

Diabetes Care in Guinea: Challenges and Solutions

Amadou Kake^{1,✉}

¹Department of Endocrinology, University Gamal Abdel Nasser of Conakry, Conakry, Guinea

Address for correspondence Amadou Kake, MD, MSc, Department of Endocrinology, University Gamal Abdel Nasser of Conakry, 6306 Conakry-République de Guinée, Guinea (e-mail: amadoukake@gmail.com).

J Soc Health Diab 2019;7:34–35

In Guinea, the 2009 Steps survey conducted in Conakry highlights a prevalence of 5.6% in patients aged 25 to 64 years. Undiagnosed diabetes cases were 57.3%, and of the known cases, 68.5% were untreated.¹ Poor control of diabetes (hemoglobin A1C (HbA1C) \geq 7%) was noted in 84% of Guinean diabetics, of whom, 41% had HbA1C \geq 10%.²

Moreover, different studies showed that diabetes is often complicated: 20% of patients on dialysis.² In addition, 5% of diabetic patients seen in 2000 were blind,² and 10% of them sustained an amputation in the thigh in 2001.³ Nearly one-half of men with diabetes (48.4%) surveyed in a study in 2003 showed erectile dysfunctions.⁴ A study conducted in 2000 showed that 8% of patients had a stroke.⁵

Cardiovascular risk factors were also noted in the 2009 Steps survey in Conakry. Hypertension was found in 33.4% of the population aged 25 to 64, 67.9% of them were not known before the study, and 87.5% of all patients with high blood pressure were not treated. In addition, 14.3% of the population had hypercholesterolemia (total cholesterol \geq 190 mg/dL), 10% were smokers, and 59.3% did not have any physical activity.¹

In the hospital, diabetes-related mortality (7.67% of admissions) was essentially the result of acute complications (ketoacidosis) entangled with infectious complications including diabetic foot lesions.⁶

Diabetic patients in Guinea face enormous difficulties in accessing care because of the lack of qualified medical and paramedical personnel, insufficient diabetes care facilities, the scarcity of affordable and reliable drugs and equipment, and limitation of geographical and financial accessibility (high out-of-pocket payment). Less than one-third of the patients can afford the direct cost of diabetes. Less than 1.5% of Guineans are covered by multiple fragmented community health insurances, whereas 47% of the population is living below poverty line.^{7,8}

In Guinea, all diabetic patients are managed at the tertiary level, and the gaps at the first line and secondary level are filled by a various number of providers. These include, but are not limited to, private for-profit care providers and traditional healers.⁹

These barriers are an impediment to the early diagnosis and appropriate diabetes case management. They lead to more complications and diabetes-related deaths.

The growing number of people in need of care for diabetes is proving to a challenge for the Guinean health system. This situation is worsened by the burden of communicable diseases including the Ebola virus disease (EVD).¹⁰

It is important to decentralize the care (first and second lines) and also build a partnership between the health system and community to reduce the economic burden of management of NCDs through continued care within the community and to enhance patients' awareness and knowledge via counseling activities revolving around drug adherence, lifestyle changes, psychosocial support, and peer support groups. It is also important to train and task shift (from doctors to nurses or from nurses to stable diabetic patients), to negotiate standardized price for a selected package of activities and generic drug, and to introduce social health insurance in Guinea.

Conflict of Interest

None declared.

References

- 1 Ministère de la Santé. Guinée (Conakry et Basse Guinée) Enquête STEPS 2009 Note de synthèse Guinée (Conakry et Basse Guinée) Enquête STEPS 2009 Note de Synthèse; 2010:6–7
- 2 Camara A, Baldé NM, Sobngwi-Tambekou J, et al. Poor glycaemic control in type 2 diabetes in the South of the Sahara: the issue of limited access to an HbA1c test. *Diabetes Res Clin Pract* 2015;108(1):187–192
- 3 Balde NM, Kaké A, Diallo AB, Condé B, Camara A. DiM. Pied Diabétique: Facteurs de risque dans le Service de Diabétologie du CHU de Donka. *Le Bénin Médicale*. 2005;30:52–55
- 4 Baldé NM, Diallo AB, Baldé MC, et al. Dysfonction érectile et diabète: Fréquence et profil clinique à partir de 200 observations. *Andrologie*. 2012;22(2):96–101
- 5 Baldé MD, Baldé NM, Condé M, Camara MY. Atteintes cardiaques au cours du diabète: étude de 112 cas. *Guinée Médicale*. 2000;29:1–5
- 6 Ministère de la Santé. Politique Nationale de la Santé; 2001:24
- 7 Baldé NM, Camara YB, Kaké A. Barry IS S-BMDA. Coûts médicaux directs de la prise en charge hospitalière du diabète au CHU de Donka. *Guinée Médicale*. 2000;29:21–27

✉ Amadou Kake's ORCID is <https://orcid.org/0000-0003-0520-6545>.

received

November 19, 2018

accepted after revision

November 21, 2018

DOI <https://doi.org/>

10.1055/s-0039-1685244

ISSN 2321-0656.

©2019 Novo Nordisk Education Foundation

License terms



- 8 Baldé NM, Kaké A, Barry ISS-BM. Sources du financement de la prise en charge médicale du diabétique en Guinée: étude de cas à partir d'une série hospitalière. *Guinée Médicale*. 2001;31:32-36
- 9 Baldé NM, Youla A, Baldé MD, et al. Herbal medicine and treatment of diabetes in Africa: an example from Guinea. *Diabetes Metab* 2006;32(2):171-175
- 10 World Health Organization. Ebola Situation Reports: Ebola [Internet]. [Cited January 10, 2016]. Available at: <http://apps.who.int/ebola/ebola-situation-reports>