastern Europe has helped to learn important lessons. Prior to shipping the packages containing cytostatics, the vials need to be securely packed in a sturdy sealed plastic bag before packing them in a strong carton. A yellow-hand label (warning cytostatics) is attached to the outside labels to inform the carrier about the content of dangerous products (not classified by IMCO as "hazardous"). Recipients are instructed about necessary appropriate safety measures (gloves, masks and safe disposal of waste, etc).

If we want to make chemotherapy more broadly available in resource limited settings, it is also necessary that we have Standard Operation Procedures (SOPs) within the country, at storage places (Drug Supply Organizations or Central Medical Stores) and at the point of care.

Rules of action in case of breakage and leakage of product content

1. Avoid any direct contact with the product.
2. In case of contact with the eyes and/or skin, rinse thoroughly with cold water for at least 10 minutes and consult a doctor or ophthalmologist immediately.
3. In case of spillage or damage, do not touch but put on gloves and personal protective equipment for cleanup.
4. Cleaning is only allowed by special trained staff, not by the general cleaning staff. Remove spilled liquid and particles with absorbent cloth or paper wipe. Gather breakages and put them into a plastic bag or other suitable container and dispose properly.
5. Clean contaminated area thoroughly.
6. Pregnant or breastfeeding women and minors must avoid contact with the product.

a. International Maritime Control Organisation classification for hazardous cargo, based on the UN recommendations which outline the requirements for safely transporting dangerous goods by sea and air.
In HIV and AIDS, the risk of infection of health workers is taken seriously today. It is time to take a similar approach with regard to the handling of cytostatic medicines.

We have learnt many lessons from the distribution of Antiretroviral Treatment (ART) and standards are being implemented and controlled to protect staff and patients from contamination. In HIV and AIDS, the risk of infection of health workers is taken seriously today: employees are trained, Post Exposure Prevention (PEP) measures are in place and PEP medicines are kept in stock. It is time to take a similar approach with regard to the handling of cytostatic medicines.

Albert Petersen is head of the Pharmaceutical Department at DIFAEM - German Institute of Medical Mission in Germany. He is also Chair of the EPN board.

Your comments, experiences and suggestions

The author is very interested to receive comments, experiences or suggestions. DIFAEM will take up this issue and assist partners in this regard. Also EPN would like to take it up to develop and provide specific tools and activities. Church health facilities could/should take the lead to provide best practice examples and share case studies. What specific methods are needed and practicable to create relevant awareness, to be translated into specific SOPs? What policies and guidelines already exist in some countries, developed by the Ministry of Health and others that should be taken seriously and followed? The EPN Drug Supply Organizations have been supported to enable hospitals and clinics to handle therapeutically effective cytostatic medicines in a proper way. Most of these medicines are listed to be Essential Medicines and are available as generics because they have been known and marketed in developed countries for years. Now it is time to make them accessible for certain institutions in LDCs as well, but also to discuss about how to safely handle and use these potentially toxic products.

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More information


THE CASE FOR PALLIATIVE CARE: FRESH VISION FOR THE CHURCH

A Kenyan peasant farmer with a wife and nine children, Joseph was 72 years old when later, in March 2012, he told his story to Kijabe Hospital’s Palliative Care team. He had first noted the onset of backache, muscle spasms and generalized body weakness late in 2010. Over the course of the next year, he had sought help from many different hospitals and clinics and even a traditional herbalist, which consumed his financial assets and even required the selling of some of the family’s land. Despite all this, his symptoms continued to progress. He developed numbness and weakness in his feet and legs and the pain became so severe that he had become unable to walk. Finally in January 2012, Joseph was referred to an orthopaedic specialist who ordered a CT scan of the spine. The scan revealed metastatic bone lesions, which led to the diagnosis of advanced prostate cancer. Unfortunately in his financially depleted state, he could not afford chemotherapy or radiation therapy, and surgery was not an option at this late stage. This is when Joseph heard the shocking words, “There’s nothing more I can do for you.” The words from the doctor hit Joseph (alias) like a tsunami. “Your cancer is advanced and has already spread to other parts of your body. It is now incurable. It is time for you to go home and set your house in order.” Shocked, bewildered, discouraged, hopeless and in pain, Joseph left the doctor’s office with only a prescription for morphine, that no street pharmacy could legally fill.

Joseph and his family came to Kijabe in the desperate hope that something, anything, might be done to help him. After a thorough evaluation, Joseph was enrolled in the Palliative Care programme and received counselling and symptomatic treatment including oral morphine at a subsidized, affordable price. Joseph’s response to this kind of care was remarkable. Now six months later, his pain is controlled, his appetite and strength have returned and his weight is increasing. He is no longer bedridden or dependent on his family for the usual activities of daily living, and he comes for his follow up visits on his own using public transport. The medications he needs to control his symptoms are available and affordable, and although he knows he has a life-limiting illness, he and his family have seen a profound improvement in his quality of life for which they remain exceedingly grateful.

Cancer hitting developing countries

Joseph’s battle with cancer is hardly unique. In Kenya alone more than 28,500 cancer cases are diagnosed yearly, with over 22,000 cancer-related deaths; and these numbers continue to rise. In fact, at the national referral hospital in Nairobi, the diagnosis of cancer has surpassed a. Morphine is a potent opioid pain reliever, almost ideal for the control of cancer pain, but with addictive potential when abused. For this reason, it is highly controlled in many countries and even banned in some. In Kenya, it is only available through government-licensed health institutions and hospice/palliative care programmes.
the diagnosis of HIV for the past two years.² Perhaps Kenya is getting better at diagnosing malignant diseases as pathology services become increasingly available. But undoubtedly the true incidence of cancer is also increasing as carcinogenic agents, both biological and chemical, become more prevalent among populations and as Western diets and lifestyles become more common.

The increase in cancer diagnoses is not limited to Kenya but is being seen throughout the African continent, and indeed globally. The World Health Organization reports that cancer kills more people than AIDS, TB and Malaria combined.³ Four figures compiled and reported by the International Agency for Research on Cancer (IARC) reveal that in 2008 there were 12.7 million new cancer cases diagnosed worldwide, and 7.6 million deaths.² Two-thirds of these cancer deaths occurred in developing countries. The IARC expects these numbers to double by 2030. In fact, some projections foresee a quadrupling of cancer rates in Africa over the next 50 years.⁴

An analysis published in 2004 by Harding and Higginson found that in sub-Saharan Africa, 80% of cancer patients present, like Joseph, with advanced, incurable disease.¹ The combination of inadequate national economic development, overburdened healthcare systems, lack of diagnostic and therapeutic capacities, widespread poverty and other economic and developmental challenges all conspire to make many developing countries ill-equipped to handle even their current caseload of cancer patients, let alone the increasing numbers expected in the future. In such a setting, the great need for palliative services is glaringly obvious.

Adding life to the days

The World Health Organization defines palliative care as “an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.”¹ This definition incorporates several important aspects of palliative care:

- Its primary concern is quality of life, not quantity of life.
- Its focus is on symptom anticipation and alleviation, not on the specific diagnosis except in so far as the diagnosis helps to predict symptoms or influence symptom control.
- It includes important relationships such as family and friends in its sphere of vision.
- Far from the “benign neglect” assumed by those unfamiliar with the philosophy of palliative care, it requires close attention to and involvement with the client.
- It is holistic in scope, recognizing the importance of addressing not just physical needs but also the psychological, social and spiritual needs of the patient.

Other important aspects of palliative care are:

- That it affirms life and regards dying as a normal process; it intends to neither hasten nor to postpone death; it supports the patient to maintain as active and engaged a life as possible until death; and it extends beyond the death of the patient to assist the bereaved family to cope with their loss.

In order to successfully accomplish all aspects of this holistic approach to patient management, it is important that palliative care be seen as supplementary to, not subsequent to, standard medical care. In the past, palliative care (or “hospice” initially) was reserved for after a patient’s doctor had attempted all that curative care could offer. After stating, “there’s nothing more we can do,” the patient would then be sent to the hospice to die. Many patients, like Joseph, remember the day and the hour when this awful pronouncement was made. Unexpectedly this view of palliative care still persists, especially among medical practitioners.

The potential of holistic palliative care is significantly limited when patient referrals occur late in the illness rather than early. The greatest good is gained when referrals are made as soon as possible after making the diagnosis of a life-limiting condition, allowing both medical management and palliative care to be undertaken collaboratively for the maximum benefit of the patient and his family. Such an approach maintains hope and sustains dignity.

While cancer screening and prevention programmes are indisputably cost-effective and greatly to be encouraged, for those already diagnosed with cancer or other life-limiting illnesses, the cost and inaccessibility of curative services in developing countries frequently make palliative care the only financially attainable option. Unfortunately, palliative services are few and far between in developing countries. The WHO deems fortunate. There is a great need in Africa as in most developing countries for a scaling up of palliative services. This is an area of unrestricted opportunity for the Church.

Calling on the Church

For many reasons, the Church is ideally situated to address the escalating need for palliative care:

- The heart of Christ is the heart of the Church. It is a heart of compassion that seeks to relieve suffering and to bring comfort, hope and encouragement. If the Church is not touched by the suffering around it, then it has lost touch with the heart of Christ. Faith unaccompanied by action is a dead faith (James 2:14-26).

- Palliative patients and their families wrestle with end-of-life issues, often including questions of eternal significance. The spiritual ministry of the Church can be of infinite value to those facing this situation. The message of salvation through faith in Christ is more readily embraced; and if already believers then the prayers, words of encouragement and fellowship in the Spirit are more gladly welcomed.

The Church is ubiquitous, being found even in the most remote rural areas. It exists even where government infrastructure has not yet reached.

The Church widely promotes community involvement and fosters a spirit of volunteerism. It is therefore ideally positioned to give emotional and practical support to families and caregivers of community or church members facing life-limiting illnesses.

The vision of the Church is holistic, making it ideal for facilitating the holistic vision of palliative care.

In contrast to other health-focused services, palliative care is not expensive. Most palliative patients and their caregivers prefer a home environment to an institutional one, and most palliative drugs are relatively inexpensive. Thus, the promotion of palliative services may be an achievable vision for many local churches to pursue in conjunction with local or regional health-care providers.

The global suffering caused by cancer and other life-limiting illnesses is immeasurable and largely unaddressed. What we see in our health institutions is just the tip of the iceberg, and is growing steadily. As one doctor recently commented, “The expectation that we can be immersed in suffering and loss daily and not be touched by it, is as unrealistic as thinking we can walk through water without getting wet.”¹² For Joseph and millions like him, it’s time for the Church to get wet.

Robert A. Carter MD, MPH works at the Kijabe Hospital Palliative Care Unit, Kenya. Kijabe Hospital is a member of EPN.

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There is great need in Africa as in most developing countries for a scaling up of palliative services. This is an area of unrestricted opportunity for the Church.
FROM SINGAPORE WITH LOVE... THE STORY OF AFFORDABLE MORPHINE IN AFRICA

This is the story of the introduction of palliative care into a continent. A continent with more people suffering than any other continent in the world. Where people are suffering from pain due to cancer, AIDS, sickle cell disease, burns, trauma and other diseases, without adequate pain relief.

When the founder of Hospice Africa, Dr Anne Merriman, worked in Singapore in the eighties, palliative care was not yet available there. On bringing this to discussion with health professionals through a conference meeting for nurses and doctors, it was found that there was a great thirst to relieve the suffering of the many patients, who having failed to respond to the excellent chemo and radiotherapy available, were sent home as there was nothing more that could be done. Having visited some of these patients, she worked with the local pharmacists, requesting for a formula for oral morphine, which could be compounded easily, and be used orally in the home. The request was for a simple solution.

The pharmacists quickly came up with a solution of morphine powder in water, adding a preservative and different cake colours for the different strengths. Home visiting now brought hope to those who were discharged from hospitals. Their pain was relieved very quickly, using the analogous ladder of WHO, and the new formulation of morphine. Other simple methods to control the symptoms, so common in advanced cancers, were added. This opened the door for holistic support for the patient and family during this often difficult time of life.

This voluntary service was taken up by the Community Chest in Singapore, around the time that the University contract for Dr Anne was coming to an end. The first office was in the master bedroom of her home, an 18th floor flat. From this office, the first records in detail were kept including those of the 400+ patients already seen and cared for by the volunteer nurses who worked together with Dr Anne in the evenings and weekends before the formal setting up of the Hospice Care Association. Patients would call and the volunteers would meet a relative to guide them to the patient. Singapore is a small island of 242 square miles with 2.5 million people at that time (this has increased to 5 million now!). They were mostly living in self owned high rise flats. From this office, the first records in detail were kept including those of the 400+ patients who had already been seen and cared for by the volunteer nurses who worked together with Dr Anne in the evenings and weekends before the formal setting up of the Hospice Care Association. Patients would call and the volunteers would meet a relative to guide them to the patient.

From Singapore to Africa

A conference was held for South East Asia around this time and two visitors came from UK, Dr Robert Twycross and his Administrator, Mrs Gill Hunter. As well as attending the meeting, they asked to come out on home visits. There they witnessed the care that was being given by volunteers who had brought together the medications required for these patients to keep them comfortable. Mrs Gill Hunter was on the Board of a new initiative beginning in Nairobi, Kenya. This was Nairobi Hospice, the first home care Hospice in Africa, developed primarily for Africans. There were already Hospices in Zimbabwe (1979) and South Africa (1980), but both were modelled on the work of Dame Cicely\(^a\) in London, where the economy was highly developed and medications were very available. At that time, both Zimbabwe and South Africa had large white populations and medications available to them similar to that in Western countries.

Through Mrs Gill Hunter, Anne was invited to apply to be their first medical director. Going there from Singapore in 1989, she was devastated on meeting patients with terrifying, untreated and advanced cancers, and with little more than paracetamol available for their severe pain. There was cocaine but it was too expensive for most. The oral formula for morphine was brought to them from Singapore together with the address of the supplier of morphine powder in Hungary. A pharmacist on the Board took on the task to make the morphine using the Singapore formula. The Chair of the Board, Professor Edward Kasili, Oncologist, had a relationship with the Government and in 1990 the morphine was in use accompanied by training programmes, based on the Singapore programmes.

This new initiative brought many dying and suffering people to the attention of the small team. Once the pain was controlled, it was essential to bring all the tools to provide holistic care to the patient and family. This could not be done without the elements of the Ethos\(^b\) (later to be written from Uganda) and making a team with the spirit of hospitality and love for each other as well as the patients and family. Sadly, it was almost impossible to establish this spirit in the bureaucratic system at that time. Around this time, Anne was requested, by Dame Cicely Saunders, to write an article in this very journal\(^c\). Contact. Dame Cicely Saunders, the editor, devoted this edition to the history of palliative care in the world. She requested for an article to explain the new palliative care initiative in Nairobi. A patient’s story explained the difference holistic care could bring to the suffering. At that time, Contact was given freely to African countries and Anne received letters from 5 African countries asking her to help them bring a similar service to their country, to relieve suffering and bring peace to the many who were dying in particular of cancer and AIDS. It was now clear that Africa needed a hospice that would be a model adaptable to the cultures and economies of African countries.

Thus Hospice Africa was born. In 1992, the constitution was written. The Mission was to support palliative care in Africa. It was in Liverpool, following a feasibility study by Dr Anne and Mbaraka Fazal, who had worked with her in Nairobi Hospice that Uganda was chosen for the model. On September 23rd 1993, the Hospice was declared viable in a little house on the grounds of Naamba Mission Hospital in Kampala. Undeterred by the lack of major funding raised over the previous 6 months, the first team commenced with enough money for salaries for 3 months for 3 team members, nowhere to live and a 10 year old Land Rover donated by the British High Commission. The initial funding came from the Church in Singapore, which having seen what had been achieved in Singapore and Nairobi, had faith in this new venture.

Taking it further

Today, Hospice Africa Uganda is looking after 1,600 patients and has trained more than 8,000 health professionals and community volunteers. The training of undergraduate doctors was the first priority and this was made examinable a few years later. Now, most doctors know what palliative care is and are prepared to refer or provide it for their patients. Nurses are the backbone of palliative care and spend most of their time with the patients and families. It was recognized that Uganda was extremely short of doctors to prescribe morphine so a request was put to the parliament to change the statute, allowing midwives to prescribe pethidine for women in labour, adding that nurses specially trained in Palliative care could prescribe oral morphine. This was passed in 2003 and a Diploma in Clinical Palliative Care was commenced for nurses and clinical officers. Later, a “rapid prescribers” course of 6 weeks was introduced for clinical officers which is allowing us to train faster. It is through those trained that palliative care is reaching more in Uganda and since 2000 in other African countries.

A diploma programme in palliative care for Africa was commenced in 2004 and raised to BSc level in 2010 in conjunction with Makerere University. There are up to 15 countries taking part in this degree programme. The initiators programme is part of the International Programmes and many of those beginning and introducing palliative care have attended. If requested, the International team will visit other countries.

\(a\) Community Chest was a fund contributed to by Singaporeans for those in need and controlled by social services.\n
\(b\) Dame Cicely Saunders, the founder of the modern Hospice movement based on holistic care provision including control of all pain, was a nurse, social worker and doctor. Her biography is most inspiring and recommended reading. Shirley du Boulay and Marianne Rankin (2007) Cicely Saunders: The Founder of the modern Hospice Movement, London: SPCK.
programme in country and support them with advocacy and work alongside them to help the establishment of a programme with standards. Today, the Government of Uganda provides free morphine to patients prescribed it by a recognised prescriber. The true cost is $1.5 for 10 days treatment for the average patient. This solution can be made up in a pharmacy with the original formula and in three strengths. Green is 5 mgs per 5 ml, red is 50 mgs per 5 ml and blue is 100 mgs per 5 ml. As morphine solutions are made up in different countries, and because patients are moving across borders seeking treatment, we are encouraging standard colouring in all African countries.

About morphine

What is the miracle of oral morphine? It is from the poppy flower thus God’s answer to pain. Being affordable and having no therapeutic ceiling (dose is tailored to the needs of the patient) it is the only step 3 (strong) analgesic in palliative care. Patient (or family) it is the only step 3 (strong) analgesic in palliative care. It has opened the door to the possibilities of oral morphine for those countries who have taken on to produce it for their people. It has opened the door to the holistic care of each person, not only physical but also psychological, spiritual, cultural and social care.

Today, almost all in need can reach a palliative care service in Uganda. The map (figure 1) shows the Districts with a trained palliative care nurse or team and oral morphine available to them. Those in the districts in white can be referred to their nearest district. The shaded sections are increasing year by year as training is quickly followed by morphine availability and support from the Palliative Care Association of Uganda (PCAU) who follow up the services and maintain a register of prescribers.

An example

Sam, four years old, has a nephroblastoma, a tumour of the kidney. He looks like a child with severe malnutrition, except for his swollen abdomen because of the tumour and fluid. He lives in a rural area in the South West of Uganda with his mother, grandmother and elder sister. He is one of the 5% who actually had chemotherapy. But he has failed to respond, is now at home deteriorating and has been for some months. Initially he was in severe pain. This is now controlled with the help of morphine and holistic care to him and the family. When we visited him, he was taking advantage of his debilitated state to order his mum to make his food and his granny to make the sauce as he knew who was the best cook for each! He has grown very attached to his palliative care nurse Honest and looks forward to her visits.

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Letters from Chad on Diabetes and Psychiatric Illness

Bebalem is a village in Southern Chad, with about 13,000 inhabitants. The hospital serves a much wider area than its district of about 300,000. I followed a youth with diabetes since 2008. He had been diagnosed with diabetes 8 months before I saw him. At 12 years old, he was thin and pot belled but not acidic. His parents hadn’t gone the 80 km to buy insulin for him as prescribed. The hospital didn’t keep it in those days because it was rarely used. Now at 16 years, he seems on the surface to be in good health but what is his future? He only survives because of a well wisher who buys insulin and syringes. His insulin is kept in a cool box in the hospital because temperatures rise regularly to over 35°C in Chad. We use a twice daily dose of intermediate insulin. But he rarely has regular meals, particularly at this time of year when his parents stay out in the fields. Thus, it is impossible to control closely his serum glucose if he will eat only peanuts between morning and 5 pm.

One other diabetic who arrived in 2011 never returned when I said his lack of response to oral treatment meant he needed insulin. As he came from 80 km away, he may well have bought insulin nearer home - or not, as the case may be.

This year I have seen three new diabetics. Two are children. One of 12 years was very unwell but improved with insulin and although badly controlled still when he stopped coming for treatment, was nonetheless much better than he had been. Even with help for buying the insulin and the syringes, his parents did not return for the second bottle of insulin. We will find out what happened when the father returns to the local bible school for the start of the academic year. Did he consider it unrealistic that his son would continue for the rest of his life on insulin? It may well be true. The father has to be posted somewhere near a fridge and will there always be a well wisher to buy the medicine which costs more than his monthly salary?

The second child has been diagnosed 3 years ago but never treated. She comes from the “Big town” 80 km away so why has she never been treated? She has ketones in her urine but is not very unwell, only very tired and very thin - 32 kg at 14 years. What will be her future? Her family are educated but will they have the money for her treatment? Only time will tell.

My third new patient is an adult of 30-35 years age who has been unwell since February 2012 and who has not responded to oral hypoglycaemics (only glibenclamide and metformin available and the former we have bought in Kenya). Her husband is a farmer. Will he buy the insulin regularly? Can she eat three meals a day in a culture where once a day is more usual?

Insulin treatment may well be impossible for any length of time but even those on oral hypoglycaemics will often take them intermittently because of financial difficulties. It appears difficult for patients to understand the concept of prevention of complications. For many they only see that they are tired, thin and passing lots of urine. When there is barely enough to eat in the house, treating chronic disease is not considered a priority.

Ann Fursdon, Medical Doctor, supervising pharmacy Centre hospitalier de Bebalem, Chad, a member of EPN
Contact n°195 – November 2012

BASE OF PYRAMID INSULIN ACCESS PROJECT

The Base of the Pyramid Project (BoP) in Kenya is a collaborative agreement between the Danish government, the Ministry of Public Health and Sanitation, the Christian Health Association of Kenya and the Kenya Episcopal Conference which has the goal of increasing access to insulin in Kenya for effective management of diabetes.

The initiative targets to increase awareness and knowledge of health workers and communities on diabetes management, reduce cost of insulin and ensure uninterrupted availability of insulin in many faith-based health facilities in areas of the country that bear the greatest burden of diabetes. The programme was recently launched and is expected to come to full implementation in November 2012.

On 12th April, 2012, the Prime Minister of Kenya (PM), the Rt Hon. Raila Odinga launched the BoP programme for low-income people at a ceremony held at Kanyariri dispensary which is one of CHAK’s health units located in Kikuyu District.

During the launch, the Prime Minister noted that Kenya was experiencing a rapid increase in the prevalence of non-communicable diseases such as cardiovascular diseases, cancer, diabetes and chronic respiratory diseases. He attributed the rapid increase in diabetes and other non-communicable diseases to high exposure to risk factors for these diseases such as tobacco use, consumption of unhealthy diets, alcohol abuse, physical inactivity and exposure to environmental pollution.

The Prime Minister noted that diabetes is now more common in our society than it was two decades ago. The PM noted that about 5% of the Kenyan population had diabetes, translating to about one and half million people living with the disease.

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During the pilot stage from January to June 2012, the project has managed to deliver on:

- Accessibility of affordable insulin at 500 Ksh (approx USD) per 10ml vial
- Increased community mobilization through awareness and screening activities
- Training of 46 healthcare providers (HCPs) from 24 faith-based facilities (FBOs)
- Training of 116 Lay Educators in both Nyeri and Dagoretti
- Formation of patient support groups
- Data collection through the diabetes registries

CHAK member health facilities have been involved in the project implementation in both Nyeri and Dagoretti and there have been notable achievements in capacity building and increased access to low cost insulin for the

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aving seen a number of patients with severe psychiatric illness in my 6 years working in Chad, it was clear that there is little provision for them. There is only one psychiatrist who works in the capital and also in the refugee camps in the East of Chad. He is supported by 4 trained psychiatric nurses who see most of the patients in the capital. Others outside the capital suffer without treatment, sometimes in chains.

Having met a French speaking psychiatrist willing to visit us for two months, we made a radio announcement on two local radio stations detailing her arrival. In total over 200 patients came to see her, of which 85 were considered to have psychiatric disorders. She saw a mixture of schizophrenics, schizoaffective disorder, bipolar disease, mania with psychosis, personality disorders, learning difficulties, and various cases of hysteria. Most of the medicines necessary are not readily available here in Chad in government pharmacies either for psychiatric disease or epilepsy. It is only through the generosity of supporters and this psychiatrist that we are able to treat patients at low cost. Our experience is that relatives are not always willing to treat such patients despite the suffering that their illness causes for all. Some travelled over 100 km to see us because there is no such treatment possible near them. This is a significant cost without paying for treatment. Despite this, many keep coming and new patients arrive. The most recent arrival was brought 500 km to see us with a severe psychotic depression.

The majority of the remaining patients were epileptics (120), many of whom had suffered without treatment for many years. Our supplies of anti-epileptics quickly ran out and it proved impossible to buy medicines for them in the regional government pharmacy so we were forced to buy privately which more than doubled the price. For the rural poor of Chad, this price was impossible. Through the generosity of a supporting church we have been able to subsidise treatment more recently and this helps to keep patients coming regularly for treatment. This is a disease which is relatively easy to control but treatment is not available. Why? Many patients and their relatives had thought that it is impossible to treat. Patients are ostracised, they miss school, they may not be able to play a useful role in society and they suffer the dangers of being burnt, falling from trees, drowning, etc.

We have been able to make a small impact through the generosity of others. Already some of our patients and their families are informing others suffering from epilepsy and psychiatric disease of the possibility of receiving help at Bebalem. But we will need to continue informing by radio and other means to reach the maximum number of such patients and to assure their continuing treatment.

Ami Fursdon, Medical Doctor, supervising pharmacy Centre hospitalier de Bebalem, Chad, a member of EPN

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diabetic patients in need of treatment. In the second phase, the scale up of the BoP Project intends to extend these benefits to the rest of the country. CHAK is proposing a phased scale up to other FBO health facilities in the counties around the Mt Kenya Region. There are over 50 CHAK member health units targeted for implementing the scale up beginning in November 2012.

Expected outcomes:
1. Reduced socio-economic costs due to improved and timely treatment of diabetic patients leading to fewer complications
2. Improved access to quality health care for diabetes patients
3. Improved data collection leading to improved planning and service delivery for diabetes
4. Improve on quantification of medicines including insulin for diabetes

Mike Mugweru is ACHAP Communications Officer and responsible for the launch of this project. CHAK is a member of EPN.

TREATMENT OF EYE DISEASES AT BETHESDA HOSPITAL IN BENIN

The faith-based hospital Bethesda, located in the 8th district of Cotonou in Benin, specialises in healthcare and offers services mostly to those in need, as a Christian gesture through healthcare services.

Among the many non-communicable diseases that are treated at Bethesda, there are the eye diseases which cause suffering to a large part of the population in Cotonou and its environs. A considerable number of patients also come from the heart of the country. They are from all layers of society and all age groups.

The epidemiological profile of the diseases is not too varied. In decreasing order of prevalence, the following are seen:
1. Refractive errors (myopia, hypermetropia, presbyopia and astigmatism)
2. Conjunctival diseases (bacterial, viral or allergic conjunctivitis among which are tropical endemic limbo-conjunctivitis – TELC, and pterygium)
3. Diseases of the eyelids (chalazion, stye, foreign objects)
4. Eye trauma
5. Glaucoma (primary open angle glaucoma - POAG, angle closure glaucoma - ACG)
6. Corneal diseases (ulcers, keratitis, foreign objects, leukemia)
7. Cataract
8. Maculopathy
9. Optic neuropathy
10. Convergence insufficiency
11. Diabetic retinopathy, or due to HTN (hypertension) or sickle
disease

Repairing vision
Three main approaches are used in the care for these diseases: surgery, eyewear and medication.

The treatment of some of these diseases requires surgical interventions. In 2011, 592 patients had an operation. The case of cataract comes to mind with 66.34%, followed by pterygium (10.46%).

The department of eyeglass manufacture also contributes largely to the care of eye diseases. In 2011, 1035 spectacles were fitted. The quality of the service offered by Bethesda in this domain means that numerous demands come from other ophthalmology centres.

Bethesda hospital has a pharmacy specialised in ophthalmology, which allows the hospital to respond to the patients’ demand for medicines. There are about twenty products, of good quality and at an affordable price, hence attracting patients from other centres. It must be said that all prescriptions are done based on diagnosis. The automated visual field test allows a better screening of glaucoma and earlier diagnosis of this insidious disorder. In 2011, 262 automated visual field tests were done.

With regard to ocular ultrasound A and B, this allows a calculation of the potency of the implant needed during cataract surgery (A) or the exploration of the posterior segment of the eye if the eye area is dark and making the back of the eye inaccessible (B). In 2011, a total of 403 ultrasounds were done.

Pachymetry makes it possible to measure the thickness of the cornea. In the course of 2011, 90 pachymetries were done.

The automatic refractometer is used to measure the number of the glass needed for every eye (refractive measure) so as to prescribe the right glasses. In 2011, 1169 automatic refractometer tests were done.
During this operation, 224 patients were seen for screening and treatment of eye diseases. In the area of Allada (about 30 km north of Cotonou), centre of the district of Lon Agonmey in the creation of an outreach in 2011, to the health of 1471 cases per month. The extent of these diseases has lead to the creation of Bethesda hospital in 1993, the ophthalmology department with 224 patients seen every year is only increasing, with an average of 1471 cases per month.

The extent of these diseases has led to the creation of an outreach in 2011, to the health centre of the district of Lon Agonmey in the area of Allada (about 30 km north of Cotonou), for screening and treatment of eye diseases. During this operation, 224 patients were seen (children, women and men).

Limitations

Despite the technical level of the department, there is a lack of certain important equipments such as the Laser Yag which allows the treatment of several forms of secondary cataract by posterior capsulotomy. Bethesda’s laser broke down 4 years ago and still has not been repaired. A portable slit-lamp is also an urgent necessity to renew the existing equipment. And there is only one operation microscope. These insufficiencies limit the hospital in its interventions and management is actively looking for ways to remedy the situation.

Bethesda

Bethesda hospital is a faith-based protestant and evangelical hospital, located in Cotonou, the economic capital of Benin in West-Africa. It was opened more than 22 years ago, on 19th February 1990 and currently has over 12 medical departments and several administrative departments. The hospital has a large internal pharmacy and 2 specialised pharmacies for ophthalmology and maternity.

The hospital is run by the NGO Bethesda, which has also 2 other departments dealing with community development and environment, and microfinancing. Bethesda’s choice is to serve the country’s lowest-income populations.

Reaching more patients

In 2011, a total of 17653 patients were seen, as opposed to 17564 in 2010, meaning an increase of 4%. In the months of January to June, the number of registered cases is lower, with an increase in the months of September and October.

Having been established in 1995, the ophthalmology service of Bethesda was a consultation department with equipment taken over from the Christoffel Blind Mission (CBM). Funding for the Project Viso Plus by the Belgian Rotary Club and the Belgian government has boosted the department and the number of patients treated every year is only increasing, with an average of 1471 cases per month.

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The fame of the ophthalmology department of Bethesda hospital comes from the fact that it employs a group of specialists. The team is made up of four ophthalmologists of which three are permanent, three high-level technicians, one licensed nurse, three nursing aides and one temporary eyewear technician.

Dr Constant S. M. Hounmenou is the hospital director at Bethesda, a member of EPN.

a. A refractive error is an error in the focusing of light by the eye and a frequent reason for reduced visual acuity.

b. The conjunctiva lives the inside of the eyelids and covers the white part of the eye.

c. A pterygium is a non-cancerous growth of the clear, thin tissue (conjunctiva) that lays over the white part of the eye.

d. Glaucoma is an eye disease in which the optic nerve is damaged in a characteristic pattern. This can permanently damage vision in the affected eye and lead to blindness if left untreated.

e. The cornea is the transparent front part of the eye that covers the iris, pupil, and chamber behind.

f. A maculopathy is any disease condition of the most central part of the retina that is associated with highly sensitive, accurate vision.

g. Optic neuropathy is a disease of the optic nerve or nerve system in the eye.

h. Convergence insufficiency is a disease or disorder which affects the possibility to move both eyes properly.

i. Diabetic retinopathy is a damage to the retina caused by complications of diabetes, which can eventually lead to blindness.

H. Convergence insufficiency is a disease or disorder which affects the possibility to move both eyes properly.

A TURN-AROUND AT THE DIOCESE OF BOUAR, CAR

The term non-communicable diseases sounds foreign to us in Africa, at least in our country, Central African Republic, where maternal deaths are the highest of all the countries in central Africa (850 deaths for 100 000 live births) and where one in five children go to heaven before the age of 5.

For years, the world has been talking about non-communicable diseases, but our ears were deaf, our eyes too busy observing the suffering in front of us.

Enforcing the right to sight

In 2010, the health commission of the Diocese of Bouar, member of ASSOMESCA, decided to intervene in this domain. Negotiations were started with the Ministry of Health on the framework of a national programme to fight against blindness. In fact, a public health programme called “Vision 2020 – the right to sight”, targeting the elimination of preventable blinding diseases, but our ears were deaf, our eyes too busy observing the suffering in front of us, if not more painful, definitely much more frequent. The situation in Africa can always be summarized in two words: limited resources. The golden rule is to select the priorities from the priorities.

But Africa is changing, luckily: for a few years now we have not seen measles outbreaks, or polio epidemics; leprosy is disappearing; river blindness is no longer a public health problem: thanks to the distribution strategy of Mectizan through mass campaigns, it is now under control with realistic possibilities of moving from a controlled situation to elimination.
2. In 1 Corinthians 10:31 we read: So whether you eat or drink or whatever you do, do it all for the glory of God. In 1 Corinthians 11:20-22 When you come together, it is not the Lord's supper. You don't need to dive deep into the Bible. The Ten Commandments are the basis of each faithful Christian and in my classes at school it was one of the core elements of the subject religion.

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Screen the cases eligible for surgery. Result: 142 interventions of which 125 for cataract, 14 for entropion, 3 for pterygium. 2 children were operated on for congenital cataract. One single failure to repair sight was noted. The average cost for the patient was calculated at 15USD per patient.

In March 2012, an ophthalmological mission of 14 days was organised in the city of Bouar, principal town of the Diocese. The situation was comparable to that of 2010. Results: 96 interventions of which 88 for cataract, 2 for glaucoma, 2 for pterygium, 4 for entropion. 2 children were operated on for congenital cataract. One single failure to repair sight was noted. The average cost of the patient was 17USD. The increase of the indicator cost/effectiveness was attributed to the increase of the price of fuel, which had happened at the start of the year, as well as the increase in the price of certain medicines such as eyewash and eye creams.

The missions in these rural areas are so much more important when one considers the fact that in Central African Republic, there are only 5 ophthalmologists, who stay in Bangui, and there are only 2 ophthalmological centres, one in Bangui, the capital, and one in Bossanganga, 300km from Bangui and 450km from Bouar. It is therefore impossible for a blind person of the Diocese of Bouar, to travel to Bangui or Bossanganga because of financial difficulties and the challenges of travel.

For the future, the Diocese wishes to organise a mission every year, in collaboration with the Ministry of Health which is in touch with the CBM.

Dr Ione Bertocchi is Vice-President of the Board of ASSOMESCA (Association des Œuvres Médicales des Églises pour la Santé en Centrafrique) in Central African Republic, a member of EPN.

a. Cataract is a clouding that develops in the crystalline lens of the eye or in its envelope (capsule).

b. CBM is a German NGO of the Protestant Church that has as its mission to fight blindness. The relationship with the diocese goes back to the years 1982-1984 when there were no ophthalmologists in CAR. CBM sent several times even, a team of Germans to run activities against blindness, i.e. screening and operations. Afterwards, CBM has financed the ophthalmological clinic of Bossanganga in CAR. The relationship with ASSOMESCA is more recent.

c. Entropion is a medical condition in which the eyelid (usually the lower lid) folds inward.

d. A pterygium is a non-cancerous growth of the clear, thin tissue (conjunctiva) that lays over the white part of the eye.

e. Glaucoma is an eye disease in which the optic nerve is damaged in a characteristic pattern. This can permanently damage vision in the affected eye and lead to blindness if left untreated.

You don't need to dive deep into the Bible. The Ten Commandments are the basis of each faithful Christian and in my classes at school it was one of the core elements of the subject religion.

As the Lord spoke through Moses, He gave us guidance on how to treat each other, how to live within our family, with our neighbour, in our relationship with Him, our Lord. He also told us to work and to rest. Remember the Sabbath day by keeping it holy. Six days you shall labour and do all your work (Exodus 20:9-11). A balance of activity and rest is key to healthy life. Lifestyle diseases occur predominantly if we disturb this balance. A symbol of wealth and a decent lifestyle is wine. Again advice is laid down in the Bible. Do not gaze at wine when it is red, when it sparkles in the cup, when it goes down smoothly! In other words it is a snake and poisons like a viper. Your eyes will see strange sights and your mind imagine confusing things (Proverbs 23:31-33).

The increase of the indicator cost/effectiveness was attributed to the increase of the price of fuel, which had happened at the start of the year, as well as the increase in the price of certain medicines such as eyewash and eye creams.

The other half being taken up by the patient.

The hospitalisation costs for the patient above 2USD, some consumables and some simple medications such as compresses, eyewash and anaesthetics for children.

3. Christoffel Blind Mission® (CBM) offered:

- Sophisticated material (eye microscope, implants, surgical thread)

Two small villages in the rural area, Ngoundaye and Bocaranga, which have a health centre with an operating room, were chosen, as well as the city of Bozoum, principal town of the prefecture. The mission was carried out in 27 days, from 30th June to 28th July 2010.

Before the start, an evaluation of the blind and visually impaired was carried out, as well as the city of Bozoum, principal town of the Diocese. The situation was comparable to that of 2010. Results: 96 interventions of which 88 for cataract, 2 for glaucoma, 2 for pterygium, 4 for entropion. 2 children were operated on for congenital cataract. One single failure to repair sight was noted. The average cost of the patient was 17USD. The increase of the indicator cost/effectiveness was attributed to the increase of the price of fuel, which had happened at the start of the year, as well as the increase in the price of certain medicines such as eyewash and eye creams.

The missions in these rural areas are so much more important when one considers the fact that in Central African Republic, there are only 5 ophthalmologists, who stay in Bangui, and there are only 2 ophthalmological centres, one in Bangui, the capital, and one in Bossanganga, 300km from Bangui and 450km from Bouar. It is therefore impossible for a blind person of the Diocese of Bouar, to travel to Bangui or Bossanganga because of financial difficulties and the challenges of travel.

For the future, the Diocese wishes to organise an operation every year, in collaboration with the Ministry of Health which is in touch with the CBM.

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References

1. Presentation on CAR by the Ministry of Health, held in Dar es Salaam in March 2012.
Contact deals with various aspects of the churches’ and community’s involvement in health, and seeks to report topical innovative and courageous approaches to the promotion of health and healing.

Contact is available on the World Council of Churches’ Website:

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WHO Global status report on noncommunicable diseases 2010
This report sets out the statistics, evidence and experiences needed to launch a more forceful response to the growing threat posed by noncommunicable diseases. The report gives particular attention to conditions in low- and middle-income countries, which now bear nearly 80% of the burden from diseases like cardiovascular disease, diabetes, cancer and chronic respiratory diseases. The health consequences of the worldwide epidemic of obesity are also addressed.


Noncommunicable diseases country profiles 2011
A WHO global report featuring information about the noncommunicable diseases situation in 193 countries. This includes details of what proportion of each country’s deaths are due to diseases such as cancer, heart and lung diseases, and diabetes.


Diabetes, Fact sheet N°312, September 2012
Key facts, definition and explanations on diabetes, listing also consequences, prevention strategies and details on diagnosis and treatment.


Cardiovascular diseases, Fact sheet N°317, September 2012
Key facts, definition and explanations on cardiovascular diseases, listing also risk factors, common symptoms and strategies to reduce the burden.


2008-2013 Action plan for the global strategy for the prevention and control of noncommunicable diseases
This document is written primarily for the community of international development partners, as well as those in government and civil society concerned with urgent action to address the rapidly increasing burden of noncommunicable diseases in low- and middle-income countries.


NCDnet - Global Noncommunicable Disease Network
The NCDnet is a voluntary collaborative arrangement comprised of United Nations agencies, intergovernmental organizations, academia, research centres, nongovernmental organizations, and the business community, as identified in objective 5 of the 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases (NCD Action Plan). The overall vision is to reduce risk, morbidity and mortality related to tobacco use, physical inactivity, unhealthy diets, and the harmful use of alcohol, and four groups of diseases (cardiovascular diseases, diabetes, cancers and chronic respiratory diseases) through effective collaboration focused on achieving results in low- and middle-income countries.


NCD Alliance
The NCD Alliance unites a network of over 2,000 civil society organizations in more than 170 countries. The mission of the NCD Alliance is to combat the NCD epidemic by putting health at the centre of all policies.

http://www.ncdalliance.org/
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