Diabetes education in Africa: what we need to know

Margueritte de Clerck

Education is the cornerstone of diabetes care and management. Yet while many health-care professionals subscribe to this idea, it is not applied universally. In developing countries in particular, much work remains to be done in order to improve the content, structure and provision of diabetes education. Margueritte de Clerck looks at education needs in Africa and makes some recommendations on the role and responsibilities of fellow health-care professionals, particularly those who work in low-income countries.

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Roadblocks to education

Many of the challenges faced by those who promote diabetes education in Africa are also found in developed countries: a lack of awareness of the need for education or limited funding, for example. But the dimensions of these challenges vary greatly from one region to another, and some of the greatest roadblocks to education are specific to Africa and the other developing regions. Indeed, it is important to realize that awareness amongst health-care professionals of the need for diabetes education has existed for only a few years.

Poor communication

Traditionally, we health-care professionals do not communicate well with the people in our care. All too often we consider our knowledge superior to that of the patient and that any efforts to share this knowledge will be a waste of time. It is often the case that upon diagnosis of diabetes, a health-care professional proceeds directly to the prescription of insulin or glucose-lowering drugs without first offering an explanation of the nature and demands of the condition. In Africa, many people with diabetes receive no advice whatsoever on coping with their condition. Often, this leads to a potentially dangerous situation in which vulnerable people seek diabetes information from unreliable or even unscrupulous sources.

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Lack of funding and awareness

Life-threatening infectious diseases such as HIV/AIDS, tuberculosis and malaria affect millions of people throughout the continent. An estimated one million people per year die from malaria; 70% of these deaths are in children under five years. In this context, the chronic limitations on the health budgets of the sub-Saharan African countries force health planners into a tragic 'either or' situation: a choice between tackling one group of epidemics or another. Furthermore,

A relationship of trust and respect is crucial in diabetes care.

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diabetes and other chronic non-communicable diseases receive limited attention from the agencies that promote development in low- and middle-income countries. This is true even in the case of health-promotion funding from the World Health Organization (WHO): in 2002, only 3.5% of the total WHO budget was devoted to non-communicable diseases.

The continent-wide lack of awareness among people with the condition compounds the roadblocks to education represented by widespread acute poverty. The lack of publicly funded diabetes care in most African countries creates a scenario in which those who are already vulnerable are forced to make choices that might potentially make their situation even more precarious. People who must divert money from a severely limited family income in order to pay for medication or laboratory tests are often unwilling or unable to pay for health education.

Hospitals and health centres face similar choices. When budgets are insufficient to cover treatment needs, the allocation of funds for a diabetes educator is often pushed down the list of priorities.

Inappropriate material

The bulk of the educational material in diabetes care in Africa originates overseas. This is not always adapted to the local setting. Apart from the cultural incongruence that renders much of this material unsuitable to certain groups, its effectiveness is often limited by complexities in language and content. At times, the advice offered is not suitable in the African context: recommendations on the exploitation of the advantages offered by the new technologies, such as computer-mediated communication, are impossible to follow in many places and might even have a demoralizing effect.

Huge distances

The African continent is vast and transportation, where accessible, is for the most part rudimentary, uncomfortable and relatively expensive. These conditions further limit efforts to promote therapeutic health education: while people with diabetes might be willing to attend an educational programme, a lack of affordable transportation might make attendance impossible.

The tremendous opportunities for enhanced communication and learning that are provided through the Internet are not on offer in much of Africa. Many hospitals have no Internet access; for those with a connection, problems with the electricity supply – including frequent power cuts – are an every-day aspect of Internet use, making the downloading of information a time-consuming, frustrating and often fruitless task.

Cultural incongruence and linguistic complexity limit the effectiveness of educational material.

Lessons for the health professionals

The current shortcomings in training for trainee doctors and nursing students in the care of chronic diseases must be addressed. A comprehensive approach to chronic disease care should be included in the training of all medical personnel.

Our experience is that appropriately presented health messages are received positively by people with diabetes. Many groups throughout Africa have a rich tradition of the oral transmission through generations of their knowledge and customs. Particularly in the context of widespread low literacy, the onus is on health-care professionals and those designing educational material to recognize the importance of oral communication. Printed material should include culturally sensitive illustrations (including cartoons and simple diagrams) and serve as a springboard for discussions.

It is imperative that health-carers acquire knowledge of educational theory; this should be included in the training of nurses and doctors. The quality of diabetes health education will be enhanced when more health-care professionals are made aware of the progressive nature of the education process.

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Learning must be perceived as life-long; self-care is always open to improvement. In terms of the retention and comprehension of data, an inductive approach to imparting knowledge – involving the active participation of the learner – can produce markedly improved results compared with a traditional teacher-pupil model based on the passive reception (by the 'patient') of knowledge from on high (the doctor). If education is the cornerstone of diabetes care and management, active learning, frequent repetition and constant revision are the cornerstones of the effective long-term acquisition of knowledge.

We health professionals need to be aware of the impact of our body language. As the saying goes, one never gets a second chance to make a first impression. This can be of crucial importance in diabetes care – the difference between the early establishment of a relationship of trust and respect through which advice can be offered, understood, and followed, and a series of frustrating and potentially dysfunctional interactions.

The importance of developing excellent listening skills should not be understated. Active listening involves body language that reflects the listener's involvement and interest in the words of the speaker. By facilitating open communication, particularly in the context of a person who has difficulties describing symptoms, fears or wishes, the opportunity is provided for people to enhance the very process of comprehension.

While in this age of advanced technologies, the search continues for the optimum multimedia to support an interactive approach to communication, it is excellent face-to-face communication skills that are of a premium in diabetes care in Africa – and luckily, no sophisticated technology is necessary.

Margueritte de Clerck

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