The International Diabetes Federation (IDF) is a global alliance of diabetes associations that has been promoting diabetes care since 1950. It is an umbrella organisation for over 190 diabetes associations in more than 150 countries, divided into seven regions. There are currently 25 member associations in the African Region of the IDF, which includes more than 37 sub-Saharan African countries plus the islands of Madagascar and Seychelles. From 3 to 7 December 2006 the 19th World Diabetes Congress will be hosted by South Africa in Cape Town – thus presenting a number of unique opportunities, not only for the local diabetes community, represented by the Society for Endocrinology, Metabolism and Diabetes of South Africa (SEMDSA), Diabetes South Africa (DSA) and the Diabetes Education Society of South Africa (DESSA), but in fact for the entire African Region.

The prevalence of type 2 diabetes on the African continent is still too often perceived as low in both rural and urban black communities, although its high prevalence in the Indian population is now well acknowledged. Recent epidemiological studies have, however, suggested that diabetes occurs in up to 5 - 8% of black urban South African females – a prevalence which exceeds that of the disease in the white population. Furthermore, Levitt and co-workers have documented a prevalence of type 2 diabetes in the mixed ancestry (Coloured) community of the Western Cape of 11% – this figure approximates 30% in those over 65 years of age. Even more disconcerting is the pandemic prevalence of the other components of the so-called metabolic syndrome, namely hypertension, obesity and dyslipidaemia, where rates of 25 - 40% are not exceptional, especially in black populations. The global burden of diabetes was 120 million in 1995, is currently about 200 million, and is estimated to approximate 300 million in 2025. Despite the HIV/AIDS epidemic, the total number of people with diabetes in this country is predicted to increase appreciably in future.

Optimising metabolic control and ensuring regular, adequate assessment of micro- and macrovascular complications of diabetes remain a challenge at all levels of health care in South Africa. An unacceptably high prevalence of microvascular complications has often been documented – and invariably ascribed to poor glycaemic and blood pressure control, in those with longstanding disease. The prevalence of retinopathy and nephropathy appears to be similar in different races although more severe degrees of retinopathy have been associated with African ethnicity. Macrovascular complications are also increasing in all groups, although diabetes is generally underestimated when a single cause of death is coded, as is the case in South Africa. The association of known cardiovascular risk factors and myocardial infarction in sub-Saharan Africa was recently explored in the Interheart study – five risk factors, namely diabetes, smoking, hypertension, abdominal obesity and dyslipidaemia, accounted for 90% of the population attributable risk for acute myocardial infarction in the overall African population, and for 88% in the black African subjects. Diabetes is clearly a major risk factor for MI in all ethnic groups in sub-Saharan Africa.

We do, however, live in a country and continent of contrasts – in South Africa, numerous diabetics have ready access to expert clinical care, state-of-the-art diagnostic facilities and modern pharmaceutical drugs, enabling optimal management. Moreover, we also have a long and distinguished history of excellent clinical, basic and translational research in the field of diabetes and metabolism. We pride ourselves on the training of exceptional health care professionals and innovative scientists. In Diabetes SA, established nearly 40 years ago, individuals with diabetes have a superb patient care lay organisation, taking care of their every need. And finally, while as far as the National Department of Health is concerned there is of course always room for improvement, a growing appreciation and prioritisation of diabetes as one of the most important health care problems facing the country has become apparent of late.

A quick perusal of the scientific programme of the 19th World Diabetes Congress will suffice to convince anyone that this enormous meeting covers every conceivable aspect of diabetes – from basic science to clinical advances, epidemiology and education, including lectures and symposia on Diabetes in Africa. Furthermore, the IDF and local organisers deserve praise for their efforts to attract not only international but also local delegates – these include special registration fees for South African citizens, travel grants, etc. It is therefore anticipated that this congress will not only prove to be a success in
broadening research and academic horizons, but that it will also impact significantly and directly on the health care of patients with diabetes in this part of the world.

Looking forward to seeing you in Cape Town.

Stephen Hough
Scientific Editor

Division of Endocrinology
Department of Medicine
Stellenbosch University
Tygerberg, W Cape


SA’s favourite risk can now be enjoyed by diabetics too

From humble beginnings in 1939 in Molteno in the Eastern Cape, Ouma Rusk has become firmly entrenched in the South African way of life. Time and again Ouma has proven to be the perfect anytime, anywhere treat, and it’s the snack that accompanies us everywhere: to work, school, on road trips, camping, even overseas on holiday. Ouma Rusk truly are proudly South African, and as our most iconic food export, are highly sought after among ex-pats around the world.

But until recently, diabetics were precluded from enjoying this much enjoyed and beloved treat. Which is why, in keeping with healthier eating trends worldwide and a growing awareness of lower GI ratings, Ouma recently introduced Nutri Rusk to the range.

A completely new recipe allows diabetics to enjoy Nutri Rusks as an intermediate treat, subject to their doctors’ or dieticians’ approval. For added peace of mind, Nutri Rusks carry the much-respected GI Foundation of South Africa accreditation. Ingredient listings and nutritional information below will assist you in advising your patients. Nutri Rusks are available in 500g and 1kg boxes and convenient single wrapped servings.

<table>
<thead>
<tr>
<th>Nutrient</th>
<th>Per 100g</th>
<th>Per 30g serving</th>
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</thead>
<tbody>
<tr>
<td>Protein</td>
<td>9.7 g</td>
<td>2 g</td>
</tr>
<tr>
<td>Total Fat</td>
<td>9 g</td>
<td>2.7 g</td>
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<tr>
<td>Of which:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polysaturateds</td>
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<td>0.46 g</td>
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<td>Monounsaturateds</td>
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<tr>
<td>Saturates</td>
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<tr>
<td>Cholesterol</td>
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</tr>
<tr>
<td>Fibre</td>
<td>6.4 g</td>
<td>1.9 g</td>
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<tr>
<td>Carbohydrate</td>
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<tr>
<td>Sodium</td>
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<td>1235 mg</td>
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<tr>
<td>Energy/30g</td>
<td>1565 KJ</td>
<td>4706 KJ</td>
</tr>
</tbody>
</table>

**Ingredient List**

Wheat Flour, sugar, raisins, digestive bran, vegetable shortening, raising agent (E450, E500, E170), peanuts, coconut, oats, buttermilk powder, flavour (honey), vitamin premix.

**Nutritional Information**

A single rusk serving = about 30g

Nola, a division of Foodcorp (Pty) Ltd
2 Desert Street, Homelake Extension, Randfontein 1759
Nola Customer Service: (011) 411 5406
www.nola.co.za

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