

That is why a separate structure such as a resource center accessible to all diabetic patients is required with the following objectives:

- Care and information for diabetic children;
- Prevention of degenerative complications;
- Training for regional and provincial health professionals, necessary to improve quality of care in the provincial clinics.

Another guarantee for sustainability is to gather all partners involved around the project. Indeed, diabetes in children is a problem with many different aspects: clinical, but also social, political, scientific and economic. These partners are:

- public health and university doctors;
- communities through parents association;
- Faculty of Medicine;
- Ministry of Health;
- health insurance companies;
- sponsors and chemical laboratories.

III. Interventions

1. Care for diabetic children: the role of the medical team

This role is beyond simple outpatient consultation. Contact with the family of the diabetic child starts at the admission into hospital. A doctor from the medical team examines the patient to announce to the parents the diagnosis and its chronic aspect, as well as guidelines for care. Initial treatment – most of the children are admitted for decompensated keto-acidosis – is monitored. A protocol for initial care has been already developed and is available in all pediatric services.

Initial information and training starts the day after and include three steps:

- Daily learning of technical gestures under the supervision of a nurse.
- Basic theoretic program of five days, taught by a doctor.
- Basic dietetic program.

The educational material provided to all are an audio tape in dialectal Arabic developed locally and targeting above all illiterate mothers, as well as a range of educational cards illustrated in Arabic/French funded by the sponsor and a logbook in Arabic designed and produced locally.

The Hospital teacher contributes to this training by integrating educational messages in her lessons and giving literacy classes to children and sometimes mothers.

Continuous training after leaving hospital is provided twice a week. On-going training sessions are provided by a doctor and gather about thirty families. These group sessions allow deepening basic knowledge, recycling former patients, sharing experiences among families, and providing psychological support.

Methodology is different depending on the issue, but gives enough time to families' participation (focus groups, workshops, etc.). While one session aims at detailing the issues initially addressed at

the hospital, the other session focuses on adapting insulin dosage: parents bring along their logbooks and discuss their decisions with the doctor. Children who followed a 8-week training session receive a symbolic diploma which is always very much appreciated.

Clinical monitoring is provided at the outpatient clinic, on the second floor of the Children's Hospital. Each young diabetic is seen at least once a quarter for:

- monitoring his growth, weight, height, puberty development (each medical record includes a growth curve);
- seeking local complications (lipodystrophy), or a morbid association;
- motivating and deepening his knowledge;
- testing HbA_{1c} haemoglobin

A personalized letter is sent to parents to inform them about the results and measures to be taken.

After five years of evolution (earlier in case of poor follow-up), young diabetics are screened for complications: retinopathy through angiography, and nephropathy through microalbuminuria. This screening (performed every 2 years on average) is carried out thanks to a not yet formalized collaboration with ophthalmologists and nephrologists, with whom regular meetings have been held.

2. The community association's role

The parents association distributes insulin doses and strips to the poorest families according to a grid elaborated on the basis of social survey. This grid takes also into account assiduity and efforts. The association is also active in schools where it gets in touch with teachers in case of children difficulties, thus allowing the latter to follow classes as normally as possible. With the collaboration of the medical team, it contributes to children information living in difficult conditions and organizes summer camps.

Since 1995, it manages a cooperative to provide families with tools (injection kits, meters, glycaemia strips) required for the treatment and not reimbursed by health insurance. In addition, it organizes special events at the hospital and a fête at the end of the year to award diabetic children who provided efforts for their treatment.

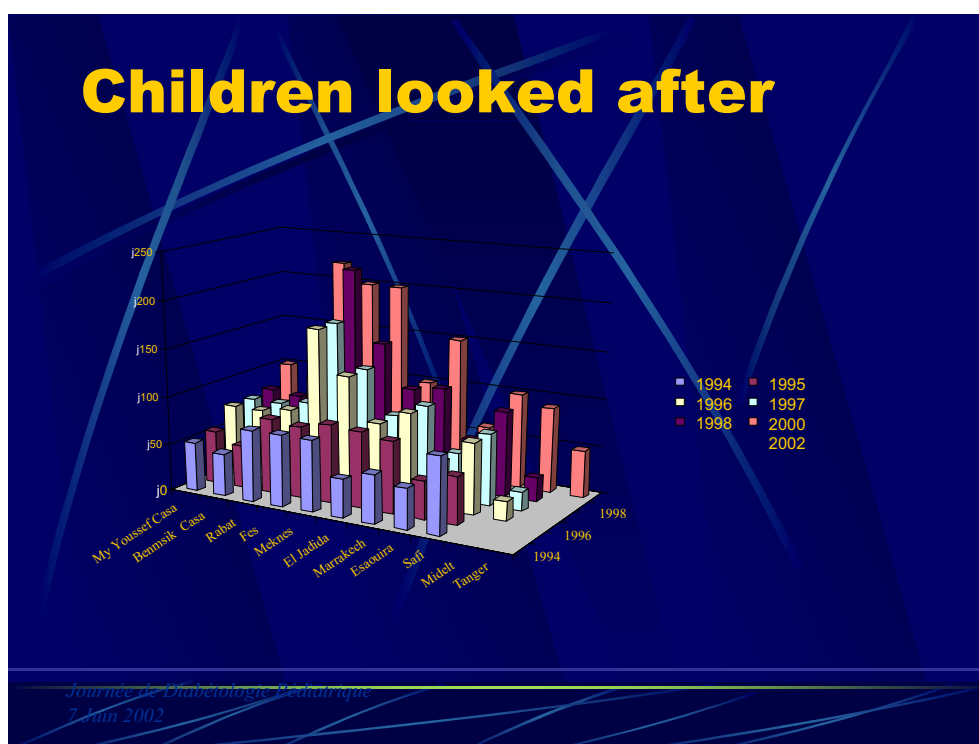
3. The sponsor's role

The sponsor provides quarterly the Rabat outpatient clinic for diabetic children with insulin and reactive strips. He funds educational materials production as well as a yearly continuous training session where participate health professionals in charge of peripheral consultations (see below). His material contribution allowed extending the experience to other hospital endocrinology services (see below). In 2001, he financed a database development, freediab, specifically designed for diabetes consultations.

4. Experience extension

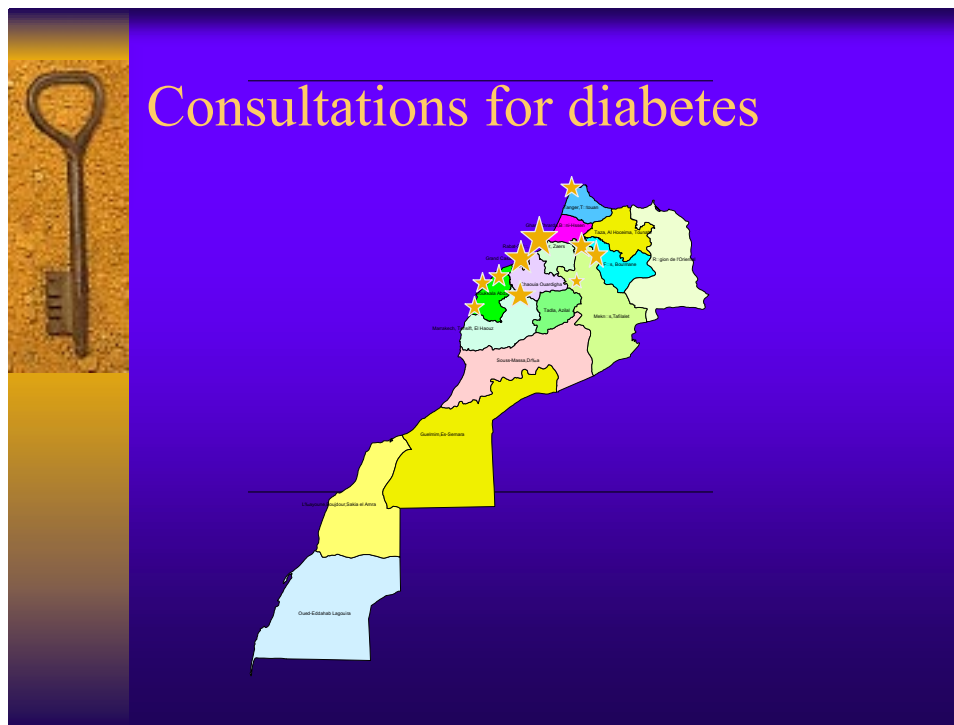
Since 1992, and thanks to the sponsor contribution, ten other clinics running on the same pattern have

opened in provincial public hospitals: Casa Ben Msik, Casa Moulay Youssef, El Jadida, Safi, Essaouira, Marrakech, Meknès, Fes, Midelt, Tanger. Sponsoring concerns insulin and urine strips, two HbA_{1c} haemoglobin tests per patient and per year, as well as medical files and logbooks. Altogether, 3,000 out of about 10,000 young diabetics in Morocco are monitored in these clinics linked via a network to the Rabat clinic.



In addition to sharing common educational materials, this network includes a database developed by a group of young Moroccan computer specialists in collaboration with the Rabat team. This database is available on Internet and is already been used in Rabat, thus allowing monitoring harmonization among the different clinics and operational research thanks to a programmable explorer.

Beyond insulin and strips, another important issue for these peripheral clinics is the quality of care. The quality required to avoid diabetes complications supposes the patients and their families' information and training which means theoretic and practical initial and continuous training of health professionals. Quality means also follow up and monitoring: The connection to the Internet network with different code accesses, will allow a central administrator quality (growth and HbA_{1c} haemoglobin rate, number of consultations per patient and per year, etc.). Quality depends also on early screening for complications possibilities. Specialists (ophthalmology, biology, nephrology) shall be hired and trained and a screening protocol jointly developed by clinics for diabetic children and the Ministry of Health regional Centres.



Clinics for diabetic children:

Rabat, Casablanca, Meknes, Fes, Marrakech, El Jadida, Essaouira, Safi, Midelt, Tanger.

IV. The results

1. General results

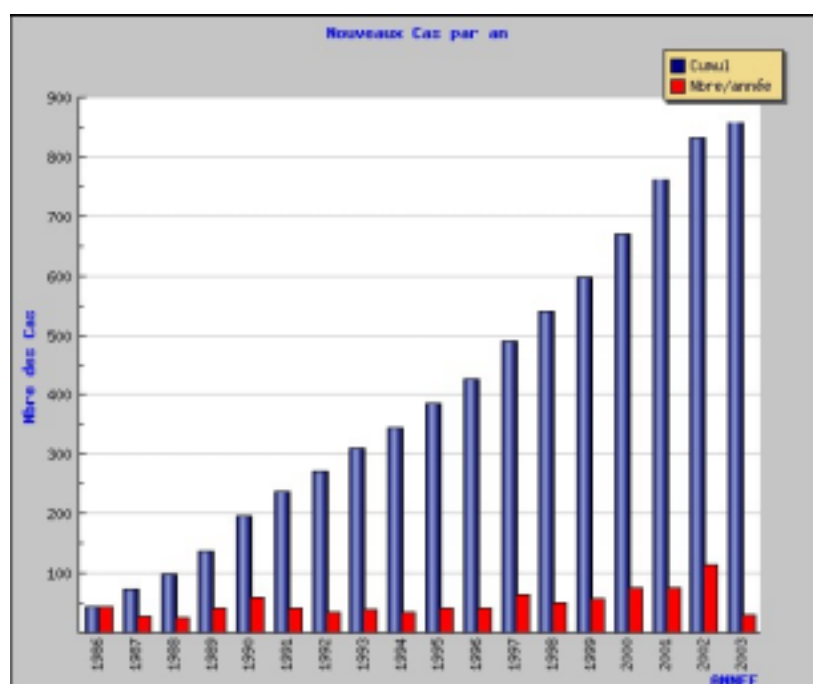
The results are particularly encouraging:

- All children are autonomous for their injections and daily monitoring.
- Their growth has notably improved: while 25% out of the 131 young diabetics looked after at the children's hospital had a short height, the 236 children looked after since the beginning of their diabetes up to the end of their growth have a normal height⁴.
- The number of hospitalization days significantly decreased: while in 1985, the number of hospitalization days amounted to about 700 for 131 young diabetics, among which 7 new annual cases who used to stay in hospital around two weeks for diagnosis, it amounted to 500 in 2000 for 600 young diabetics among which 80 new cases.
- The lack of statistics before 1986 does not allow us to demonstrate a decrease of mortality (in our case, ten deaths in fifteen years among children living almost always far from hospitals and related mostly to a major hypoglycemia, but also to a 4 times associated pathology and severe acidosis).
- It is also too early to appreciate the impact on degenerative complications incidence, but these occur later today and are only seen in young diabetics who have a poor metabolic control¹. A recent study done in Rabat demonstrates that after 10 years of diabetes, retinopathy is six times less frequent among regularly monitored children since the beginning of their diabetes.

2. Specific monitoring indicators

1. Care of diabetic children

a. New cases of diabetes



The clinic includes today more than 800 children among which about 650 are regularly monitored. These children mean age currently 12,5y with extremes, from 14 months to 23 years. While the mean age of onset is 10.64 years (9 months-15 years), early cases are more frequent and 137 children started their diabetes before being 5 years old.

The number of new diabetes cases per year recorded at the consultation measure the consultation relevance. The number of new cases of children under 15 years amounted in 2002 to 110, which shows that this clinic is adapted to the diabetic population needs and is the only place where information/training are delivered in a systematic and organized way.

Apart from a few exceptions, this figure corresponds probably to the yearly diabetes incidence on the population aged below 15 years from Rabat-Salé. It shows a dramatic 27% increase compared to 2001. This increase might be related to the public and physicians better knowledge of the clinic. We also notice that while the number of children coming from the region (89) has not really changed, 21 children come from other Moroccan regions. This is related to the lack of appropriated follow-up in some moroccan areas.

b. Patients social and economical profile

Young diabetics hospitalised in 2002 represent as in all the region social categories (civilian servants, teachers, artisans, workers).

While 41% of the families have no steady work and 7% are totally poor, 8.4% of diabetic children

are senior executives, i.e. a slightly increasing rate compared to last year. 27.36% of these children have parents who are civilian servants, teachers or military and 32.6% have a medical insurance (mostly *mutuelle générale des fonctionnaires*), which significantly represents the same rate as in 2001.

c. Mortality due to keto-acidosis

This indicator is the first one to reflect the quality of initial care. No death due to keto-acidosis has been recorded in Rabat in 2002, even if we include the twelve cases initially admitted in intensive care. This result might be partially related to a better knowledge of child diabetes and thus an earlier diagnosis and a stricter implementation of protocols upon arrival into the service. It must nevertheless be explained by the relative weak mortality rate due to keto-acidosis and is to be observed during a longer period.

d. HbA_{1c} haemoglobin rate

This indicator shows objectively that metabolic control quality decreased from 9% to 8.29% $\pm$ 2.05 in the Rabat consultation. This decrease is only partly related to a higher number of new patients during the last ten years and thus with a higher percentage of diabetics with partial “honeymoon” remission.

It is linked to the adoption of a more precise HbA_{1c} dosing technique similar to the HPLC technique. The improvement of metabolic control on most diabetics is also probable, but it needs more time to determine if this improvement is definite. About 36% of the patients have a very satisfying HbA_{1c} haemoglobin rate, inferior to 7.2%.

Provincial Centres for diabetic children suffered this year from technical difficulties, thus impeding to centralize dosing in Casablanca. These Centres will be equipped in 2003 with performing dosing machines and will be able to perform their own analysis. Training has been provided during the last annual meeting held in Casablanca on June 7, 2002.

f. Number of re-admissions

The present report can be assessed on the number of re-admissions due to keto-acidosis in diabetics already monitored at the clinic. This metabolic complication which is a cause of mortality can indeed be prevented through information and appropriate training and early care at home. Re-admissions increases the care cost and means a prevention failure.

In 2002, 19 re-admissions due to keto-acidosis have been observed. This percentage (2.5% of all diabetic children) is approximately the same than in 2001. Nevertheless, these 19 hospitalizations concern only 14 patients. Iterative re-admissions in these cases were due to insulin unavailability as well as families low income. Generalizing visits at home should improve the current situation.

2. Partners' involvement

a. The vice-director of the public health insurance company sent a note to his staff asking them to reimburse strips and diabetes devices. We are waiting for implementation after the decisions (number of reimbursed daily tests, validated devices and strips, etc.) of the Committee where we are included. In this Committee, all decisions will be based on already developed treatment standards.

b. The diabetic children's parents association has launched a new experience on small scale (three visits per week, six visitors): since April 2002, visits at home for poor diabetic children or with family problems. Even if we still do not have a formal assessment, this action seems already to be very useful. The visits are performed by young diabetics who use to be monitored at the clinic. They were provided training: technical recall, assignment limits, communication notions. Briefing meetings are monthly held at the children's hospital

c. A partnership about child diabetes is organized in Rabat. During the first meeting held on June 28, 2002, all actors concerned by child diabetes have been gathered: parents, professors from the faculty of medicine and health Centres professionals, the public health insurance company manager, physicians in charge of diabetes at the Ministry of Health, chemical laboratories representatives. The dean of the Faculty of Medicine promised to participate to the creation of a future association. This meeting led to the creation of an association, Badil (alternative) whose objectives are: sensitising on diabetes, building an integrated Centre to looking after diabetic children and discussing with public health insurance. For more efficiency, this association should merge with the diabetic children parents' association whose status does not allow managing a clinic. Badil gathers in his Board of members main stakeholders and families, Ministry of health, Faculty of Medicine, University hospital and sponsors' representatives. It should delegate the clinic management accordingly to diabetic children needs. Meetings of the Board were held on November 29 and December 21, 2002. The Board already developed sensitising materials and a logbook that has been validated by diabetic children Centres during their annual meeting in June 2002.

V. Conclusion

Progress performed at the Rabat outpatient clinic are beyond previsions . Some progress is still to be done in the provinces, but it is related to the creation of a Resource Centre in Rabat.

It seems also necessary to guarantee quality and effectiveness to organize diabetic children monitoring in appropriated clinics through all Moroccan provinces.

These clinics linked via a network are naturally integrated in the health system. They are connected to the MOH dispensaries who remain in charge of daily monitoring for diabetic children living far from hospitals and to MOH provincial resource centers for early screening of degenerative complications.

In 2001, action for diabetic children was selected as Towards Unity For Health project , a WHO initiative aiming to improve Health status by fighting against fragmentation of the Health offer and following some criteria. Referring to it's design and implementation, the experience runed at the Rabat children hospital with diabetic children sticks totally to TUFH criteria of relevance, quality, equity and efficiency at the best value for money.

The example of child diabetes could be used for the follow-up of other chronic diseases. Programming based on in-site health professionals and patients needs, initiation on a small scale, focussing on geographically targeted population, standardizing the approach based on equity and efficiency, are elements to be extrapolated. As for other chronic diseases, the diabetic children medical follow-up must combine care services and preventive action concerning behaviour, style of living, nutrition, schooling and socialization. All these interventions must be integrated.

For chronic diseases, resorting only to health professionals is not enough, especially that their cur-

rent specialized training does not entitle them to do so; for sustainability and viability, the approach must also appeal to political, economical and social operators. As well as necessary alliances with the Faculty of Medicine (train doctors more socially involved), political decision makers (for more beneficial regulations) and health insurance (for total refunding), partnership with funders seems to be necessary to ensure the same care quality for all.

Above all, the patient himself and his family must become allies and well informed partners thanks to this approach based on information and training.

References

1. A. Balafrej, B. Benhammou, N. Bennani, A. Jamaï, Z. Mohcine, Retinopathy in young diabetics at the Rabat Hospital, 28th Annual meeting of the international Society for Pediatric and Adolescent Diabetes, September 2002, Austria.
2. A. Balafrej, M. Khattab Bulletin de la SMSM. Tome 10, N°4, août 99, pp.40-41
3. Boelen C. Vers l'Unité Pour la Santé. Défis et opportunités des partenariats pour le développement de la santé. Document de travail. Genève Sherbrooke Québec, OMS, 2002.
4. Fatiha Halimi Croissance des enfants diabétiques suivis à l'HER. Thèse de médecine n°244, June 2000, 62 p.
5. International Society for diabetic and adolescent diabetes Consensus Guidelines for the Management of type 1 Diabetes Mellitus in Children and Adolescents, 2000, Medical Forum International, 128 p
6. Jamaï A « Rétinopathie chez le jeune diabétique : épidémiologie et facteurs de risque ; expérience de l'hôpital d'enfants de Rabat 1986-2000 » [Thèse med], Rabat, Université Mohammed V, 2002, 110 p
7. Mouzouni F Z, El Madani T, Saad A, Ottmani S, Chaouki N, Mahjour J. Bulletin épidémiologique, ministère de la santé du Maroc, 1999, n°38 : 2-10
8. WHO Study group on diabetes mellitus. Technical report series, N°727 Geneva

Sustaining Comprehensive Health Care for Diabetic Children in MOROCCO



*Amina Balafrej
Genova , 1.08.04*

OUTLINE

- **I. Context**
- **II. Methodological approach**
- **III. Interventions**
- **IV. Results**
- **V. Conclusions**

CONTEXT

- **2 million Moroccans suffer from Diabetes in Morocco**
- **Around 100,000 of them are insulin dependent.**
- **About 10.000 children under 15y have type1 diabetes .**

Mahjour J. Bulletin épidémiologique, ministère de la santé du Maroc, 1999,n°38 : 2-10

Diabetic Children in Rabat

- Until 1986 young diabetics relied on the health centers for their daily insulin injections
- Frequent readmissions into the hospital
- Delayed growth concerned 25% .
- Early onset of degenerative complications .

METHODOLOGICAL APPROACH

Health Care for diabetic Children at Rabat Children's Hospital

- Created in **1986** to reduce medical and social impact of diabetes by :
- **Informing and training .**
- **Standardizing medical follow-up.**
- **Providing material support to the poorest**

Health Care for diabetic Children at Rabat Children's Hospital

Objectives :

Prevention of

- Iterative rehospitalizations (acute metabolic complications)
- Delayed growth
- Degenerative complications .
- Exclusion from school and from social environment.

Combines medical and preventive approach

Health Care for diabetic Children at Rabat Children's Hospital

Assistance provided by :

Ä Associations of :

- Parents of diabetic children (1987)
- Promotion of pediatric diabetology « Badil » (2002)

Ä Sponsor (1990)

Ä Health specialists(nephrologists, ophtalmologists)

INTERVENTIONS

At the Rabat Children's Hospital

Interventions

- **I-Role of the Medical team**
- **II-Sponsor**
- **III-Community's Association role**



The role of the medical team

The role of the medical team

- Initial treatment (protocol)
- **Initial information and training**
- **Continuous training for children and families**
- Medical monitoring
- Screening for complications

Initial training



Educational materials



I-2 Clinical monitoring

Once a quarter :

- Monitoring of growth (curve) and puberty development
 - Checking Blood Pressure
 - Testing HbA1c
- ★ **All data recorded in a specifically designed Database « Freediab » (2001)**

I-3 Screening for complications

After 5 years of evolution screening for :

- **Diabetic retinopathy by angiography**
- **Nephropathy by microalbuminuria**

II-The sponsor's role

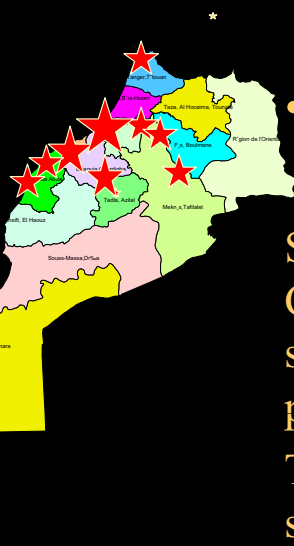
- **Provides regular subsidies**
- **Funds educational materials production**
- **Organizes yearly continuous training sessions**

Allowed extending the experience to other hospitals

Health Care for diabetic Children at Rabat Children's Hospital

E3

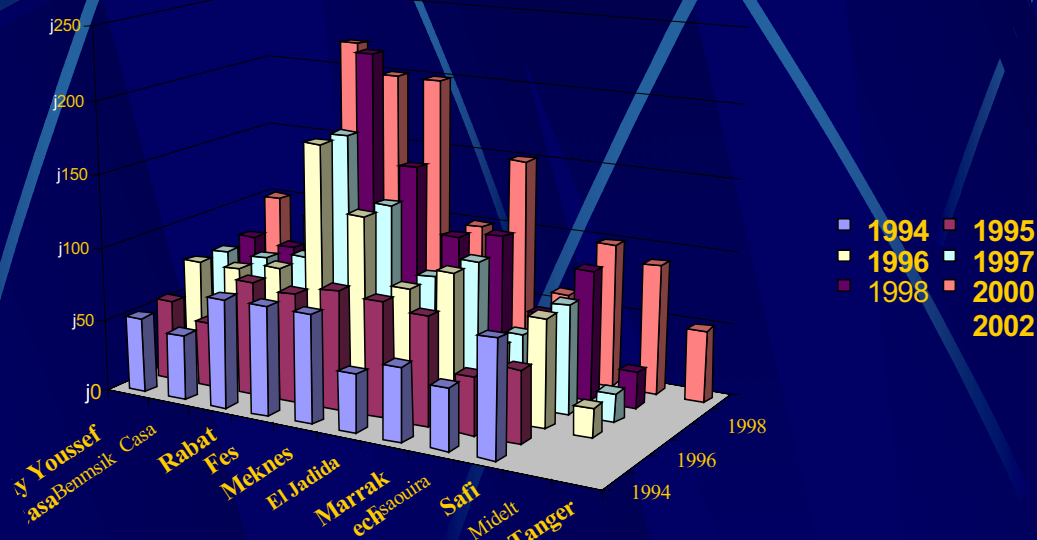
WORKSHOP III



•Extension

Since 1992 , ten new Clinics running on the same pattern opened in provincial public hospitals
Thanks to the same sponsor

Diabetic children monitored in the clinics



III-The community association's role

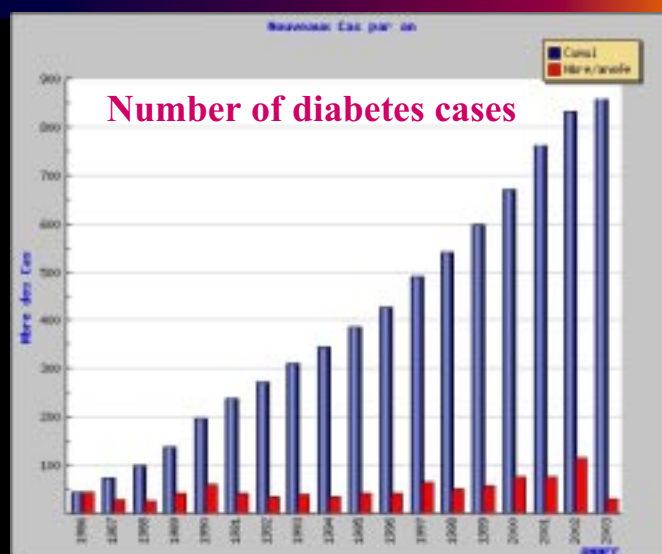
- **Distributes sponsor's subsidies to the poorest families**
- **Manages a cooperative**
- **Acts helping students in schools**
- **Organizes summer camps**

RESULTS

General Results at the RCH

- I-Better knowledge of Diabetic Children**
- II-Children's and families autonomy**
- III - Better metabolic control**
- IV-Improvement of growth**
- V- Decrease of hospitalization days**
- VI -Degenerative complications**

I-Diabetic children :New cases at the Rabat Children's Hospital



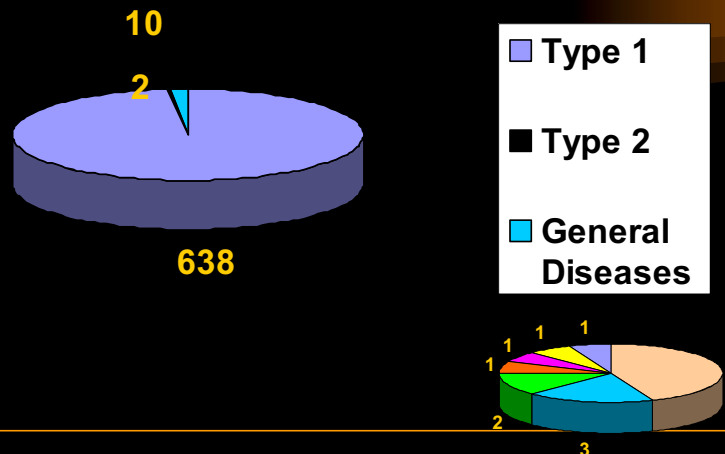
I-Diabetic children at the RCH

- 650 regularly monitored in 2002 (36 in 1986)
- M Age of onset : 10,64y (9 ms -15 y)
- M Age : 12,5 y (14ms – 25 y)
- 110 new cases under 15 y in 2002(7 in 1986)
- Medical insurance : 32,6%

I-Diabetes at the RCH : Incidence in young children

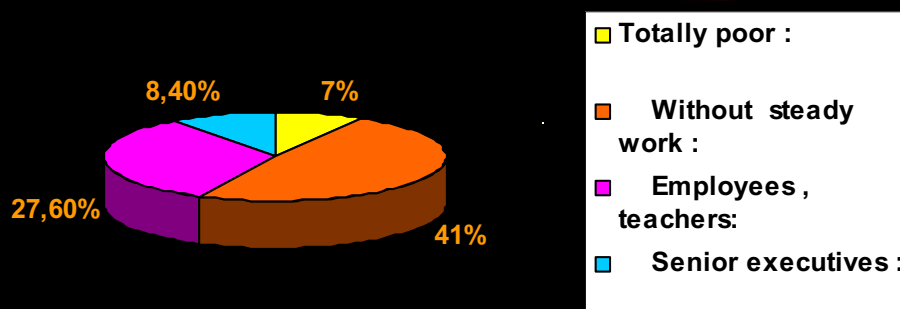
- **Age of onset under 3 y :**
Incidence 1986-2000 : 21 (4%)
2001-06.2003 : 43 (13%)

I-Diabetes Type



Consanguinity : 32% (vs 6% for non diabetics)

I-Social categories



All social categories represented

II-Metabolic control

Since 1989 , steady improvement of metabolic control

- **HbA1C M (2000) $8,29 \pm 2,5 \%$**
- **NV= 4-6% (9% in 1998)**

III-Growth

- **Normal Final Height of the patient's group monitored from the beginning $-0,85 \pm 1,11$ S.D. vs $-2 \pm 1,38$ S.D. for others.**

*(Halimi , F Thèse N° 244 , 2000 Fac de médecine Rabat),Balafrej A
ISPAD , Nov.2000)*

IV-Readmission's rate

- **2% of diabetics readmitted for DKA in 2001 , vs 25% in 1986 .**



Significant decrease.

V-Degenerative complications

After 10 years of DD :

- **Sixfold decrease of DR .**

90% of diabetics, monitored from the beginning, present a normal angiography vs only 30% of those without initial medical monitoring .(124 patients screened)

Jamai A , thèse de médecine 2002 , Balafrej A ISPAD , Graz , Sept.2002

- **Threefold decrease of DN .**

M delay before medical monitoring 5 y for diabetics with DN vs 3 months for the healthy ones.(N: 215)

Zairi A , Thèse N° 294 , Rabat , Déc. 2001

Conclusion

- **Progress** performed are beyond previsions
- Approach based on **information and training** turns the patient into a well informed allie
- **Partnership** with Faculty of medicine as well as community's association and funders necessary to ensure th **same care quality** for all
- The example of child diabetes could be used for the **follow-up of other chronic diseases**



T1D IN THE YOUTH LEBANESE

El Sandid Mohamed MD

Président of the Lebanese Diabetes Society

Genoa 8 jan 2004



DEMOGRAPHICS (2003 ESTIMATIONS)

Ñ **TOTAL POPULATION # 3.5 M**

Ñ **ENDOCRINOLOGIST/DIABETO = 104**

Ñ **TOTAL NB PHYSISIANS # 10 000**

CS 09/01/2004



L.D.S ENQUIRY 2003

QUESTION :

- HOW MANY T1D < 20 YEARS ARE YOU FOLLOWING NOT AT CCC???

PHONE CALL TO:

- 100% DIABETO/ENDOC.
- 78% MEDICAL COMMUNITY

C.S 09/01/2004



RESULTS

631 REPORTED CASES

C.S 09/01/2004



C.C.C.??

~ CHRONIC CARE CENTER

- CARITATIVE INSTITUTION

- THALASSEMIC CHILDREN

- T1D CHILDREN

~ 985 T1D < 20 YEARS OLD

C.S 09/01/2004



DEMOGRAPHICS

~ TOTAL CHILDREN WITH T1D # 1516

~ INCIDENCE AT CCC 194/2003

~ ESTIMATED ERROR =>> 2000

~ ESTIMATED T2D ADULT # 350 000

<1%?

C.S.09/01/2004



Etude sur 110 DT1

~ Centre de la société Libanaise du D

~ Durée : 4 ans 1998-2002

~ Age 5-16 ans

~ 3 Groupes:

~ 45 DT1 ont un D-5 ans

~ 35 DT1 ont un D entre 5-10ans

~ 30 DT1 ont un D entre 10-16 ans

~ 58 filles –52 Garçons



Examens Pratiques

~ HbA1c tous les 3-4 mois

~ Micro Albuminerie/24 H tous les ans

~ Fond D'oeil tous les ans

~ Glycemie à jeun-PP (par les patients)



TRT

- Protocol DCCT
- 78% des patients sous 4 inj. Insuline/j
- (2 Rapid-2 NPH)
- 12% des patients sous 3 inj/j
- (2Rapid-1 NPH)
- 10% des patients sous 3inj/j
- (1 Rapid –2 NPH)



Resultats

- Ñ Tous les patients ont un F.O NI
- Ñ Microalbuminuries /24 h surveillees
- Ñ HbA1c à diminuée en moyenne de 1.9%
(durant les 4 ans d' etude)
- Ñ Hypoglycemie moyenne 2.5/100 P/ans



Situation des DT1 au LIBAN

- ~ 20% des DT1 entre age 0-5 ans
- ~ Mères de ces Diabétiques: 25-35 ans
- ~ La majorité : première gestation
- ~ 90% diagnostiqués à la suite d' une A-C- D



Conclusions

- ~ DCCT (TRT Intensif) est le modél idéal
- ~ L'education a donnée une reduction remarquable de l'HbA1c.
- Chaque patient a participé à 13 séances
- D'education en moyenne pdt 4 ans (au centre de la société libanaise du diabète.
- ~ Difficultés:
 - Convaincre les patients et leurs parents au TRT intensif.
 - Prise en charge couteuse (400-500\$/mois-Ins-tests-bandelettes-cons...)

Children and the Mediterranean

I Bambini nel Mediterraneo: Salute, Cultura e Assetto Urbano

Workshop 3
January 8th 2004
"Diabetes mellitus and children
in the Mediterranean"

Background paper:
"The concerted action
of IDF in the
Mediterranean Countries"

Prof. Massimo Massi Benedetti
University of Perugia – Italy
Vice-President IDF

Genova 7-9 gennaio 2004



E3

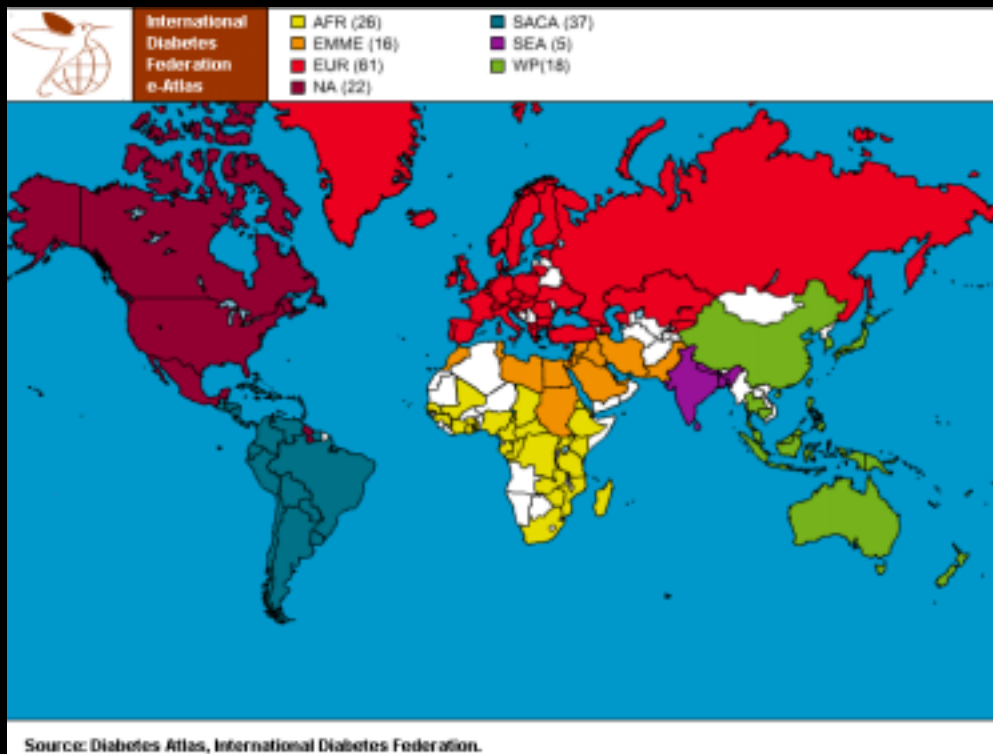
WORKSHOP III

INTERNATIONAL DIABETES FEDERATION **MISSION**

The mission of the
International Diabetes Federation
is to work with the Member Associations
to enhance the lives of
people with diabetes



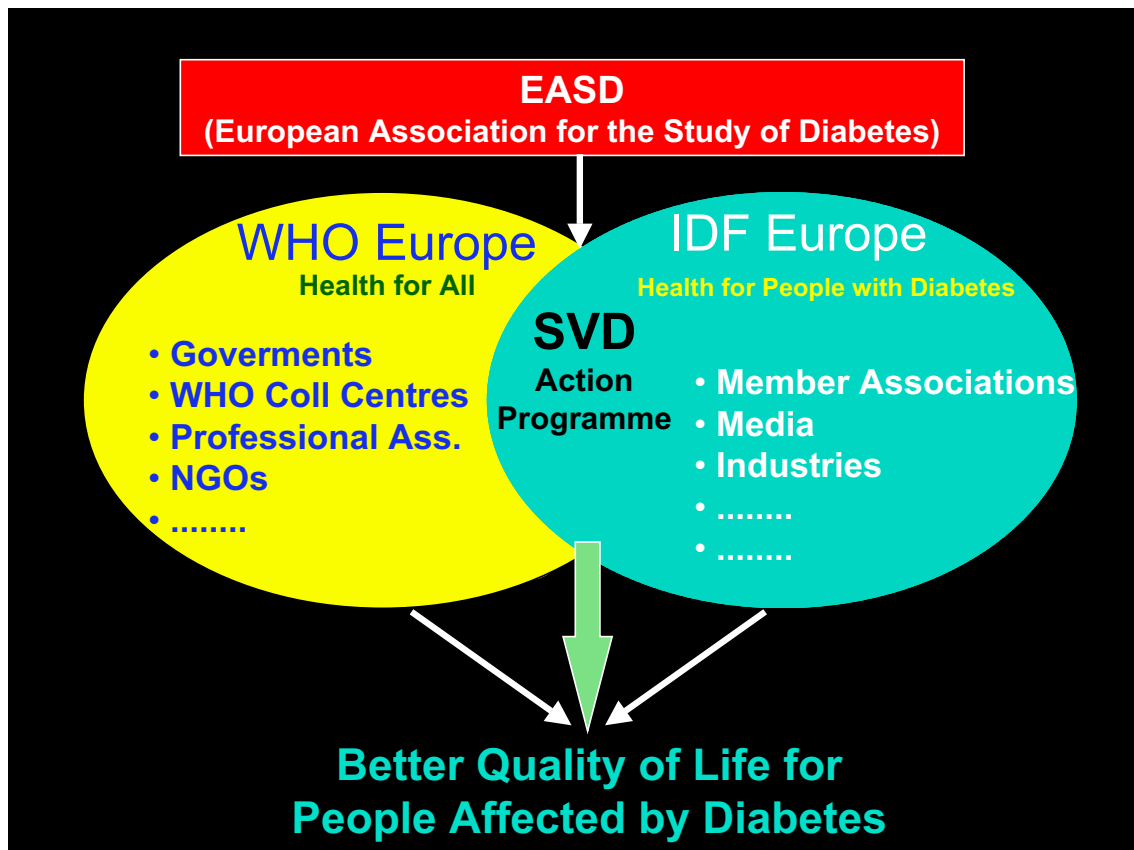
IDF MEMBER ASSOCIATIONS (185) AND REGIONS (7)



IDF European Region



Total population:	655 millions
People with diabetes:	22.5 millions
Member associations:	61
Countries represented:	40



IDF EUROPE STRATEGIC PLAN 2000-2006

TARGET

To prevent the diabetes condition and its complications

HOW ?

By rising awareness and influencing top decision makers

- at national, regional and local levels
- at the European Union level

THROUGH

- the People Living With Diabetes
- healthcare professionals
- politicians
- administrators
- the public in general

IDF EUROPE STRATEGIC PLAN 2000-2006

ACTIONS

Areas of general interest

- Ethics
- Socio-economics
- Communications

Local regional activities

- EU
- Mediterranean countries
- Central European countries
- Eastern European countries

IDF EUROPE STRATEGIC PLAN 2000-2006

PARTNERSHIPS

- Member Associations
- IDF Global
- EASD
- EU
- WHO
- Governments/Health Care Authorities
- International NGOs
- Industries

IDF EUROPE STRATEGIC PLAN 2000-2006

EU

IDF Europe's role :

- Recognised diabetes presence in Brussels (lobbying)
- Intelligence gathering (documents...)
- Central point for exchange of information for MAs
- Ensure unity: uniform priorities & messages agreed by the MAs
- Coordinate individual lobbying campaigns, informing MAs of threats & opportunities + advising appropriate action.
- Reporting to MAs of E.U. legislative developments
- Maintain a 'managed knowledge base' about campaigning at E.U. level
- European legislation watchdog activity.
- EU Projects

ACCREDITATION



IDF EUROPE STRATEGIC PLAN 2000-2006

MEDITERRANEAN COUNTRIES

Specific characteristics

Geo-cultural area of contact of 3 continents

Actions

1. Improve live of people with diabetes in developing countries through the training of professionals and local investment deriving from EU and/or Governmental agreements.
2. Diabetes care to immigrants (legal and illegal)



EURO-MED PARTNERSHIP

REGIONAL STRATEGY PAPER
2002 - 2006

&

REGIONAL INDICATIVE PROGRAMME
2002 - 2004



The **MEDA Regulation** focuses on supporting the participation of Algeria, Cyprus, Egypt, Israel, Jordan, Lebanon, Malta, Morocco, Syria, Tunisia, Turkey, Gaza/West Bank in the Barcelona Process, which is the cornerstone of the EU' policy in the Mediterranean Region

MEDA HEALTH PRIORITIES

- Support policy making, regulatory and monitoring role of Ministries of Health.
- Help establishing sustainable financing of health services.
- Provide equal access to quality health services.
- Improve quality of services and to develop health information.

IDF EUROPE PROJECTS



EU MEDA Programme

for cooperation in the area of the Mediterranean countries.

“Catania (I), May 24-25 2003”

Training session and preliminary meeting for proposal submission in the area of diabetes

IDF Europe Catania MEDA workshop

COUNTRIES REPRESENTED

Cameroon, Cyprus, Croatia.

Egypt, France, Greece,

Israel, Italy, Jordan,

Lebanon, Malta, Syria,

Tanzania, Tunisia

PARTICIPATING ORGANISATIONS

International Diabetes Federation

World Health Organisation

BROAD AREAS OF WORK FOLLOWING THE MEDA HEALTH PRIORITIES

INFORMATION SYSTEMS

establishing surveillance systems for diabetes integrated into national programmes

POLICY DEVELOPMENT

developing legislative, managerial and technical components for primary prevention programmes

HEALTH FINANCING

costs of diabetes cost-effectiveness of interventions

ACCESS TO QUALITY HEALTH SERVICES

primary health care projects: integrating diabetes care into PHC: guideline development-evidence based medicine, training and education (e.g. developing model projects – discrimination...)

IDF Europe Catania MEDA workshop outcomes

INFORMATION SYSTEMS

- Prevalence of diabetes/risk factors
- Improvement of current surveillance system
- General database (~registry)
- Develop “simple” registration form
- Collect information per country (questionnaire)
- Surveillance system NCDs

IDF Europe Catania MEDA workshop outcomes

POLICY DEVELOPMENT

- Ministry of education and Ministry of health.
- Creation of education programmes.
- Prevention campaigns.
- Children, general public, professionals, policy-makers, welfare officers.
- Networking.
- Primary prevention: food, smoking control, physical exercise.

IDF Europe Catania MEDA workshop outcomes

FINANCING

- **Cost-effectiveness research**
- **Analysis of investment in education and self-management**
- **Cost-effectiveness of risk-reduction.**

IDF Europe Catania MEDA workshop outcomes

ACCESS TO CARE

- **Training programmes – GPs “Train the trainer”**
- **Awareness campaigns / behavioural changes**
- **Improving and implementing national programmes (include rapid “appraisal”)**
- **Motivating medical professional for education and networking**
- **Improve food care (schools, technical centers, factories)**
- **Building centres**
- **Diabetes training centres**
- **Local health centers (e.g. provision of insulin)**
- **Screening**
- **Integrating optimal diabetes care: primary care**

IDF Europe Catania MEDA workshop outcomes

THREATS

Difficulties in operative cooperation between Diabetes Associations, Governments and Local Authorities.

OPPORTUNITIES

- **IDF Europe credit amongst the EU Institutions**
- **So far low MEDA investment in health sector**
- **Request of the EU Parliament for heavier involvement of NGOs**

THE WAY FORWARD



- **Formalise the Mediterranean Action as a 3 IDF Regions (Europe, East Med-Middle East and Africa) initiative within the IDF Global Strategic Plan**
- **Look for synergies**
- **Finalise projects**
- **Lobbying for successful MEDA applications**
- **Implementation of the projects**