

NO MORE EXCUSES

It always seems impossible, until it is done. – Nelson Mandela

These words first uttered by Nelson Mandela seem particularly appropriate and current for what is most critical to the status of diabetes care in the world today, especially concerning human rights and survival. Mandela's words reflect the pressure most nations, governments and municipalities must accept in order to improve the current state of care for all people living with type 1 or type 2 diabetes worldwide – especially children. With cautious optimism, and with the largest coalition of diabetes advocates behind us we must be ready to fight for and protect the fundamental rights of each and every child living with diabetes. It may seem impossible today, but it must get done.

There was a time when it seemed impossible to save the lives of children suffering from diabetes, that is until Drs. Frederick Banting and Charles Best, mentored by Professor Macleod and assisted by James Collip, discovered insulin in 1921. The first child successfully treated with insulin took place in 1922 at Toronto General Hospital. Dr. Banting injected 14-year-old Leonard Thompson, a 'charity patient,' with the hormone insulin and Leonard survived, as so many children have done ever since. However, it also must be pointed out that even today many children do not thrive, and many die within weeks of diagnosis, if they are even diagnosed at all.

We must ask ourselves again and again how can it be that we live in a world where type 1 diabetes is still considered a death sentence, even though a life-saving treatment was discovered nearly a century ago?

In 2006, landmark UN Resolution 61/225 was the first step toward advancing the rights of people affected by type 1 and type 2 diabetes. Resolution 61 validated the debilitating and costly nature of diabetes.

Tragically, within one year of Resolution 61, nearly 5000 children still died from diabetes mellitus worldwide (WHO Global Burden of Death, 2008). Even this shameful statistic is a probable inaccuracy due to under-reporting, misdiagnosis and guilt. What is not alluded to in Resolution 61 is the multitude of children, from low- and middle-income countries, who develop diabetes and find themselves very much alone. Many of these children suffering with poorly treated diabetes are too afraid to reveal their condition to teachers or schoolmates and many won't be afforded the same opportunities for career or life. The undiagnosed and neglected child who develops diabetes will not be satisfactorily cared for and now we know that care in the beginning is key to diminishing the risk for complications later in life. Most tragically of all, the child who develops type 1 diabetes, but who also lives in poverty, will die within 2 weeks without insulin.

It is time that we ensure that medical standards for all children suffering with type 1 diabetes are met. It is time the provision of insulin is made accessible to all who might need it – but especially children.

No more excuses.

Today, under the leadership of Graham Ogle, IDFs Life for a Child (LFAC) Programme helps 11,200 children and youth in 43 countries and provides them with essential care including insulin, test strips, and expert diabetes education. However, it is estimated that 80-100,000 children and youth around the world are still in urgent need of assistance.

In 2011, IDF developed the first ever *International Charter of Rights and Responsibilities of People with Diabetes* providing fundamental guidelines for the rights of more than 371 million people living with diabetes. This landmark document places the rights of people with diabetes, their parents and carers into three focus areas: the rights to care; information and education and social justice, whilst at the same time acknowledging the responsibilities held by people with diabetes.

The Charter aims to bridge the gap in the quality of care as well as customs and practice that impact the health of people with diabetes in many ways. But there is so much more we need to get done for the promise of a healthy future for the child living with diabetes.

Children must have a voice. In order to have an understanding of their health requirements, our youth must be able to communicate their needs and explain what aspect of diabetes is troubling them most so they can begin to live healthy lives with the promise of a future. For this reason psychosocial counselling and care is key for the child who is not meeting targets. This aspect may be especially apparent in adolescence and young adult life well into the mid-twenties. Communication between doctor and patient, counsellor and patient and parent or carer brings to mind the triangle of care. As a child develops into a young adult it is important that the right transitional care is chosen. We know that young adults and adolescent children are more susceptible to complications. We cannot overlook the importance of teaching children living with diabetes to fight their condition and overcome perceived barriers. We must teach them to be masters of the disease rather than its servant, but only with adequate care and access to life-saving medicines can we begin to show them the way.

No child should die of diabetes, and we must ensure this gets done.

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