A BRIEF HISTORY OF THE INTERNATIONAL DIABETES FEDERATION
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2017
It is with great honour that I present this brief history of the International Diabetes Federation (IDF), a journey which began over 67 years ago, led by a few inspirational individuals who dared to transform their dream into reality.

Why do we need this compilation? It has been rightly said that if we do not learn from the past, we will make the same mistakes in the future. And there is a lot to learn from what the IDF has gone through over the years. Since its humble beginnings in 1950, with just 16 countries as initial members, we have grown into a global organisation representing 165 countries and territories, and people with diabetes all over the world. We have achieved a lot, carried forward by the tireless enthusiasm and commitment of a vast army of volunteers and professionals, dedicated to a common cause - improving the lives of our people with diabetes.

Despite our achievements, diabetes remains a significant global problem. In 2011, one person died of diabetes related problems every seven seconds. Four years later, in spite of increased knowledge, newer Guidelines and Clinical Recommendations and newer therapies, a person died of diabetes related complications every six seconds. Why? All of us will agree that we have to find solutions to stem this diabetes “tsunami”. We have to think out of the box for the future as well as understand our actions in the past, many of which have improved the lives of people affected by diabetes, but also accept that some have not, and learn from this.

IDF has achieved much over the last 67 years but much remains to be done as evidenced by the continued rise in the number of people living with diabetes and the complications and mortality associated with it. We would all agree that we are in a war against diabetes. But “Bad things happen not because of bad people, but because good people are not willing to come together to fight it!” Today the International Diabetes Federation has many “good” people and we all have to come together to try and defeat diabetes.

I am confident that taking heart from the energy, dedication and inspiration shown by the countless individuals that fill the pages of this brief IDF history, we can shape a better future for the millions of people currently affected by diabetes and the many more at risk. This is in the end what we are all about! I hope you find our past interesting and inspirational. Let us learn from this but also let us get on. We have a lot more to do!

“The woods are lovely, dark and deep, But we have promises to keep, And miles to go before we sleep!

Many people have helped in this compilation and although it would not be possible to name all of them, I must mention the help and inputs of Wendell Mayes Jr., Maria de Alva, George Alberti, Pierre Lefebvre, Martin Silink, Jean-Claude Mbanya, Paul Zimmet, Morsi Arab, Nam Cho and many, many more. I would specially like to mention Lorenzo Piemonte and Claire Poelmans and others from the IDF Office.

This is a brief compilation based on the material we could access from our archives and inputs and remembrances of many people who have been deeply involved in the working of the IDF. If any relevant material has been left out, I apologise for the same and hope you would let us know so that it can be incorporated if possible.

Shaukat Sadikot
IDF President 2016-17
The foundations of the International Diabetes Federation (IDF) were formally laid out on the 23rd of September 1950, in Amsterdam.

But the story of the IDF really starts a year earlier in Brussels, in June 1949, when the 1st International Symposium on Diabetes took place. This was the first recorded meeting which was truly international on the subject of diabetes with 75 patients and doctors from eleven countries gathered together to discuss problems about the care and consequences of diabetes. It was here that the first discussions on the need for and the formation of an international body on diabetes took place.

The “People’s Poet” Carl Sandburg once said, “Nothing happens unless first a dream.” One could say that the people discussing the formation of such a federation were just day dreamers. But “Those who dream by day know of many things which escape those who dream only at night.” – Edgar Allen Poe.

But then a dream remains a dream unless it is turned into reality!

The “daydreamers” were lead by J.P. Hoet, President of the Belgian Diabetic Association and R.D. Lawrence, his British counterpart and Monsieur Paz from France. To turn the dream into a reality, a meeting of participants from national diabetes associations was scheduled for the next year in Amsterdam.

The seeds were planted in Brussels in June 1949 and lead to the birth of a federation named the INTERNATIONAL DIABETES FEDERATION on 23rd September 1950.

Based on an assumption that all national diabetic associations would be a mix of patients and professionals, one of the first major decisions taken at this meeting in Amsterdam was that the International Diabetes Federation would be a federation of national diabetic associations governed by a General Council which would have as its members one patient and one doctor from each member national association.

The assumption turned out to have exceptions and there were member national associations which were only for professionals. In spite of this, and possibly to be widely representative, the decision to have one patient and one professional from each member was kept, and continued to be in force for many years.

To ensure administration, it was decided to elect an Executive Board consisting of a President, Vice Presidents and a Secretary-Treasurer.

The results of the elections were:

**President:** R.D. Lawrence (U.K)

**Vice Presidents:** J.P. Hoet (Belgium); Maurice Paz (France); Howard Root (USA). Secretary

**Treasurer:** F. Gerritzen (The Netherlands).

In addition, it was decided to “appoint” Hon. Presidents who would also be members of the Executive Board. These were Charles Best (Canada) and Elliot Joslin (USA).

Annex1 shows the membership of the IDF Boards since that time.
At their meeting during the formation of the International Diabetes Federation, in 1950, the attending members agreed for the need to hold a truly international Congress on Diabetes. The Dutch Diabetic Association offered to host one in Leiden and this was accepted. The entire organization of this meeting was left entirely in the hands of the Dutch Diabetic Association and this was to be the norm for many decades that the handling of the Congress would be the responsibility and carried out by the local Association of the country where the Congress was being held.

The 1st IDF Congress was thus held in Leiden in 1952.

And the International Diabetes Federation was on its way!

A brief Timeline, see Annex 2, is provided at the end of this compilation.

IDF CONSTITUTION AND ARTICLES OF ASSOCIATION

Once the foundations of the International Diabetes Federation (IDF) were laid out, in 1950, a number of the lay delegates as well as medical personnel met and to decide on the initial way forward.

The need for a Constitution was initially discussed in 1950 and consequently at the Leiden Congress, a sub-committee was formed under the Chairmanship of Maurice Paz. The members were Gerritzen (Netherlands), Connelly (USA) and Digby-Beste (UK). The draft they produced was distributed to all the then members and subsequently ratified by 16 national associations. Twelve of these, Belgium, Denmark, Finland, France, Germany, Italy, Norway, The Netherlands, Portugal, Spain, Sweden and the United Kingdom, were from Europe and they were joined by Australia, Canada, Uruguay and the USA.

Initially the member associations affiliated to the International Diabetes Federation were “invited” members but in 1958, during the General Council meeting held amidst the Dusseldorf Congress, a motion regarding membership applications was approved and it was decided that new members would have to be sponsored by two existing member associations. For the first time, Argentina, Pakistan, Ecuador, Romania and Turkey were asked to do this so that their existing applications could be taken further. Moreover, it was for the applicant associations to supply as much relevant information as possible to be considered by the EB and then the GC.

In order to make the Constitution as well as the work and activities of the IDF more widely accessible, French was added to English as the official language of the IDF. It was also decided that the third language would be of the country where the Congress was being held but that this would only be for the duration of that Congress. If finances permitted translations in Spanish would also be available but that also only during the Conference time.

A proposal that would allow new members of the Executive Board to be nominated without having to be called Vice-Presidents was defeated as a Notice of 90 days was required before any alteration to the Constitution.

As with all new Constitutions, amendments were made and ratified at the Congresses in 1961, 1964 and 1967.

In 1961, it was decided that instead of electing individuals as Vice Presidents, Member Associations would be appointed to the Executive Board. With the benefit of hindsight, this may have been a mistake as it took away the personal element and removed the focus and responsibility that individuals could bring to the Board.
Possibly with this in mind, in 1967 in Stockholm, it was decided that they would elect an individual as Vice President along with the election of the President. But member Associations continued to be on the Executive Board. It was at this meeting that it was decided that the Vice President would be the Acting President in the absence of the President.

This was also the first time when the concept of disaffiliation of a member association was looked into. The General Council unanimously passed the following addition to the Constitution of the Federation as Section 5 of Article VI:

“If the Federation does not receive any communication or proper amount of financial contribution from a member association for a period of three years or between two Congresses, whichever is longer, then the Secretary of the Federation shall send a letter by registered or recorded post to such association at its last known address warning such an association that it may be disaffiliated. If no or no satisfactory reply is received within four months of its dispatch, the General Council may on recommendation of the Executive Board disaffiliate such a member association”.

In 1974, at the meeting in Israel, it was decided that there was a need for a revised Constitution.

In the original Constitution, no association from a country could be admitted as a member association of the IDF if the affiliated member association of the new applicant’s country raised an objection. This was virtually a “veto”. It had been inserted into the Constitution with the aim of restricting the number of member associations and making the Federation more manageable. In Jerusalem, the Executive Board had decided to open up membership to more associations. Some felt that this should not be opened to associations which have a small number of members but this was not accepted and the membership of associations was opened up no matter how small the size depending on what was the ground reality.

The “veto” was not altered.

There was a need to lay down specific rules for the appointments of delegates as in countries where there was more than one member association there may be disagreements as to who would choose the delegates. The rules governing the number of delegates were formalized into the Constitution. It was accepted that each member association was entitled to one delegate and that there would be an additional delegate for any association which had more than 4000 paying members of any national association up to a maximum of five per country. Each delegate would be entitled to one vote.

It was also here that it was agreed that the IDF would also have individual members.

Consequent to the decision taken by the meeting held in Jerusalem in 1974, that the Constitution needed looking changes and that possibly a new Constitution should be voted on, during the meeting of the General Council held alongside the IDF Congress in New Delhi in 1976, the existing 1967 Constitution was formally repealed and the new Draft Constitution and By-laws were adopted unanimously by the General Council. The Jerusalem meeting had been held between two Congresses and there had been a lack of quorum amongst the delegates attending the General Council there.

In 1979 at the General Council meeting during the Vienna Congress, the recommendation of the Executive Board that By-Law V, Section A1 be amended to increase the number of countries to the Executive Board to twelve. This was passed. Questions were raised during the discussion as to how the members are decided. Was it based on geography, activities or what were the criteria. The Secretary General informed the members that for the coming triennium, UK, USA, Sweden and the Netherlands had been recommended as they were the largest subscribers to the IDF. Hungary, Finland and Japan were the most active in the last Executive Board, Kenya as the next Congress was to be held there, Colombia was chosen as it was the seat of the Association of Latin American Diabetes Associations, Bangladesh was selected being a densely populated developing country and Israel and Australia representing other parts of the world and had been long standing members of the Federation. No questions were raised about the democratic process.
although it had to be admitted that countries could
be nominated from the floor of the general Council!

There was unanimity in the Executive Board and the
General Council that the prevailing state of affairs
needed to be thoroughly reviewed, and to plan for
future strategies that would accelerate the progress
and facilitate the fulfillment of the Federation
objectives. Rolf Luft was made the Chair of the
Special Review Committee along with J.S. Bajaj, E.F.
Pfeiffer, L. Krall and R. McN. Decker, all known for
their expertise and well known amongst the medical
as well as the lay people.

An interim Report of the Committee had been
presented to the Executive Board when it had met
in Athens in 1980 and there had been many inputs
from the members. Taking into consideration many
of these recommendations, a Final Report was again
presented to the Executive Board when it met in
Amsterdam in 1981. Along with this, was presented
a list of By Laws which would have to be amended

In accord with the proposed new structure. Although
most of the amendments were accepted, there were
a few which required minor amendments to what
had been proposed. The Executive Board accepted
the Final Report along with the amendments and
asked that these be presented to the General Council
in Nairobi. The final Report had been circulated to
the members associations in the General Council
much before the meeting in Nairobi in 1982

A major change in the Constitution and administrative
structure of the IDF took place when on the 14th of
November 1982 when the General Council met during
the Nairobi Congress. They ratified a resolution which
may have been the most significant milestone in IDF
history to date. A major restructuring of the IDF into
seven regions, each with their own representatives
and each with inclusion in the central IDF Executive
Board was proposed and accepted. This served to
provide for a democratic decentralization of power
and make it possible for the IDF to be the real voice
of the people with diabetes all over the world.

But there were some who felt that this was a way
in which the Regional members were being pushed
away. This as Luft explained, was far from true.
Under the new laws, the Chairs of the Regions would
be members of the IDF Executive Board and this was
also a guarantee that that assistance needed by the
Regions in carrying out their activities which were
in keeping with the Aims and Objectives of the IDF
would be provided. The rationale was to strengthen
the regions to work on aspects more relevant to their
people.

In fact, the General Council was reminded that that
when the Constitution of the IDF was first written
and approved, the authors and members of the then
General Council has accepted that in time to come
Regional Offices would have to be established and
Article 5 of the Constitution which still was valid
then, said very clearly” Regional Offices could
be established with the approval of the General
Council.”

Another resolution, adopted at the same General
Council at the Nairobi Congress in 1982, looked at
improving the functioning of the IDF through the introduction of a Board of Management, which was to be a policy planning body.

This generated a lot of discussion. The rationale for this was that the General Council could meet face to face only once every three years. Thus, much of its responsibilities were delegated to the Executive Board which included regional representation. It made sense that the responsibility for the “appropriate” functions for business administration was delegated to a Board of Management. Thus the structure would be that the Board of Management would look after the day to day management and report to the Executive Board, when the latter met, which would have to approve the decisions of the Board of Management just as the decisions of the Executive Board needed approval of the General Council.

Questions were raised about the need for a Board of Management. Why was it not possible for the Executive Board to carry out these functions? If required, they could always delegate some responsibility, if necessary, to an appropriate person or group of people on a temporary basis rather than have a standing Board of Management. Moreover, there was a worry that this would lead to increased financial cost to the IDF which should in reality be spent on making the lives of the people with diabetes better! A point was raised that the IDF would not help out the Regions financially but they had money to spend on extra meetings as well as travel!

The other main areas which generated much discussion was the passing of the By-Laws. One of these By-Laws was By-Law IV: Officers and Nominating Committee.

The US delegation wanted to make sure that the members of the Nominating Committee would be elected by the General Council and not nominated by the Executive or the Management Boards. They also felt that the recommendations of the Nominating Committee must be circulated to all the member associations at least 90 days before the meeting of the General Council where the election for the Officers would take place. During further discussion it was also made clear that the Nomination Committee needed to have a broad vision and propose suitable candidates from all over the world rather than focus on just one region. They were asked to be in touch with regional councils for this as well as the member associations. Moreover, the Executive Board had a right to recommend candidates and as the Regional Chairs were a part of the Executive Board, this would also help in an international reach. The final part agreed was that the General Council was not obliged to accept the recommendations of the Nominating Committee and could also accept further nominations from the floor.

These recommendations were accepted and formed Section B of the By-Law IV. By-Law IV Officers and Nominating Committee Section A.

Nomenclature

The Officers of the Federation shall be a President, President Elect, and Vice Presidents (not exceeding ten in number).

The Nominating Committee shall consist of five members, no more than three of whom shall be physicians. One of the members shall be the outgoing President who shall serve as Chairman. The remaining four members shall be elected by the General Council.

It was also formalized that the members of the Nominating Committee would not be eligible for re-election.

The UK delegation was unhappy with the fact that no mention was made of a permanent Secretariat which was based at that time in London. Moreover, the designation Secretary general had been deleted and wanted to have some clarification for these matters.

Bajaj pointed out that the By-Law V, Section F had not been changed and already provided for the location of the Executive Office. Moreover there was no precedent to always have a “Secretary General.” Mr. Jackson had been elected as Secretary from 1973 to 1976 and then as Secretary General in 1976 but this had made no difference to the powers and duties.

Moreover, By-Law VI, Section B which dealt with the
Board of Management had already looked into the matter but possibly needed a minor amendment.

BY-Law VI, Section B: Board of Management

To perform all such functions as shall be entrusted to it by the Executive board. Section C: Staff

The Chief of Staff shall be the Executive Director who is appointed by and responsible to the Board of Management.

The Executive Director shall perform such functions as directed by the Board of Management including the employment of additional staff, as deemed necessary and authorised by the Board of Management, and the maintenance of the Executive Office.

In an associated By-Law it was proposed that all members of the Board of Management would be members of the Executive Board. The proposed By-Law read,” The Board of Management shall be constituted by the Executive Board from amongst its members and shall consist of........”

It was at this General Council meeting that it was formalised that the “Secretariat” would be known henceforth as the “Executive Office”.

The Report of the Special Review Committee and the proposed amendments to the By-Laws were accepted by the General Council.

Incidently, when it came time for the General Council to consider the restructuring and the amendments to the Constitution that would need to be discussed and voted on, A.E. Renold excused himself and asked D.D. Etzwiller who was thought to be an expert on the constitutional matters to assume the role of Acting Chairperson. The reason given was that this would help expedite matters. Many felt that this was due to the fact that Renold and Luft who would be presenting the Report as well as taking forward the constitutional amendments did not see eye to eye in many aspects of this. Moreover, Renold seemed to be unhappy at the very British style of the amended Constitution and wanted a more broad based approach. Be that as it may, the General Council accepted that the President recuse himself and Etzwiller take over as Acting Chair.

In Madrid in 1985, one of the first matters on the agenda was the modifications of the IDF By-Laws as approved by the General Council in Nairobi. This had to do with the composition of the Nominating Committee. It was proposed that the membership of the Nominating Committee be composed of (1) one member each from every region; (2) two non-physician members of the IDF each of whom is from a different region and (3) The Outgoing President who would serve as the Chairperson.

This was a change from the existing By-Laws wherein “The Nominating Committee shall consist of five members, no more than three of whom shall be physicians. One of the three members shall be the outgoing President who shall serve as Chairman. The remaining four members shall be elected by the General Council”.

It was also pointed out that there had obviously been an error whilst drafting this By-Law and this has gone unnoticed when passed by the General Council in Nairobi. A reading of the above could be taken to mean that the President of the IDF would always be a physician which was not the case. This should have read as “The Nominating Committee shall consist of five members, no more than three of whom shall be physicians. One of the five members shall be the outgoing President who shall serve as Chairman. The remaining four members shall be elected by the General Council”.

During the discussion it was pointed out that having a ten members committee did not always mean better results. Moreover, one had to consider the costs as
even with the smaller five member group the cost of travel and stay was significant.

The amendment was voted on, defeated and consequently withdrawn.

By 1985, when the Madrid Congress was held, members of the Board were elected in their individual capacity and this would continue thereafter.

It was also decided that the Executive Office of the IDF would be established in Brussels, Belgium which would again lead to problems with the adherence to Belgian laws as we shall see later.

In Sydney, in 1988, the General Council met during the IDF Congress. As the Articles of Association were still being finalized, it was thought necessary to define certain aspects. One of the By-Laws, By Law IV, Section A part (i) Stated that the Officers of the Federation would be the President, President Elect and the Vice Presidents not exceeding 12 in number. The second part of the amendment which stated that four Vice presidents be such that they represented special interest groups was removed and the amendment was passed.

In Helsinki in 1997, An important By-Law was discussed and passed by the General Council dealt with “Granting the Federation some or all of the fiscal and operational responsibility of its Congresses” It was felt that by having greater control over the operational aspects of the Congresses, the Federation would be in a position to more clearly determine its financial future. This had been cleared by the Executive Board and was passed by the General Council. It took the place of the By-law which asked members who applied to host the Congress to assume all administrative and financial responsibility.

Important amendments which were also cleared by the General Council which dealt with the Honorary Presidents and also the Provisional members.

By-Law Section E Honorary Presidents

“The Executive Board shall establish a Special Nominating Committee. However each Executive Board shall establish only one Special Nominating Committee that shall exist from the close of one Congress and end with the closing of the following Congress. The Executive Board shall appoint members of this Special Nominating Committee, which will consist of three persons, one of whom will be the President of the Federation who shall act as the Chairperson of this committee. The remaining two persons shall be Hon. Presidents of the Federation, who, preferably, shall not be from the same region of the Federation. If there is an insufficient number of Hon. Presidents willing and capable to serve on the Special Nominating Committee, The Executive Board shall appoint any Vice President of the Federation to serve in place of a Hon. President. No member of the Special Nominating Committee may be nominated as Honorary President or a member.

The Special Nominating Committee may, but shall not be required to, nominate persons as Hon. President or Hon. Member, provided that the Nominating Committee shall nominate only that number of persons for the post of Hon. President of the Federation, that if all nominees are elected, the total number of Hon. Presidents shall not exceed twelve (12). Only the Executive Board, Board of Management, IDF Regional Councils or Boards or Full members may suggest names to the Nominating Committee to be considered for Hon. Membership.

The General Council may elect Hon. Presidents and Members of the Federation, provided that 1) the number of Hon. Presidents does not exceed twelve and 2) the persons elected to these positions would have been nominated by the Special Nominating Committee.
Committee."

This was passed by the General Council.

When Maria de Alva became President and learnt that the IDF was not legally based in Belgium, due to the Constitution and By-laws that IDF had. The IDF had been based in London for many years and had an “English-style Constitution and By-laws” that did not comply with the “French-style Constitution and By-laws” of Belgium. She consulted with the Board to see if the IDF should move out instead of changing the whole structure. It was voted by a majority that the IDF should stay and so with the help of a Belgian lawyer, the structure was modified to comply with Belgium law.

Thus, in 2000, in Mexico City, the delegates to the General Council were informed that there was a need to adopt new Articles and by-laws if the IDF were to abide with the Belgian laws or else they could be asked to move out of Belgium.

Luc Houben, a lawyer from Belgium clarified the then situation of the Federation vis a vis Belgian laws to the delegates at the General Council. The IDF was an international organization that was approved by a Royal Decree that was approved by the King or the Minister of Justice of Belgium. This gave the IDF a special status which was not available to a company based in Belgium. IDF was a legal entity, a nonprofit organization with a special tax status.

But the manner in which the IDF was functioning was such that it was moving away from the requirements set by Belgian law for organizations. As an example, Belgian law required that the General Body meeting of any association meet every year whilst with the IDF this occurred every three years.

Another requirement was that the accounts be approved by the General Body every year and this was not done by the IDF who did this at its triennial meeting, although this could be done by postal ballot.

How could one make the functioning of the IDF consistent with the requirements under Belgian Law. For this to occur, the former IDF Constitution needed to be changed into Articles of Association and By-Laws. The Executive Board would no longer have the right to change policies. There would be a much more formal method. The Articles of Association and By-Laws could only be modified and approved by the General Council and not by the Executive Board.

Informal approval for the draft of the Articles of Association and the By-laws had been obtained but formal approval could only be obtained once the draft was voted on and passed by the General Council. This then would be sent to the Ministry of Justice after translating it into French and then only an approval by Royal Decree could be given.

Barring further queries, the new Articles of Association and By-Laws would be in place by the first quarter of 2001.

In 2003, under the Chairmanship of the then President Sir George Alberti, some minor changes which had to be done were carried out. The three sets of proposed amendments to the Articles: changes to comply with Belgian law, linguistic changes, and changes of substance.

One of the changes was important as it changed the power structure in the IDF. The Broadest powers were given to the General Council and taken away from the Executive board. This motion was carried with a two thirds majority.
The passing of Amendments to the Articles of Association as required under Belgian law continued in Paris 2006 and then in Dubai in 2011.

In Dubai, when the General Council met, this resolution was placed before it:

21/13 Proposed Amendments to the Articles of Association:

To approve the proposed new articles of association of IDF subject to their confirmation in accordance with legal requirements during a further meeting of the members of the General Council scheduled to be held in Brussels on 15 December 2011 or a later date if adjourned before the Belgian Notaries Hisette, Roggeman, Derynck & Desimpel.

These with some minor changes was approved by the General Assembly of the IDF still remain as the basis of our “Articles of Association”.

The IDF World Diabetes Congress 2011 in Dubai, UAE

THE “SECRETARIAT” AND “OFFICE” OF THE IDF

The first Office or “Secretariat” was in Amsterdam and set up in 1950 after the Congress held there in which the International Diabetes Federation was formally launched. F. Gerritzen had assumed the role of Secretary-Treasurer and since 1952, Pieter Duys from the Netherlands served as Executive Secretary to the Federation. In 1956, both gave in their resignations and new headquarters had to be found. A move to Geneva to be close to the World Health Organisation was not seen to be financially feasible.

In 1956, The Executive Board decided to shift to London. They rented space from the British Diabetic Association but remain independent from it. They appointed L. L. Frank as the interim Secretary but he resigned in 1958 and as the Board was still not sure of where they should establish the Office as the trend was to have somebody local as the Secretary, they asked the then General Secretary of the British Diabetic Association if he would agree to be the interim secretary for a period of six months. He continued in office until the Geneva Congress in 1961, although the Board, to relieve him of the stress of dual duties, did appoint a Joint Secretary, F. S. Schleisinger from the Netherlands. However, this could not happen as the latter moved to the USA.

In 1961 after the American Diabetes Association refused to take over the Secretariat, the Board held discussions with the Dutch Diabetic Association and appointed Jae Witte as Secretary, and the Secretariat moved to the Hague from London. P.J. Scharring, a Vice president of the Dutch Diabetes Association was appointed as Treasurer. In 1965 it was felt that the work of the federation was increasingly rapidly and also, possibly to maintain a show of independence, it was decided to open an office separate from the Dutch Diabetic Association. On 1st June 1966, the office was opened in Utrecht and later moved to Losser when Witte moved there for a new personal work related appointment.
Both Witte and Scharring were re-elected to the posts in 1964, 1967 and 1970.

They may have been willing to continue but the General Council felt that the duties could not be undertaken by a part-time person and decided to appoint Mr. Jim Jackson as a full-time Secretary of the Federation. In keeping with the trend followed in those times, the Secretariat moved back to London in 1973.

In 1982, Dr. Pfeifer who was the Treasurer, reported that the financial dues from the member associations as well as all other categories had increased from January 1st 1980. He said that the income of the IDF had increased from British Pounds 70,000 to almost 100,000. But to negate this, the expenses had gone up from around 58,000 Pounds to 99,000 Pounds. Half the expenses related to the salary of the Secretary General and a secretary employed at the London Office. There was also a significant increase in rent, travel expenses and audit fees and miscellaneous office expenses.

J.G.L. Jackson

It was in view of this that during this meeting at Nairobi Congress General Council that questions were raised by the British Diabetic Association regarding the financial costs associated with the new proposed structure, especially the cost of the regional offices amongst other aspects.

These all had been considered by the Special Review Committee and also by the Executive Board. R. Luft pointed out that although the Final Report did contain some guidance about the functioning and activities of the Regions, it would be for the Regional Councils to further develop their own areas of activities based on their own needs and priorities. They would have to seek realistic solutions within the framework of the financial resources available to them in their regions. It was not envisaged that the IDF would be responsible for the financial state of the Regions and these would have to be generated through local sources.

In fact, Luft reminded the General Council that that when the Constitution of the IDF was written and approved, the authors and members of the then General Council has accepted that in time to come Regional Offices would have to be established and Article 5 of the Constitution which still was valid then, said very clearly “Regional Offices could be established with the approval of the General Council.”

A By-Law had also been passed dealing specifically with the Office staff.

BY-Law VI, Section C: Staff

“The Chief of Staff in the executive Office shall be the Executive Director who is appointed by and responsible to the Board of Management.

The Executive Director shall perform such functions as directed by the Board of Management including the employment of additional staff, as deemed necessary and authorised by the Board of Management, and the maintenance of the Executive Office.”

In 1982, Leo Krall was the president and Wendell Mayes Jr. was the Hon. Treasurer. The IDF shared the services of Jim Jackson and his part-time secretary with the European Association for the Study of Diabetes (EASD) at an office (of the British Diabetic Association) on Queen Anne Street in London, England. IDF was bearing more of the expense than
EASD. Having visited the London Office, Wendell Mayes Jr. learnt from Jackson that the workload of the two organizations was about the same. He visited the EASD Treasurer, Michiel Krans, in Leiden, Netherlands, and they agreed that the two organizations would share the expenses of the office equally, thus bringing down some of the Office costs.

It was in 1985, during the Madrid Congress that the General Council decided to have some degree of permanency and the Executive Board authorized the establishment of an IDF Office. J.J. Hoet, who was a Vice-President, urged that the office be established in Brussels. One of the main reasons was that the European Union was in Brussels. His suggestion was accepted. He recruited Hilary Williams as Executive Director.

Since 1985, the Executive Office has been based in Brussels, Belgium.

Between 1997 and 2000, when Maria de Alva was President, she learnt that the IDF and its Office was not “legally” based in Belgium, due to the Constitution and By-laws that IDF had. IDF had moved from England where it had an “English-style Constitution and By-laws” that did not comply with the “French-style Constitution and By-laws” of Belgium. She consulted with the Board to see if we should move out instead of changing the whole structure. It was voted by a majority that the IDF should stay. With the help of a Belgian lawyer, the structure was modified to comply with Belgium law. It was a long process but this change was finally approved in the General Assembly in year 2000.

Between 2000 and 2003, when George Alberti was the IDF president and Pierre Lefebvre was the President- Elect, they learnt that the IDF Office was very short staffed with just three full time members. They asked the then Executive Director to leave and advertised the position of Executive Director.

Having received more than 50 applications, they shortlisted eight possible candidates and after a thorough evaluation and audit, Luc Hendrickx was given the job. One of his main tasks was to reorganize and develop the IDF Office.

This was also the time when the Paris Conference was on the anvil. The 2003 Congress was organized by a PCO and the French member association AFD. Pierre Lefebvre who was given the task of oversight of the organization of the Paris Conference soon realised, and the others agreed when this was reported, that the International Diabetes Federation Office was quite capable of organizing Congresses. Luc Hendrickx was given the task of setting this up and he established a Congress Team in the based in Brussels IDF Office.

In 1997, the relevant By-Law had already been passed giving the IDF Executive Office the right to do this. “Granting the Federation some or all of the fiscal and operational responsibility of its Congresses” It was felt that by having greater control over the operational aspects of the Congresses, with the Executive Office being in charge, the Federation would be in a position to more clearly determine its financial future. This had been cleared by the Executive Board and was passed by the General Council. It took the place of the By-law which asked members who applied to host the Congress to assume all administrative and financial responsibility.

In his address to the General Council in Paris, George Alberti reported the changes that were taking place in the Executive Office in Brussels.

MEMBER ASSOCIATIONS AND MEMBERS OF THE INTERNATIONAL DIABETES FEDERATION.

When the International Diabetes Federation
A brief history of the International Diabetes Federation

(IDF) started out in 1950, there were 16 member associations which were “inaugural” members. Thirteen of these, Belgium, Denmark, Finland, France, Germany, Italy, Norway, The Netherlands, Portugal, Spain, Sweden and the United Kingdom, were from Europe and they were joined by Australia, Canada, Uruguay and the USA.

Membership of the IDF has grown significantly. From the 16 member associations from 15 countries in 1950, it now stands as we near 67 years of existence in 2017 at 230 member associations from 165 countries and territories. In addition, the IDF has 6 transnational members.

The members in each region and when they became accepted as Full member Associations is provided in the Annex.

In 1958, during the General Council meeting during the Dusseldorf Congress a motion regarding membership was approved and it was at this meeting that it was decided that new members would have to be sponsored by two existing member associations. For the first time, Argentina, Pakistan, Ecuador, Romania and Turkey were asked to do the needful so that their existing applications could be taken further.

It was also at this meeting that for the first time there was a proposal to raise the membership dues to 20 Dutch cents per member per annum but this was not accepted by the delegates as it was felt that all the member associations may not be able to afford such an increase.

Accepting the increasing diversity, French was added to English as the official language of the IDF. It was also decided that the third language would be of the country where the Congress was being held but that this would only be for the duration of that Congress. If finances permitted translations in Spanish would also be available but that also only during the Conference time.

In 1961, the General Council accepted the recommendation that instead of electing individuals as Vice Presidents, Member Associations would be appointed to the Executive Board. With the benefit of hindsight, this may have been a mistake as it took away the personal element and removed the focus and responsibility that individuals could bring to the Board.

Possibly with this in mind, in 1967 in Stockholm, it was decided that they would elect an individual as Vice President along with the election of the President. But member Associations continued to be on the Executive Board.

This was also the first time when the concept of disaffiliation of a member association was looked into. The General Council unanimously passed the following addition to the Constitution of the Federation as Section 5 of Article VI:

“If the Federation does not receive any communication or proper amount of financial contribution from a member association for a period of three years or between two Congresses, whichever is longer, then the Secretary of the Federation shall send a letter by registered or recorded post to such association at its last known address warning such an association that it may be disaffiliated. If no or no satisfactory reply is received within four months of its dispatch, the General Council may on recommendation of the Executive Board disaffiliate such a member association”.

At a meeting held in between two Congresses in Jerusalem, Israel, in 1974, the annual subscription which had to be paid by the member associations was raised and would come into effect on 1st January 1975. This was the first time that this had been done which was noted in the Minutes and it would mean a significant increase in the IDF finances provided that all the member associations paid as per their present membership.

In the original Constitution, no association from a country could be admitted as a member association of the IDF if the affiliated member association of the new applicant’s country raised an objection. This was virtually a “veto”. It had been inserted into the Constitution with the aim of restricting the number of member associations and making the Federation more manageable.
In Jerusalem, the Executive Board had decided to open up membership to more associations. Some felt that this should not be opened to associations which have a small number of members but this was not accepted and the membership of associations was opened up no matter how small the size depending on what was the ground reality.

The “veto” was not altered.

Members who had not paid their fees for the previous triennium and with whom also there had been no correspondence during that period would be disaffiliated but only after they had been given a chance to rectify the problems.

The Diabetic Association of Trinidad and Tobago was disaffiliated as it no longer existed and the Association Tunisienne de Diabetiques was asked to show proof of its existence and activities if it was not to undergo the same fate.

Financially, the US dollar became the official currency for auditing purposes and not the Dutch Currency.

The fees for Full Membership was approved to be 10 US cents per person with a minimum of US 100 Dollars for all full member association. The fees for individual members was fixed at 10 US dollars per annum. A discounted registration fee for the next Congress of 15%, 10% or 5% would be given to individual members depending on whether they became members and paid the fees for three, two or one year respectively.

The economic constraints facing some member associations was discussed but the generally accepted view was that help from outside sources such as Foundations, Trusts, or other interested sources should be obtained to pay the fees. It was felt that if the IDF was to play its proper role every member association should pay at least the minimum annual subscriptions.

By 1979, when the Vienna Congress was held, under the Presidency of R. Luft, the General Council approved the recommendations of the Executive Board that the member associations of Cuba, Sri Lanka, the Philippines and Sudan be given three more months to pay off their dues of 1977-1979 or face disaffiliation.

Between 1977 and 1979, the IDF accounts were based in U.S. Dollars and due to this the income from subscriptions had dropped by 25% due to drop in the value. During the same period, the prices in the U.K. where the accounts were maintained had increased by 31%, leading to a significant loss to the IDF. In view of the fluctuating rates of exchange between currencies, it was resolved at this General Council that the UK Pound Sterling be used as the official IDF currency.

Individual membership: 1 year UK Pounds 15; 2 year UK Pound 22.50; 3 years UK Pounds 30;

Association Dues: Per member UK 7.5 pence with the minimum amount being paid by a member association be 75UK Pounds;

Supporting members: UK pounds 500

It was reported that some member associations were unable to send the money to the IDF account due to currency restrictions which were in place in some countries. J.S.Bajaj pointed out that they were unable to transfer the profits of US dollars 5000 from the IDF Congress held in New Delhi, India in 1976 due to this reason. He suggested that member associations be allowed to open accounts in their own countries and use the money for carrying out IDF related activities. This was not accepted as it would lead to significant audit problems and the final decision was left to the Special Committee which was being formed to look in detail at the administration and activities of the IDF and which would report to the General Council in Nairobi in 1982.

Based on feedbacks received from many pediatricians and doctors on a January 1979 article in the IDF Bulletin, it was decided to have a subsection of Juvenile Diabetes and a Steering Committee headed by D.D. Etzwiler was set up to prepare recommendations for bettering the lives of juvenile diabetics.

A Working Document on Diabetes and Primary
Health Care. Member associations were asked to interact with the health authorities in their countries to see that diabetes was made an integral part of primary health care. The document authored by J.S. Bajaj was referred to the WHO Expert Committee for their consideration.

It was at the Nairobi Congress in 1982 that a major change in the Constitution and administrative structure of the IDF took place when on the 14th of November, the General Council ratified a resolution which may have been the most significant milestone in IDF history to date. A major restructuring of the IDF into seven regions, each with their own representatives and each with inclusion in the central IDF Executive Board was proposed and accepted. This was done with the intention to provide for a democratic decentralization of power and make it possible for the IDF to be the real voice of the people with diabetes all over the world.

There was a growth spurt in the number of associations applying for membership and being accepted as Full Members from the mid 1970s as diabetes started to rise in pandemic proportions, and with the increase in the number of “independent” nations and the increased organization of people concerned with diabetes especially in developing countries. Importantly, this also reflected the growing strength and influence of the International Diabetes Federation.

Once an applicant association had been sponsored by two existing member associations. Such applicants initially became Associate members provided they were not opposed by the member association of their country who could “veto” the application. They were only made Full members when they were voted “in” by the General Assembly. Since the General Assembly usually met every three years at the IDF Congress, Associate members were asked to pay half the annual subscription fees and were not eligible to stand for elections at the upcoming general Assembly when their Full membership would be voted upon.

In 1972, the Association Belge du Diabete, which had served the French and Flemish speaking communities for thirty years had been reformed into two entirely separate societies. The name Belge du Diabete was retained by the French speaking society and the Flemish speaking association called itself Belgische Vereniging voor Suikerzieken. The two societies continued to work closely together and as per the rules of the IDF in those days, jointly agreed to the nomination of one delegate each to the general Council. Their example of goodwill and collaboration was an excellent example for how more than one association in a country could still work well for their people and within the framework and rules of the IDF. It was a good example of why the IDF should remove the “veto”!

But that would take decades!
The dues that each members association had to pay was again revised in Madrid in 1985. The General Council voted to adjust the membership dues from 1986 onwards.

Individual membership: 1 year US $ 20; Life membership: US $ 200;

Association Dues: Per member US $ 0.09;

GNP/1000x US $ 1.25


GNP per capita > US $ 2000: US $ 112.50

Supporting members: US $ 750

Alluding to the importance of the members associations, in 1991, Wendell Mayes Jr. reminded the delegates that the meeting was in Washington D.C. where Martin Luther King, Jr. gave his “I Have a Dream” speech. The IDF too, had a dream. “We dreamt of the day when diabetes has been cured. And we dreamt of a better life for those with diabetes wherever they may live and whatever their other circumstances may be. But the dream had to be turned into reality.

The International Diabetes Federation was a bridging structure. But it could not succeed unless the members associations played a major role in bridging the gap between the reality and what the IDF aimed for. The members associations had to mediate or intervene to reduce the vulnerability of people left to themselves in society and turn the dream into reality”.

As President, in Kobe in 1994, he again mentioned that the Regions were getting stronger and carrying out many activities as had been envisaged when the seven regions of the IDF were formed. Member associations were getting stronger and the weaker ones were being helped by the “twinning” initiative.

The General Council also voted to adjust the membership dues for the years 1994 to 1997. Individual membership: 1 year US $ 40; 3 years US $ 110;

Life membership: US $ 500;

Association Dues: Per member US $ 0.125;

GNP/1000x US $ 1.375


And raised them again in 1997.

Individual membership: 1 year US $ 50; 3 years US $ 135; Life membership: US $ 550;

Association Dues: Per member US $ 0.137;

GNP/1000x US $ 1.512


The Task Force on Regional Development was established in 1995 and all the Regional Chairs were members along with the President and President Elect as well as Henry Rivera and Sterling Tucker, who was the Chairperson. A regional Development Plan was formulated and presented to the Executive Board in 1996 where it was adopted with dissent.
The Regional Development Plan had six main goals:

Establish strong, viable action oriented structures in all the seven regions;

Establish and strengthen the regional management support structure in all seven regions;

Make an inventory of resources, including financial resources, available in the Regions for diabetes prevention and awareness campaigns; education and training research, delivery of care and other activities, and engage new partners each year;

Following consultations with members and regions, to develop a strategic development plan that would reflect the regional needs and priorities;

From December 1999, the IDF would assist in the implementation of the strategic plan and have an annual evaluation;

Through each phase of this Plan, the IDF would strengthen co-ordination and communication between the Regions and the IDF Executive office;

The Congress was taking place on the 50th Anniversary of the forming of the International Diabetes Federation. The President Maria de Alva noting this in her welcome to the delegates at the General Council noted that the IDF had grown significantly from the 16 member associations at the start in 1950 to 176 members from 136 countries in the world if all the provisional members were accepted as Full members by this General Council.

She spoke of the Regional Development Plan which was passed by the General Council in 1997 to aid and assist the member associations throughout the world.

The emblem for this development plan was a Tree symbolizing the IDF with the leaves being the member associations; the stems were the Regions and the trunk was IDF Global with the roots being the IDF mission and objectives which feed the tree!

The second spurt in membership applications and numbers of Full members occurred in the last decade when the “veto” was removed. The veto had been a part of the IDF Constitution since inception. Existing member associations from a country had the right to veto another organization from the same country to become a member of the IDF. It was believed that the veto was placed in the Constitution in order to have a selected and manageable number of MAs in order to secure a strong Federation, with the IDF striving to help and ensure that the members of the associations had the most optimal help.

But it was also widely felt that the veto was being misused and the membership was highly selective and was more based on personal relationships than on real representativeness. It was alleged that a number of original MAs were changing, not always for the better, and were protecting their international privileges using the veto even if in their countries they were not truly representing the diabetes community which in the meantime was rapidly growing.

Efforts were often made to negate the use of the veto but it was in 2009 that the veto was finally removed by the General Assembly at the Montreal Congress. This allowed many organisations which had been previously subject to the veto, to become members.

Presently every new application must be discussed at the Regional Council along with the views of the existing association(s) and then be sent to the IDF Office along with a letter from the Regional Chairperson. This is done even if the country association(s) vote against the membership. The Executive Board then decides about giving Associate membership and this is then voted on at the ensuing General Assembly before becoming Full members if passed there.

INTERNATIONAL DIABETES FEDERATION CONGRESSES

Though many Congresses were being held by National Associations and some of them had Speakers from other countries and some even foreign delegates, international Congresses on the subject of Diabetes was not common in the 1950s.

When the 1st International Symposium on Diabetes...
was held in Brussels, Belgium in 1949, this was attended by 75 patients and doctors and was deemed a success. Although the lay people were allowed to be present only on the first day, many of the people who were present felt that there was a distinct need to have a regular Congress where there could be an interactions between the medical personnel and the people whose lives were affected by diabetes in order to discuss the problems in diabetes care and find ways and means to improve the care and lives of the people with diabetes. An animated discussion came to the conclusion that there was a need to take things further and a meeting of participants from national Diabetic Associations was scheduled for the next year in Amsterdam.

At their meeting during the formation of the International Diabetes Federation, in 1950, the attending members agreed for the need to hold a truly international Congress on Diabetes. The Dutch Diabetic Association offered to host one in Leiden and this was accepted. The entire organization of this meeting was left entirely in the hands of the Dutch Diabetic Association and this was to be the norm for many decades that the handling of the Congress would be the responsibility and carried out by the local Association of the country where the Congress was being held.

The 1stIDF Congress was thus held in Leiden in 1952.

The Congress was felt to be a success with 241 delegates from 20 different countries with 47 scientific papers read at the meeting. In addition to the scientific program, a medico-social element was added in order to attract nonmedical people and people with diabetes. 16 papers were read in this section and many doctors were seen to be present here in preference to hearing medical papers! In view of the diversity of the attendees, simultaneous translations were provided at the Conference and this continued till 1973 when in Brussels it was decided that the proceedings would only be in English. It is possible that the financial costs of simultaneous translations played a role in this decision.

Annex 3 provides a list of the IDF Congresses held and the names of the key people responsible for the organization and proceedings of these Congresses is given.

The IDF Congresses were held every three years till 2009 when it was decided that three years was too long an interval and the IDF Congresses were held every two years.

The 2ndCongress held in Cambridge, UK in 1955 attracted nearly 500 people from 30 countries and again a precedent was set when an exhibition was held in conjunction with the meeting.

It was at this Congress that education started getting into focus. A Committee on Education was set up the Congress and the members were keen to further the progress of Postgraduate courses. R. D. Lawrence who was Chairing this meeting suggested that they start with holding a postgraduate course along with major meetings especially where the Executive Board would also be present. Gerritzen wanted that the courses be held simultaneously in many cities but Lawrence cautioned against being too ambitious and over reaching. The IDF would only sponsor the Course and would not take responsibility for the financial aspects. It was decided that the first course would be held in Brussels along with the 20th International Physiology Congress in 1956.

Many lay persons complained that they were not having adequate time to discuss social aspects as there were major time constraints during the General Council Meetings. It was decided that from then onwards the lay people would have a full day ahead of the General Council meeting at the next Congresses to discuss these social aspects and then report to the General Council.

It was also at this meeting that a small committee was formed which had the task of collaborating and interacting with the WHO and its subsidiaries as well as the World Medical Association. The members consisted of Rambert and Martin and H. Root.

Dusseldorf in 1958 had more than 1800 delegates from 42 countries. This again increased to 47 countries at the next Congress in Geneva in 1961 although the number of participants was down to around 1400. At the next meeting in Toronto due to the active participation of the American Diabetes Association
working along with their Canadian colleagues, there were around 3500 registered delegates from more than 50 countries. Stockholm had 2800 delegates although the numbers fell, possibly due to economic constraints and long travel distance, when for the first time the IDF Congress was held in the Southern hemisphere in Buenos Aires with 2000 participants from 28 countries.

The Congress held in Buenos Aires was the first Congress and General Council that a representative of the WHO, a Dr. Chopra was invited as an Observer, a sign of increasing collaboration between the IDF and the World Health Organisation.

It was at this Congress that it was decided that anticipating the Silver Jubilee of the IDF, the best place to hold the 1973 Congress in Brussels celebrating the silver Jubilee in advance. Israel Diabetes Association offered to host the Congress if the member association from Belgium was unable to do so for any reason.

It was decided that the IDF Congress would be held in Asia in 1976 for the first time and New Delhi in India was selected for this. Again Israel and Japan both offered to hold this Congress if the member association from India was not able to do so.

Inspite of the lower numbers at this Congress, things were back in 1973 in Brussels with 3000 delegates from more than 50 countries. It was at this Congress that along with the other aspects, a Post Graduate Course was introduced.

A totally new innovation carried out at this Congress was The Commission for the Teaching Programme, chaired by P de Moor, which had a refresher course in Diabetology with 27 internationally renowned faculty. The course was designed for Internists (diabetologists with a special focus on research or clinical studies) general Practitioners, and other medical specialists.

It ran over seven sessions (days) and started with a medico-social topic and ended with a question answer session which had six speakers from that day available to clear doubts and answer queries.

F. D. Lukens was the Dean of the faculty and all chosen speakers had to send their presentations to Lukens who vetted them for appropriateness and non repetition. He also Chaired most of the sessions and presided over and moderated the Q & A at the end of the day. Simultaneous translations in English, French, Spanish and Dutch was provided and around 174 out of the 213 registered delegates received a Diploma.

The Commission for Socio-Medical Programme was also established under G. Verdonk. It was soon realised that setting up a programme was difficult due to the different nationalities attending these lectures. Moreover the audience was ill defined, did not have much knowledge about the medical aspects and also had a major issue with the language as they came from multiple countries where the language used during the Congress may not be well accepted or known. Moreover, the faculty was usually medical and many of them had to be in the scientific sessions and so could not be present at the medico-Social programme as required. Many of the faculty for these sessions were chosen within the last few weeks amongst those who had registered for the Congress in order to save costs of having to pay for the faculty travel and registration. It was realised that such problems were difficult to avoid when medical and medico-social programmes were held at the same times. But it was felt that these aspects needed looking into and would be taken up at the earliest.
There was no simultaneous translations available due to both financial reasons as well the fact that these slow down the proceeding significantly. The 9th IDF Congress was held in New Delhi, India in 1976, the first IDF Congress held in Asia. Participants came from 54 countries including all the 44 member associations which constituted the IDF at that time.

Speaking at the Opening Ceremony, Indira Gandhi, the Prime Minister of India, expressed her belief that it was international co-operation which was the way forward, in all areas and especially in the control of disease. She commended the IDF for being a bridge between the developed and the developing worlds and expressed a hope that the sharing of ideas would benefit people with diabetes all over the world. This was pace setting and on the 25th Anniversary of the IDF, it ushered in an aspect of reformation and reaching out to people all over. It was at the General Council meeting here that the functional framework for the IDF Steering Committee for Diabetes in developing Countries was laid out.

Financially, regarding the fees for the triennial Congress it was made clear that there would be no discrimination between professional and lay qualifications. Any participant would be entitled to attend every session of the Congress and would receive the same documentation and facilities on payment of the full registration fees. If a paramedical or lay person wished to attend only the Postgraduate or Non-Physicians programme, a reduced fee would apply.

There was a section of delegates to the General Council who were not happy with the Congress programme and also facilities for the lay or non medical personnel. This was led by delegates from Diabetes Federation of Australia with more than 10000 lay members. Although totally supporting the aims of the IDF in promoting scientific sessions and Postgraduate educational programmes during the Congress, they wanted more focus on lay people. With this, they felt more lay people and non medical personnel could be attracted to the Congress. Moreover the facilities for non physician delegates was not felt to be up to mark. Some complained that the time schedule of the programme for people with diabetes was inconvenient and that the food was not catering fully to their needs.

This was discussed in detail and the majority of the General Council felt that education for patients should be left to national associations and not be a part of the IDF Congress programme. The President also pointed out that emergency facilities were always available and whilst food was provided, it would be difficult to cater to every individual food need and “like” and that patients should ultimately take the responsibility for their food needs.

In Geneva, in 1977, although this meeting of the General Council was held in between Congresses, the feeling was that it was time to take the IDF Congress to Africa and the application from Kenya to hold a Congress in Nairobi was scrutinised and accepted for hosting the 1982 IDF Congress.

But more importantly in the days of apartheid, it was also decided all IDF Congresses would only be held in countries where all the IDF Member Associations and national of that country were freely admitted and accepted as members.

At the Nairobi Congress, the President Albert Renold, in his opening remarks said that when he had taken over the Presidency three years back, there had been some “turbulence” especially with the Special Review Committee but this, he felt, was normal in the working of any normal society or association. There would be a lot of discussions and arguments and even dissent about the aims, but as long as the basic foundations were strong and not unduly disturbed, the Society or association would survive. As he came to the end of his tenure, he knew that all problems could be solved as long as all of us “stood together”! This is something that should be remembered by all of us even today.

Renold felt that the IDF should be working towards empowering the associations in smaller and developing countries. He also felt that lay people should also get importance and the fact that the Executive Board had correctly asked that three of the
people elected to the executive Board be lay people. Although this was not yet fully implemented, it did show the road ahead for the Federation.

A major change in the Constitution and administrative structure of the IDF took place in 1982 during the 11th IDF Congress held in Nairobi, Kenya. President Albert Renold did not feel comfortable presiding at a meeting using new Bylaws that stressed the Parliamentary Procedures from the culture of former British Commonwealth nations, so he asked Vice-President Donnell Etzwiler of the United States to preside.

On the 14th of November, the General Council ratified a resolution which may have been the most significant milestone in IDF history to date. A major restructuring of the IDF into seven regions, each with their own representatives and each with inclusion in the central IDF Executive Board was proposed and accepted. This served to provide for a democratic decentralization of power and make it possible for the IDF to be the real voice of the people with diabetes all over the world.

Another resolution adopted at the same General Council at the Nairobi Congress in 1982, looked at bettering the functioning of the IDF by forming a Board of Management, a policy planning body.

One of the proposals put forward was the setting up of an Emergency Relief Fund by the IDF to respond and help affected member associations and countries when they were faced with emergency situations. This did not mean just sending money, but importantly, help in distribution of relief materials and supplies in times of national emergencies, disasters and shortages.

Another area which was well focussed both at the Congress and the General Council was "Diabetes in Youth". The members of the Standing Committee on Diabetes in Youth as well as the members of the International Study Group on Diabetes in Children and Adolescents were very happy with the attitude and the co-operation given to them by the Organising Committee of the Nairobi Congress and wished that they be involved closely even in the future Congresses. In addition the hope was expressed that when regionalisation was fully established, one or two delegates from every region would be physicians caring for children with diabetes.

These were also the days of Apartheid in S. Africa. When it had been decided to hold the meeting in Kenya, it had been asked whether all delegates from all IDF member countries would be admitted into Kenya. A verbal assurance had been given and this had been repeated on numerous occasions. At no time it had even been mentioned that this may not be possible. However visas which had been granted to over 50 delegates from S. Africa were revoked two days prior to the meeting. Fortunately, in time for them to avoid travel. One delegate did reach Nairobi but was not allowed in and had to return after spending more than 36 hours at the airport.

The Minister of Health in Kenya had been present at the Opening Ceremony and at the time President Renolds had mentioned this and said that "Whilst the Federation fully understood and recognised that Governments were all powerful and independent and free to make whatever decisions they wished; the IDF was equally free and entitled to express their regret and distress".

Incidently, the same problem could have occurred when the Congress was held in India as there was no Embassy of India in S. Africa in the absence of diplomatic relations between the two countries. The Passports of all the people from S. Africa who wished to come to India for the Congress were flown by the
A brief history of the International Diabetes Federation

Indian Government representatives to London and the visa stamped there at the Indian Embassy. The passports were returned well in time and the people coming from S. Africa had no problems when they arrived in India.

A similar problem may have occurred for people holding Israeli passports to come to the Dubai Congress in 2009 but a solution was found which allowed their travel and participation at the Congress. Similar arrangements were in place for the 2017 IDF Congress in Abu Dhabi.

Unfortunately the number of lay people participating at the Congress in Kenya was much less than anticipated. This in spite of the fact that there had been much discussion about these aspects in Vienna and although some more discussion had taken place in the three years since then relating to the lay and the paramedical sessions of the Harambee programme and a pattern to improve matters was emerging, much work still needed to be done. It was felt that one of the main constraints in lay people coming for the Congresses was economical as they did not have an easy access to funding.

At the same time, it was seen that the numbers of paramedical personnel attending was on the rise which was a good sign for the future.

In his Presidential Address in Madrid in 1985, Leo Krall whilst “asking that the membership of lay people as well as medical personnel be expanded so that the IDF could truly be an umbrella for the world’s diabetics, also referred to the financial status. Whilst this had improved, it needed bolstering. Moreover, if the money raised by the International Diabetes Federation was all used for administrative and travel use, then it was not truly a great organization. The times had changed. The IDF must be able to reach out and offer help in education and services wherever they are needed. The members, most of them, could not support or finance these needs. There was a need for a broader base of funding from non member sources and he saw no reason why the IDF could not do this also as others were doing”.

One problem was the enormous numbers of physicians and officials for whom there was admittance to the Congress without any charge and this raises the cost of registration for those who pay for their registration. He had calculated that if 250 physicians and officials were allowed free entry, this would lead to a loss of around US $ 50000, and as the IDF needs the profits from its Congresses, this element needs rethinking and restructuring. Since a majority of these free access people are from larger and wealthier national associations, it would seem that the smaller and poorer member associations were in fact subsidizing the larger and wealthier ones!

President Leo Krall requested Pierre Lefebvre to Chair the Scientific Committee, although it was usually a person from the Organising country who did this, as there were difficulties in getting consensus among the Spanish colleagues. It was there that one realized that a major Jewish holiday was in the middle of the week selected for the Congress. During those times, the IDF Congresses were held over 5 days, Monday, Tuesday, Thursday and Friday with the Wednesday free (in 1985, Wednesday was the Jewish holiday). The General Council meeting was usually held on the “free” day which was usually the Wednesday. Because of the holiday that year, the Congress place was shut but excursions had been organized for those who may have been interested. When the cost of having a free day in the middle of the Congress was calculated, even a rough estimate showed the cost of this so called “free” day to be substantial. From then on, the General Council meeting was held before the start of the Congress and no free days were scheduled during the Congress. The dates of upcoming Congresses are always cleared by the Board after making sure that there were no major
holidays clashing with the dates of the Congress.

At this Congress, It was also decided by the General Council that the invitation from the American Diabetes Association to hold the 14th IDF Congress in Washington D.C. in 1991 and to hold the 15th Congress in Kobe, Japan at the invitation of the Japan Diabetes Society in 1994 should be accepted. The triennial Address of the President Jasbir Bajaj in 1988 at the Sydney Congress was different as he presented letters from Health Ministers of many countries which showed a tremendous support for the IDF and expressed that these be translated into administrative commitment and action.

The Congress was held in Washington D.C. in 1991.

This was held with J.J. Hoet, the President, chairing the General Council.

He read a message of greeting from the Portuguese Diabetic Association, the oldest national association which was a member of the IDF. He also highlighted the World Health Assembly Resolution 42.35 which lead to the setting up of the Diabetes Unit within the WHO. He also referred to the IDF long range Plan (1988 – 1994). He discussed the problems of insulin availability, education courses, World Diabetes Day and regional activities.

14 new associations were welcomes as full members. The disaffiliation of non paying members was kept on hold till the 1994 Congress.

It was also decided that the Congress in 2000 would be held in Mexico City.

Wendell Mayes Jr., the Incoming President felt that the future has never looked brighter for the IDF. It now had over 100 member associations in over 80 countries.

He reminded the delegates that the meeting was in Washington D.C. where Martin Luther King, Jr. gave his “I Have a Dream” speech. “The IDF too, has a dream. We dream of the day when diabetes has been cured. And we dream of a better life for those with diabetes wherever they may live and whatever their other circumstances may be. But the dream had to be turned into reality.

The International Diabetes Federation is a bridging structure. So are our member associations. It has to mediate or intervene to reduce the vulnerability of people left to themselves in society. And it is up to the bridging structures in the diabetes community to bring the public and the private sectors together. It is up to the IDF to get both public and private institutions to focus their attention on the problems and the needs of those in our midst who have diabetes”.

The Opening Ceremony was addressed long distance, but live, by the President of the USA, George Bush Sr., speaking from the White House and welcoming the delegates to the Congress. He spoke about the problems of diabetes and the need to do everything possible to mitigate the plight of the people with diabetes especially in smaller, poorer and developing countries.

As a coincidence, the dates of the Congress coincided with the first official World Diabetes Day, which was celebrated at the Congress. This, at the time, was the largest single worldwide public awareness effort ever undertaken for those with diabetes.

In 1994, in Kobe, Wendell Mayes Jr. in his triennial Address welcoming the delegates, noted that the International Diabetes Federation was spreading and becoming stronger throughout the world. IDF then had 130 member associations from 108 countries.
He spoke of the increasing collaboration with the WHO and the interactions with them at the World Health Assemblies and during the Executive Committee meetings of the WHO. The World Health Organisation would also be co-sponsoring the World Diabetes Day celebrations every year along with the IDF although it would remain an IDF initiative.

Again, stressing the importance of education, he reported the setting up of the IDF Education Foundation to spread knowledge, educate and thus empower personnel all over. Consultative sections on Childhood and Adolescent Diabetes as well as one on Diabetes education had been formed. Moreover, Task Forces had been formed on NIDDM and Insulin Distribution with the focus on making not only insulin but helping our people with diabetes manage their diabetes related problems and make insulin available and accessible to all those who were in need of this.

Wendell Mayes Jr. spoke of what Harry Keen, had said about the IDF in Nairobi in 1982. “The IDF evolution had gone through three stages or three phases. The first was when Jac Wille of The Netherlands was the part time Secretary-General of the International Diabetes Federation. Then there was a dividing line and the Federation moved into another phase when it established its permanent Secretariat.

The next dividing line came with the adoption of the new Bylaws during the Conference in Nairobi and IDF moved into a third phase. Interestingly enough, that dividing line occurred on November 14, 1982. November 14 is the date which has been chosen as International World Diabetes Day because it is the birthday of Sir Frederick Banting.

The Presidents who have served the IDF have all belonged to another generation. They belong to that generation of those who were first elected IDF officers in one of Harry Keen’s earlier phases. Leo Krall and Jasbir Bajaj and Joseph Hoet and I were all IDF Vice-Presidents in 1982 on the 14th day of November when that last dividing line occurred”.

Wendell Mayes Jr. felt that it was time to pass the torch to a new generation; a new generation first elected as IDF officers during the third phase of IDF’s evolution. But he felt that although a lot had been done, we still had a long way to go.

“Each generation marches to a different drummer. Each generation writes its own songs, and the best songs are yet to be written.”

In Helsinki in 1997, it was reported that the IDF was growing and now had 146 member associations from 121 countries. In his address, the President Jak Jervell spoke about The Regional Development Plan;

The IDF Bulletin was published in three languages: English, French and Spanish;

The Needs Assessment Workshop held by the Consultative Section on Childhood and Adolescent Diabetes;

Publication on Standards of Diabetes education by the Consultative Section on Diabetes Education;

Publications of Book and booklets by the Task Force on Economics of Diabetes Health Care;

Work done by the Task Force on Insulin and Task Force on Member Association Development; The IDF/WHO Working Group;

In her Triennial Address in Mexico City in 2000, Maria de Alva, reminded the delegates that the Congress was taking place on the 50th Anniversary of the forming of the International Diabetes Federation.
She pointed out that the IDF had grown significantly from the 16 member associations at the start in 1950 to 176 members from 136 countries in the world if all the provisional members were accepted as Full members by this General Council.

She spoke of the Regional Development Plan which was created in 1997 to aid and assist the member associations throughout the world. The emblem for this development plan was a Tree symbolizing the IDF with the leaves being the member associations; the stems were the Regions and the trunk was IDF Global with the roots being the IDF mission and objectives which feed the tree!

The IDF had many means of communications, including the IDF website which had been started in 1999 and was being speedily upgraded and updated. The Diabetes Voice had become a full colored magazine, printed in three languages, English, French and Spanish, and covered and reported on many aspects of interest to the people on aspects of diabetes care, economics, empowerment, health policies and research and development from around the world. It also had sections where regions could publish about their activities as could member associations.

At the next Congress in Paris in 2003, the President George Alberti presented the triennial report. He commented and reported on the changes in the Executive Office in Brussels, the IDF review, the changes in the governing structure of the federation, the many communication activities, Diabetes Voice, Diabetes Atlas, the website, World Diabetes Day and the “Time to Act” series of publications, position statements, consensus meetings, collaboration with WHO and other organizations, the strengthening of the regional offices, the Education Foundation.

Prof. Alberti reported in detail about the changes in the executive Office. When he assumed the Presidency, with Pierre Lefebvre as the President-Elect, they realized that that the IDF Office was very short staffed with just three full time members. They had asked the then Executive Director to leave and advertised the position of Executive Director. Having received more than 50 applications, they short listed eight possible candidates, and after a thorough evaluation and audit, they appointed an Executive Director. One of his main tasks was to reorganize and develop the IDF Office.

The 19th IDF Congress was held in Cape Town, South Africa in 2006. Martin Silink assumed the Presidency from Pierre Lefebvre, who presided over the Congress. George Alberti was elected as Hon. President. One of the Major areas of interest was the passing of the UN resolution 61/225 which had occupied a lot of time and effort from not only the previous Executive Board but particularly of Martin Silink. This was a truly momentous occasion in the life of the International Diabetes Federation and is discussed in more detail separately.

Lefebvre reported that he was given the task of oversight during the Paris Conference held in 2003 and he realized that the International Diabetes Federation Office was quite capable of organizing Congresses. The Executive Director had been tasked
A brief history of the International Diabetes Federation

with formalizing this and a Congress team based in the IDF Office in Brussels had been established.

In 2009, the IDF Congress was held in Montreal. In his triennial Address Silink spoke about the celebrations of the First United Nations World Diabetes Day on Nov 14, 2007 at UN; he reported that the WDD had been celebrated in many countries throughout the world and the Blue Lighting initiative had seen more than 250 buildings and landmarks lit in blue in 2007 and more than 2000 in 2008. The IDF had also launched a community awareness program for Early Diagnosis of DKA in children on WDD 2007. The DRCP Journal was now the official Journal of the International Diabetes Federation and how the IDF Advocacy initiative had been strengthened by the formation of the Task Force on National Diabetes Policy and Action. Education initiatives and spread had seen the appointments of the initial IDF Centres of Education.

There had been a restructuring of the IDF Office with the appointment of a Chief Executive Director (CEO) in 2008 and also appointments of IDF Diabetes Education Manager in 2008, IDF Epidemiologist in 2008 and a IDF Health Economist in 2009.

Prof. Pierre Lefebvre was elected as Hon. President. Professor Martin Silink presented IDF service awards in recognition of outstanding service an support to the International Diabetes Federation to Insulin for Life, represented by Neil Donelan, to Lion’s Clubs International, represented by Ms Marilee Kadar, and to Professor Morsi Arab, Mr Denis Taschuk, Ms Marg McGill and Mr Brian Wentzell.

He officially handed over the Presidency to Professor Jean Claude Mbanya.

The 22nd IDF Congress was held in Melbourne in 2013. The President, M.Hirst, reported that a full annual report would shortly be published and presented the highlights of IDF’s work in 2013. It had not been an easy year because the Federation had been without a Permanent CEO since December.

2012. A new CEO had been appointed in November 2013 after an international search. IDF was delivering a substantial range of programmes and forging new collaborations.

He welcomed the support that Member Associations were giving to the Young Leaders in Diabetes Programme and highlighted how the first Global Forum for Parliamentary Champions had met in Melbourne and there was an intention to build a strong network to support Parliamentarians to maintain pressure on governments for action. Hirst also presided over the meeting as his term was to be completed in 2015 as per the new rules wherein an IDF Congress would be held every two years and also the terms of the next Executive Board as well as the Boards thereafter would be of two years duration and not three years.

The 23rd IDF Congress was held in Vancouver in
2015. Shaukat Sadikot assumed the Presidency and M. Hirst presided over the Congress. M. Hirst reported that the General Assembly had approved the Strategic Plan and he outlined what IDF had achieved. The objective of the Strategic Plan was to improve the life of people with diabetes; he reported that IDF had done this in many ways. He highlighted the successes of the many programmes and commented on the important work carried out in governance and regional development. He thanked the General Assembly for all that it had done to support these programmes and thanked his fellow Board Members for their support.

Dr. Sadikot spoke of what would be the priorities of his Board during his tenure. He sincerely felt that Education must be very close to the centre of the IDF activities and coined the term “Education is Empowerment”.

He told the General Assembly the rationale for concentrating on the various aspects of education. “In 2011 when the 5th edition of the IDF Atlas came out, it had a significant amount of data but one stood out. One person died of diabetes related complications every SEVEN seconds! Then in 2015 when the 7th Edition came out, it showed that one person died of diabetes related complications every SIX seconds!

In the four years in between, almost every association had come out with new Guidelines and Consensus Statements, new knowledge had been published in a myriad of Journals and spread out in many Conferences and meetings, also new medications had come in the market…..BUT…for our people with diabetes, “life” had become worse!”

He informed the Congress that the IDF would set up an online IDF School of Diabetes along with IDF Centres of Education as well as IDF Centres of Excellence in Diabetes Care. A “Best of the IDF” initiative would also be launched to cover instances where there was a need for face to face education especially in the nominated IDF Centres.

Regional Development would proceed and it was hoped that all the regions would be set up as IDF

Advocacy was another area which would be in focus. One of the initiative would be the Blue Circle Voices which would again be an online forum where people could network and also have a platform to inform the IDF of what required to be done in different regions and countries to improve the standards of diabetes care as well as measures which needed to be taken to prevent diabetes in the general population. The IDF would work closely with the World Health Organisation as well as other international organizations such as the International Red Cross and the Medecins sans Frontieres to improve health care availability in areas of natural or man made disasters.

The aim at the end was to do everything which would improve the lives of our people with diabetes and quoting Mahatma Gandhi, he ended, “Before taking up any initiative we have to think of the most poor and vulnerable of our people. If what we are doing is something that will bring a small smile to their faces, then this must be done no matter how difficult it is and how hard we must strive to achieve this”.

The IDF Congresses were held every three years until
2009 when it was decided that three years was too long an interval and the IDF Congresses were held every two years.

**IDF COMMUNICATIONS (IDF NEWS BULLETIN, DIABETES VOICE, DRCP, IDF ATLAS)**

The IDF News Bulletin first appeared in February 1954. Mr. Pieter Duys, the Executive Secretary was given responsibility for this and there were four issues in the first year which were duplicated typed written pages. The material was collected from the national journals of the member countries and also carried the news from the Secretariat.

In 1955, the Bulletin changed into a small booklet format. The fourth issue of Vol.2 appeared in January 1956. The Bulletin then ceased to appear for one year due to the fact that Mr. Duys fell ill. It reappeared in January 1957 with L. L. Frank as its Editor. Whilst the Bulletin was in the English language, from the third issue in Vol. 3 onwards the Bulletin came in both English as well as French languages due to the offer of translation by the French Diabetic Association. In July 1957, an Editorial Board was appointed to assist Dr. Frank and the members were Deuil (France), Marble (USA), Rocca (Uruguay) and Tangent (Norway).

Frank resigned in 1958 and the Editorship was changed into a Co-Editorship and Deuil and Mr. Jackson were appointed Co-Editors. The issues continued in the two languages until September 1960.

From March 1962 to July 1973 Dr. J.J. Witte served as the editor and the Bulletin came out twice a year. But there was a change of format. Articles were not translated but published in their original language, French, German or Spanish. Whilst the news from the member associations was still given a lot of space, specially invited articles were also a part of the Bulletin.

Witte left his duties as Secretary and editor in 1973, but the Bulletin continued with the help of the Editorial Board which had been enlarged in these years in order to give as wide a representation as possible.

In 1974 at a meeting of the General Council in Jerusalem, one of the issues raised by many of the delegates was about the News Bulletin. Many of the delegates were unsure as to how the Bulletin was distributed within their country and it was seen that copies were distributed mainly to members of the Governing Councils of the member associations. The Secretary explained that the main aim of the Bulletin was to act as a link and keep the member associations and the IDF in touch and inform one another of the activities which were happening in the field of diabetes in various parts of the world. The readership of the Bulletin included people with diabetes, diabetologists, primary care physicians as well as paramedical personnel. The Bulletin was not meant to be a medical Journal but at the same time would carry and thereby widely spread important information about initiatives which would be of interest to the members such as camps of children with diabetes, syringes, employment matters and other welfare aspects.

The General Council wanted a wider dissemination of the Bulletin and one way was to open up the federation to individual membership which would also entail receiving the Bulletin amongst other things. Moreover, individual subscribers were also accepted.

In 1974, Mr. Jackson, as was the norm at that time, assumed the post of Editor but continued with the same Editorial Board. The format again underwent a change with photographs being included and the frequency became three times a year. Although there were individual subscribers, MA s continued to receive
10 complimentary copies and in order to showcase the work being done by the IDF, complimentary copies were also sent to a long list of societies and libraries. In order to make the Bulletin economically viable, advertisements were accepted although there was a strict ethical scrutiny before the acceptance of any advertisement.

It was in 1975 that the name IDF News Bulletin was changed to IDF Bulletin. Incidently, the expenses for the IDF Bulletin was 12907 British Pounds in 1982. When the IDF Office was set up in Brussels in 1985, another publisher of the IDF News Bulletin had to be appointed. The American Diabetes Association stepped in and published the Bulletin for nine years at no cost to IDF. Harold Rifkin, a physician from the United States, was an Associate Editor while the IDF News Bulletin was being published by the ADA and it was widely believed that it was his personal involvement which kept the IDF Bulletin “alive”.

It was during the Presidency of Jak Jervell (1994-1997) that it was felt that the name IDF Bulletin was confusing because by its name one could not know it was related to diabetes.


The focus was to make the magazine more interesting and dynamic. After changing the format, the Board decided that to spread out its reach it should also be available in other languages and started with French and Spanish along with the English editions.

By the year 2000, Diabetes Voice had become a full colored magazine, printed in three languages, English, French and Spanish, and covered and reported on many aspects of interest to the people on aspects of diabetes care, economics, empowerment, health policies and research and development from around the world. It also had sections where regions could publish about their activities as could member associations.

Between 2001-2009, the number of yearly issues increased: 4 regular issues and 1 or 2 special issues. In 2010, the design of the magazine was changed again and only two issues were brought out. The number was back to four from the following year. In 2014, the magazine was made more accessible for the visually impaired and it was only in 2015 that it went online.

Editors-in-Chief of Diabetes Voice since 1999 (in chronological order):
Leena Etu-Seppala; Philip Home; Rhys Williams; Helmut Henrichs; Stephanie Amiel; Rhys Williams; Douglas Villarroel;

The IDF had many means of communications, including the IDF website which had been started in 1999 and was being speedily upgraded and updated.

Milestones
1954 (February) – The first IDF News Bulletin appeared in February. It appeared as a duplicated typewritten quarterly, containing pages of news taken from the national journals of countries as well as IDF Secretariat news items.
1955 – The format changed to a small booklet in March.

1956 – Publication was terminated for one year starting from January. 1957-1960 – IDF News Bulletin was issued in English and French.

1975 – A complete change of format was approved to include photographs, ad IDF News Bulletin became IDF Bulletin.


1999 – The name of the publication was changed to Diabetes Voice, Bulletin of the International Diabetes Federation; steps to modernise the contents and design.

1999 – Setting up of the website of the IDF Website

2001-2009 - The number of yearly issues increased: 4 regular issues and 1 or 2 special issues. 2010 – The design of Diabetes Voice changed; two issues were released this year.

2011 – The amount of yearly issues reduced to 4, including special issues. 2014 – Diabetes Voice became more accessible for visually impaired.

2015 – Diabetes Voice became an online publication.

“Diabetes Research and Clinical Practice” (DRCP)

One area which was coming up for discussion time and again was the fact that the International Diabetes Federation did not have a scientific indexed Journal of its own. It seemed that it was the only international association which did have medical people and scientists in its member associations, which did not have an indexed scientific journal.

The Western Pacific Region did have such a Journal “Diabetes Research and Clinical Practice” and the Chair of the region decided to hand this over to the IDF Global. This was done in 2009 and the 1st issue of the Journal DRCP came out in January 2010 as the Official Journal of the International Diabetes Federation.

It has to be noted that the reputation of the Journal had been built up over several years especially by the medical personnel from the Western Pacific Region and the handing over to the IDF Global by a person who was from the region but was a lay person was not taken too well by many people in the Region! The reason given by Bunyan was that the Journal was owned by the publishing Committee Elsevier and not be the Western Pacific Region and so the people there could not have a right to stop the transfer. Sadikot who was on the Board pointed out that DiabetesIndia also had an indexed Journal which was published by Elsevier but owned by DiabetesIndia and that the WPR region could adjust the agreement which Elsevier would not have a problem with. Why the WPR region had agreed to have a Journal without owning rights and this change that could be made was not discussed as it was the Chair of the WPR

A. Ceriello
S. Colagiuri

The first issue of DRCP as the official IDF Journal
region who was very keen on transferring the rights to IDF Global.

The Executive Board cleared the transfer and the DRCP became the Official Journal of the IDF Global. Incidentally, even then the ownership question was not looked into and the DRCP still is owned by the publisher Elsevier and not by the IDF Global!

Thus the DRCP became the official IDF Journal in January 2010.

Editors-in-Chief: Stephen Colagiuri and then Antonio Cerrielo

Honorary Editors-in-Chief: C.S. Cockram, Stephen Colagiuri, N. Hotta, J.R. Turtle


Invited Reviews Editor: Pierre Lefebvre
Since its creation in 1950, the International Diabetes Federation (IDF) may have been at the forefront of the fight against diabetes, but we had no epidemiological data on how truly widespread the problem was. "Guessimates" could not be relevant when espousing the need to fight the rising pandemic.

The first attempts at calculating the severity of the problem came in the early 1990s, when Hilary King (who at that time was working with Paul Zimmet in Australia before leaving to join WHO) and Marian Rewers, from Denver, USA, published a paper in Diabetes Care: King, H., Rewers, M. Global estimates for prevalence of diabetes mellitus and impaired glucose tolerance in adults. Diabetes Care. 1993;16:157–177.

In 1994, Paul Zimmet (now an Honorary President of IDF), who had been interested in the epidemiological aspects of diabetes, presented a paper at the IDF Congress in Kobe, Japan: McCarty, D. and Zimmet, P. (1994) Diabetes 1994 to 2010: Global Estimates and Projections. International Diabetes Institute, Melbourne. They later continued their work in this area and subsequent papers were published:


It was a consequence of the significant interest shown in these papers that IDF decided to produce the IDF Diabetes Atlas, the first edition of which was published in 2000, during the IDF Congress in Mexico City.
Diabetes Atlas 2000 maps the world of diabetes. It is a world inhabited by many stakeholders with different interests. They are, however, united by a common cause, and that is to improve the lives of people with diabetes. This world, however, is not exclusive as support from others, such as governments, health-related international organizations and industry, is crucial to the success of our mission. That support must come with the realization that reducing the burden of diabetes means reducing the burden for society and that creating a conducive environment for people with diabetes to lead healthy, productive lives means a gain for the country.”

**Second Edition (2003)**

*Atlas Committee:* Bjørnar Allgot (co-chair), Delice Gan (co-chair), Hilary King, Pierre Lefèvre, Jean-Claude Mbanya, Martin Slík, Linda Siminerio, Rhys Williams, Paul Zimmet

*Editor and project manager:* Delice Gan

*Project co-ordinator:* Catherine Regniers

Published in English, French and Spanish

“Since the publication of the first edition of the Diabetes Atlas in 2000, a number of things have changed. Our appreciation of the extent of the burden of diabetes in the world has been refined, our knowledge of the risks to health as a whole and to diabetes in particular has increased and our conviction that type 2 diabetes is potentially preventable has been confirmed with solid evidence about the steps we need to make that potential a reality. WHO and IDF continue their partnership in the fight to improve the wellbeing of people with diabetes and to include in this partnership other organizations with an important part to play in this endeavour.”

Derek Yach, Executive Director Non-Communicable Diseases and mental Health Cluster, WHO

In his forward, IDF President, Prof George Alberti wrote:

*“Several years ago it was proposed by my predecessors that it would be helpful to bring together relevant data about diabetes and diabetes associations around the world. This culminated in the publication of the first edition of the Diabetes Atlas at the 17th IDF Congress in Mexico. It was beautifully produced and instantly popular. It went to Ministers of Health in IDF member countries, WHO offices, diabetes associations and many others.

Many new sections have been included since the first edition. The epidemiology section has been updated, stressing again the rapid rise in prevalence, as has that on economics. A new section on impaired glucose tolerance (IGT) is included, giving an indication of the further rise in diabetes that is to come. This is the first time worldwide data on IGT have been collected together. The prevalence of complications is now included – important for planners, health professionals and people with diabetes alike. It is also the first time that such information has been compiled in one publication. It is useful in showing not only the prevalence data but also the gaps in our knowledge in this area. Another new chapter discusses the relationship between obesity and diabetes as well as the effect of diabetes on cardiovascular disease. The vital topic of access to insulin is also covered – an area of critical importance in many IDF member countries. Diabetes education has an expanded section, emphasizing its role in the successful management of the disease. Primary prevention and socio-economic indicators complete the text.”*

Atlas Committee: Jean-Claude Mbanya (co-chair), Delice Gan (co-chair), Bjørnar Allgot, Karel Bakker, Jonathan Betz Brown, Ambady Ramachandran, Gojka Roglic, Jonathan Shaw, Martin Silink, Linda Siminerio, Gyula Soltész, Rhys Williams, Paul Zimmet

Editor and project manager: Delice Gan
Project coordinator: Olivier Jacqmain

Published in English, French and Spanish

“Diabetes presents major challenges to patients, health systems and national economies. The World Health Organization together with the International Diabetes Federation is working to raise awareness of diabetes worldwide along with improving the quality of care. This latest edition of the Diabetes Atlas is a welcome update of the trends in the global burden of diabetes and its related economic implications. It also spotlights recently documented dimensions of the disease – such as the increase in diabetes in children and the often underestimated mortality attributable to diabetes. I am confident that the Diabetes Atlas will continue to be a valuable resource for advocates, policymakers, researchers and healthcare providers.”

In his forward, IDF President, Prof Pierre Lefebvre wrote:

“The third edition of the Diabetes Atlas firmly confounds what many have believed for so long. Once thought of as a disease of affluent countries, type 2 diabetes is now a growing burden on developing economies. More than 80% of the 246 million people with diabetes live in low- and middle-income countries, where health resources are needed to combat both contagious and chronic diseases. Once thought of as a disease of the elderly, people in younger age groups now form the bulk of those with diabetes.

This edition of the Diabetes Atlas brings us face to face with these issues and challenges. It is now up to us to take up the challenge and find cost-effective ways to tackle one of the largest health problems we now face. We must unite – governments, organizations, individuals – to prevent diabetes, to improve diabetes care for the millions affected and to, ultimately, find a cure.”

Robert Beaglehole, Director Department of Chronic Diseases and Health Promotion, Noncommunicable Diseases and Mental Health Cluster, WHO

246 million people with diabetes

A brief history of the International Diabetes Federation
In his forward, IDF President, Prof Martin Silink wrote:

“The International Diabetes Federation is proud to release the fourth edition of the IDF Diabetes Atlas at the 20th World Diabetes Congress in October 2009 in Montreal.


The potential impact of diabetes as a development issue was recognized by the United Nations in 2006 in Resolution 61/225 when it stated that ‘diabetes is a chronic, debilitating and costly disease associated with severe complications, which poses severe risks for families, Member States and the entire world and serious challenges to the achievement of internationally agreed development goals including the Millennium Development Goals’. In the words of Mr Ban Ki-Moon, UN Secretary General, ‘Cancer, diabetes, heart diseases are no longer the diseases of the wealthy. Today, they hamper the people and the economies of the poorest populations, even more than infectious diseases. This represents a public health emergency in slow motion.’ The World Economic Forum 2009 Global Risks Landscape assessment report identified chronic diseases as one of the most significant risks facing the global economies, exceeded only by the risks posed by sudden oil/gas price rises, retrenchment from globalization, asset price collapse and a slowing of the Chinese economy.

Yet, despite these statements, the International Diabetes Federation recognizes that the global community still has not fully appreciated the urgent need to increase funding for noncommunicable diseases (NCDs), to make essential NCD medicines available for all and to include the treatment of diabetes and other NCDs into strengthened primary healthcare systems.”

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Ala Alwan, Assistant Director-General, WHO
In his forward, IDF President, Prof Jean Claude Mbanya wrote:

‘The International Diabetes Federation is proud to release the 5th edition of the IDF Diabetes Atlas, once again showing that diabetes is a global epidemic. The Atlas is the authoritative source of evidence on the burden of diabetes for health professionals, scientists, economists, policymakers, and national and international agencies. The evidence presented in previous editions of the IDF Diabetes Atlas has been used widely by news media, governments, and international organisations such as the World Bank, the World Health Organization, the Organisation for Economic Co-operation and Development, and the World Economic Forum. Estimates from the 4th edition were instrumental in providing the evidence to drive the unanimous adoption of the resolution for the September 2011 UN High-level Meeting on Non-Communicable Diseases. This summit will ensure that non-communicable diseases such as diabetes will no longer simply be a footnote on the global health agenda.

We need to work together to ensure the commitments made at the UN High-level Meeting in 2011 are turned into actions, not just for the millions who have diabetes today, but for the millions yet to come. People with diabetes and their families deserve a better future.’

Ala Alwan, Assistant Director-General, WHO
In his forward, IDF President, Sir Michael Hirst wrote:

“IT is a bittersweet pleasure to be presiding over the International Diabetes Federation upon the launch of this sixth edition of the IDF Diabetes Atlas. The evidence published herein on the millions of people swept up by the diabetes pandemic vindicates the Federation’s relentless efforts to promote solutions to this worldwide health crisis. Previous editions of the Atlas were a crucial tool in the successful campaign for a UN Resolution on diabetes and our figures informed the subsequent political declaration on non-communicable diseases. We have achieved much: diabetes is now firmly on the highest of decision-making agendas. But the figures in this edition are a harsh reminder of how far we still have to go.

In the last two years, progress has been made toward driving political change for diabetes. Building on the momentum of the 2011 UN Political Declaration on non-communicable diseases (NCDs), the 66th World Health Assembly in May 2013 saw the unanimous adoption by Member States of a voluntary Global Action Plan for the prevention and control of NCDs. Diabetes is now prominent on the global health agenda, with specific targets for access to essential medicines and for halting the growth of obesity and diabetes. Still, we must not miss this opportunity. Governments and policymakers, health professionals and those affected by the disease must remain engaged in the fight so that IDF may achieve its vision of living in a world without diabetes.”
In his forward, IDF President, Sir Michael Hirst wrote:

"While diabetes can cause devastating personal suffering, it is also an economic burden for every country around the world. As the incidence of diabetes rises, so too does the requirement for healthcare. Less obvious is the impact on the overall economy, but it is clear that an unhealthy population is not able to fulfil its potential in contributing to economic development.

We are pleased to report that IDF's persistent efforts to position diabetes more prominently on the political agenda are starting to yield results. This year we used the G7 Summit in Germany as a platform to urge all G7 nations to develop and implement cost-effective policies to help tackle the rise in diabetes. This call for action was just the first step in a campaign that will build momentum over the next few years.

Another milestone was reached in September this year when diabetes became part of the new United Nations sustainable development agenda, with the inclusion of non-communicable diseases in the Sustainable Development Goals. We believe that continued efforts to raise awareness are vital to encourage governments to take a more proactive role in helping to prevent the increase in people with diabetes. Governments must do more to raise awareness."
In his forward, IDF President, Shaukat Sadikot wrote:

Diabetes, a disease no longer associated with affluence, is on the rise across the globe as reported in this 8th edition of the IDF Diabetes Atlas 2017.

At present, nearly half a billion people live with diabetes. Low- and middle-income countries carry almost 80 percent of the diabetes burden. Rapid urbanization, unhealthy diets and increasingly sedentary lifestyles have resulted in previously unheard higher rates of obesity and diabetes and many countries do not have adequate resources to provide preventive or medical care for their populations. Diabetes is not only a health crisis; it is a global societal catastrophe.

Despite the worrying picture depicted by the new IDF Diabetes Atlas figures, we have both the knowledge and the expertise to create a brighter future for generations to come. We must raise awareness on the importance of a healthy diet and physical activity, especially among children and adolescents, and incorporate healthy environments into urban planning. Health professionals in primary healthcare should be adequately and appropriately trained about diabetes prevention and care, and provided with necessary screening tools and diabetes medications.

As part of the 2030 Agenda for Sustainable Development, Member States of the United Nations set an ambitious target to reduce premature mortality from NCDs—including diabetes—by one-third; provide access to affordable essential medicines; and achieve universal health coverage, all by 2030. We have an enormous task ahead of us, which is why we welcome the new edition of IDF Diabetes Atlas.

Going forward, IDF is calling for all nations around the globe affected by the diabetes pandemic to work towards the full implementation of Sustainable Development Goals and raise awareness about diabetes since ignorance and misconception remain widespread.


REGIONAL DEVELOPMENT

The International Diabetes Federation was set up as a united international body without taking into consideration continental or regional boundaries. But it was increasingly realised by the General Councils that as the IDF grew in numbers and spread, it made administrative sense to let the member associations have a greater say in the running of the federation. As countries which came from the same regions, would in many instances be facing similar problems, and have closely similar needs as well as solutions to improve the health care in their country, it made sense to have the member associations in a region have closer ties. One way this could be done was to formulate regional plans for development which would be closer to the national needs and requirements. Though the IDF would still remain united, there was a definite need to have Regions as a part of the administrative structure and function.

Although there had been continuing discussions about this, the first definitive move came during the General Council meeting held amidst the Nairobi IDF Congress in 1982. As a coincidence it was again on the 14th of November that the General Council ratified a resolution which may have been the most significant milestone in IDF history to date. A major restructuring of the IDF into seven regions, each with their own representatives and each with inclusion in the central IDF Executive Board was proposed and accepted. This served to provide for a democratic decentralization of power and make it possible for the IDF to be the real voice of the people with diabetes all over the world.

But there were some who felt that this was a way in which the members, especially those in smaller, poor and developing countries and frequently the most in need, were being pushed away into regions and further from the IDF Global whose main function was, in fact, to help these very same countries and national member associations. This, as R. Luft explained, was far from true. Under the new laws, the Chairs of the Regions would be members of the IDF Executive Board and this was also a guarantee that that assistance needed by the Regions in carrying out their activities which were in keeping with the Aims of the IDF would be provided. The rationale was to strengthen the regions to work on aspects more relevant to their people.

In fact, Luft reminded the General Council that that when the Constitution of the IDF was first written and approved, the authors and members of the then General Council has accepted that in time to come Regional Offices would have to be established and Article 5 of the Constitution which still was valid then, said very clearly “Regional Offices could be established with the approval of the General Council.”

The motion to have regions was put to vote and passed by the General Council.

The Regions were formed and although there were many early “teething” troubles, the concept of having regions seemed to be functioning as hoped. There was always scope for improvement and this was constantly being worked upon.

In 1994 in Kobe, Wendell Mayes Jr., reported to the General Council that the Regions were getting stronger and carrying out many activities as had been envisaged when the seven regions of the IDF were formed. Moreover member associations were getting stronger and the weaker ones were being helped by the “twinning” initiative.

In order to make the development of the Regions faster as well as to bring about greater co-ordination between the Regions and the IDF Global, a Task Force on Regional Development was set up in 1995. All Regional Chairs were members along with the President and President Elect as well as Henry Rivera and Sterling Tucker, who was the Chairperson. A regional Development Plan was formulated and presented to the executive board in 1996 where it was adopted without dissent.

The Regional Development Plan had six main goals:

- Establish strong, viable action oriented structures in all the seven regions;
- Establish and strengthen the regional management support structure in all seven regions;
- Make an inventory of resources, including financial resources, available in the Regions for diabetes
prevention and awareness campaigns; education and training research, delivery of care and other activities, and engage new partners each year;

Following consultations with members and regions, to develop a strategic development plan that would reflect the regional needs and priorities;

From December 1999, the IDF would assist in the implementation of the strategic plan and have an annual evaluation;

Through each phase of this Plan, the IDF would strengthen co-ordination and communication between the Regions and the IDF Executive office;

In 2000 in Mexico City Maria de Alva spoke of the Regional Development Plan which was created to aid and assist the member associations throughout the world. She said that the emblem for this development plan was a Tree symbolizing the IDF with the leaves being the member associations; the stems were the Regions and the trunk was IDF Global with the roots being the IDF mission and objectives which feed the tree!

The Regions continued to do relatively well, some doing better than others. At the same time, there were some grumbles that there was too much interference and too many permissions had to be taken from the IDF Global Office when carrying out initiatives and also the absence of substantial financial support even though the finances of IDF were getting into a better mold.

At the same time, it was seen that there were Regions which were carrying out their activities as if they were totally independent of the IDF but did not hesitate to use the “name” and good reputation of the IDF, as well as the IDF contacts, to collect funds and create partnerships. This, of course, did not go down well with the Executive board of the IDF as well as the global office, and especially other Regions which were following the correct norms.

It also seemed that some of the Executive Boards of IDF were not too involved with helping out the regions although the Chairs and Chairs Elect of the Regions were members of the Board. This was to be later changed to having only the Chairs of the Regions on the Executive Board when this was streamlined to make it smaller but more concentrated on its work. The finances too were a consideration.

When S. Sadikot was the President Elect, he chaired the Regional Development Committee and reported to the Executive Board that changes had to be made in the governance structure and the Regions should be given more freedom and power to carry out activities which would be of benefit to the people in their regional countries. At the same time, it should be made clear to all the Regions that they were not independent of the IDF and had to function within the aims and objectives of the IDF as well as have rules which were in keeping with the Articles of Association of the IDF which had been drafted keeping the Belgian laws in mind. Moreover, it was pointed out during the meeting of the Executive Board that the member associations which were in the regions were basically, and primarily, member associations of the IDF Global and had been put into regions based on their location and for better governance.

Moreover as Sadikot pointed out that whilst the IDF Global was always willing to help and would do all that it could to improve the lives of the people with diabetes all over the world, the needs and requirements of the people in various countries and regions could be better gauged by people in the regions rather than someone sitting in Brussels!

This was accepted by the Executive Board.

It was decided that the Regions would all be treated
equally by the IDF and, after taking legal opinion, it was decided that all the regions would be subsidiaries of IDF Global and have to decide where their office would be based. Once this had been decided, the Regions would need to draft their “constitution” as per the local laws of the country where the office would be based, especially the financial regulations, and also in keeping with the Articles of Association of IDF Global as the subsidiaries also had to abide by Belgian laws and were not independent of IDF Global.

The movement continued during the Presidency of Sadikot and had the full support of the Executive Board as well as the President-Elect Nam Cho. Whilst some of the regions moved ahead at a faster pace and some were lagging, the process of forming of the subsidiaries moved ahead.

LOGOS AND SYMBOLS OF THE INTERNATIONAL DIABETES FEDERATION

The logo of the International Diabetes Federation was originally being used as their logo by the Dutch Diabetes Association (DDA) which was founded in 1945. The hummingbird, also known as the “Bird of Hope”, had been chosen by the DDA as it was supposed to symbolise the optimism of their people with diabetes as they sought ways to manage their diabetes related problems, overcome the challenges and deal with the possibility of its terribly devastating complications.

In 1984, the "Diabetes Vereniging Nederland" moved that its humming bird logo be adopted as an international symbol for diabetes research, information, communication and education, and was further seconded by SOKUDI, the Sosiedad Kurasolefio de Diabetiko from the Netherlands Antilles, who, impressed by the eager flight of this elegant bird which flies over their deep blue sea, also adopted the same symbol.

This proposal was made on the occasion of DVN’s 40th anniversary of its formation, and was accepted by the Executive Board in London in September 1984 with the understanding that national associations were free to add the humming bird logo to their individual logos if they so wished. As for the Federation, a new logo to replace the existing clouds, by the bird of hope, was put into design and was presented by Jak Jervell to the General Council during the Madrid Congress, in 1985, and accepted.

In the late 1990s, it was further modified to show a hummingbird flying on top of the world so as to bring “hope” to the millions of people with diabetes all over the world dealing with their diabetes related problems, that a way would be found to overcome their health problems caused due to diabetes and improve their lives.

It became the official symbol of the International Diabetes Federation.

A grey ribbon with a drop of red

A group of people with diabetes, based in the USA, were trying to bring diabetes into focus and were frustrated that there was no symbol to help raise awareness about diabetes. No colour that would stand for diabetes in the minds of people. There was RED for AIDS, Pink for breast cancer but nothing for a disease which was spreading like a wildfire.

After a lot of discussion the colour gray was chosen with a red spot. The red spot was to signify blood used to test blood glucose levels. But why Gray? Although
definite information on this is not available, one of the explanations was that this was to show that diabetes was not something to be cheerful about. The colour was silvery gray. The gray stood for the sadness so often seen in people with diabetes overcome with their health related problems whilst the silver was the silver lining standing for the possibility of finding a cure for diabetes. After the colour was chosen, many ribbons were made but it was still not clear as to how this was to be spread or for that matter accepted by the public. It so happened that in the mid 1990s one member of Governing Council of the JDFI (now JDRF) went to a meeting in Athens and distributed hundreds of these ribbons. They were liked by the delegates and the JDRF adopted the ribbon. In the USA this ribbon became the most popular of the three ribbons available as symbols for diabetes. For a few years, the JDRF also sold a gray ribbon tie tack (and Bill Clinton actually wore one while signing a diabetes-related bill), but the drive for the ribbon petered out rather quickly.

There are stories, possibly anecdotal, that the ribbons were also presented to the IDF but were not accepted as an appropriate symbol for diabetes, possibly due to the gray colour of “despair”. The precise reasons for the decision had not been noted down.

THE Blue Circle

Although this is often taken to be the emblem associated with the World Diabetes Day, it was in reality an emblem that was developed as a universally acceptable symbol for the “Unite for Diabetes” Campaign during the efforts to get the UN Resolution passed.

There was a need felt for a unique symbol not akin to anything used by other Organisations or a cause. It needed to stand alone symbolizing the IDF quest for the UNR, similar to the way in which red ribbons promote AIDS awareness and recognition as a public health priority.

It was left for the IDF Public Relations Committee to come up with ideas and the team led by Alain Baute and Phil Riley came up with the idea of a simple plain blue circle.

They explained the reasons for this. The circle has meaning. In many societies, a circle stands for life, mother, earth, health. But most of all it symbolizes unity. And unity was the key element that made the campaign so unique and special. The unbreakable unity it represented mirrored the unity amongst the global diabetes communities; united towards a successful UN resolution on diabetes. The blue border of the circle reflected the sky that united all nations and was also the colour of the flag of the United Nations. The UN is the organization that can best help to curb the growing pandemic of diabetes. The United Nations is a symbol of unity amongst nations. Now was the time and need to Unite for Diabetes.

It was also agreed by the IDF Public Relations Committee that there would be no hard edges and so a circle, (hard edges are seen as unfavourable in some countries and societies and one needed to be international), could not have letters or numbers for international purposes, and needed to be easy to reproduce.

Hundreds of thousands of blue circles were proudly worn as lapel pins and the logo was added to all letters and advertisements.

SPECIAL INITIATIVES, PROGRAMMES AND COLLABORATIONS

The IDF Diabetes Education Foundation

In order to carry out educational and scientific activities with the focus of being of benefit to people living in low income and developing countries
which made up the majority of the then member associations, more than 60% of who were from countries with an annual GDP of less than 3500 US dollars per year. The IDF (International Diabetes Federation) Education Foundation was created and established in September 1992. A major objective was to help to lessen the detrimental impact of shortages of well trained health care professionals in these countries.

Wendell Mayes Jr. was the President of the IDF at that time.

Since its formation in 1992 the Foundation has had two Chairmen; Pierre Lefèbvre (1992-1997) and Clive Cockram (1997-2006). In addition to the Chairman, the Management Committee of the Foundation includes the IDF President-Elect (as vice-Chairman), one or more Vice-Presidents and the Chairmen of the seven IDF regions.

The IDF Education Foundation also aimed to enhance educational programmes by fostering good working relationships with IDF member associations, governmental and non-governmental organizations, private industry and the public in general. It increased collaborations, brokered by the Foundation, between many well-established training centers of international repute and private sector donors. The activities supported by the Foundation emphasized short training fellowships for individuals, but had in the past also included grants for educational projects, support for visiting professionals and support for regional leadership and health care delivery courses. In the first 3 years fundable initiatives included awards for in-country educational projects (the IDF/Eli Lilly Fund) and awards for excellence of care (IDF/Ames Fund). These initiatives were discontinued in 1996 when funding was re-allocated to other IDF activities such as regional development.

From 1996 the Foundation limited its activities to the funding of short training fellowships, usually of 3 months duration. The emphasis was on clinical training in appropriate centres where fellows could develop skills required in their home country. It was hoped that Fellows, when they returned home, could then act as a source of expertise for the training of others. The focus on short training fellowships for individuals included both global and regional initiatives.

Funding support for the Foundation came from a number of sources including individual donations, pharmaceutical companies and IDF member associations.

The Mary Jane Mayes Scholars

The Wendell and Mary Jane Mayes Fund was regarded as the most prestigious and was awarded annually to those applicants judged to be most worthy. It was set up in 1992 by Harold Rifkin to honour Mary Jane Mayes and the recipients were designated as Mary Jane Mayes Scholars. Since 1997, following exhaustion of the funds originally raised and designated by Professor Rifkin, this Fund was administered by the American Diabetes Association, which administered contributions made by Wendell Mayes Junior. To perpetuate the Mary Jane Mayes scholarship he made annual contributions to the ADA with a request that it be invested in an index mutual fund and a fixed percentage of the fund be redeemed each year with half of the amount being used by the ADA and the other half being contributed to the IDF to support the Mary Jane Mayes scholars.

The original request from Harold Rifkin was that the award be made to a recipient in such a way that the effect reached people with diabetes in the “most fundamental, personal and caring way.”

The Education Foundation did its utmost to adhere to this principle.

Other short training fellowships

The other global fund which ran continuously since 1993 was that supported by Hoechst Marion Roussel
and subsequently Aventis Pharma and Sanofi-Aventis following mergers involving the companies concerned.

Later Novo Nordisk and LifeScan Inc generously supported regional grants in Africa and the Western Pacific Region. In the case of Africa these grants allowed the funding of a large number of short training fellowships since the millennium. Servier also generously supported applicants from Cambodia as a one-off exercise in 2001. Many short training fellowships were awarded to non-medical health care professionals, particularly from the Western Pacific and African Regions. All the Fellowships were funded by the IDF Education Foundation.

More than 750,000 U.S. Dollars have been given as grants and Fellowships by the IDF Education Foundation between its inception in 1993 and 2006.

COUNTRIES OF ORIGIN OF GRANTEES AND AWARD RECIPIENTS 1993-2006

Number in brackets indicates total number if more than 1 award made.

- Estonia(2)
- Bulgaria(4)
- Turkey(5)
- Russia(2)
- Lithuania(2)
- Argentina(9)
- PR China(8)
- Nigeria(15)
- Kenya(8)
- India(13)
- Tanzania(8)
- Bangladesh(8)
- Poland(3)
- Lithuania
- Costa Rica(2)
- Albania
- Zambia(2)
- Papua New Guinea
- Belarus
- Jamaica
- Senegal
- Niue Islands
- Coted’Ivoire(3)
- Zimbabwe(2)
- Colombia

- Portugal
- Mexico
- Portugal
- Philippines(3)
- Uganda(2)
- Pakistan(3)
- Sudan
- Israel
- Mauritius
- Ukraine(4)
- Indonesia(2)
- Uzbekistán
- Cameroon (12)
- Trinidad and Tobago
- Iran(2)
- Australia(2)*
- Ethiopia
- Romania(8)
- Fiji(2)
- Cuba(2)
- Cambodia(4)
- Peru
- Libya
- Paraguay

Malaysia
- Congo
- Rwanda
- Venezuela
- Ghana
- Zaire

The IDF Education Foundation was halted in 2006 during the tenure of M. Silink.

IDF School of Diabetes

Education activities had always been at the forefront of the work which was done by the International Diabetes Federation. Having said that, there was an increasing feeling amongst members that this area of activity was not being focused on as must as it should. In 2016, when Shaukat Sadikot took over as the President of the IDF, he sincerely felt that Education must be very close to the centre of the IDF activities and coined the term “Education is Empowerment”. He had mentioned in his address to the General Assembly in Vancouver that education would be a very important part of his term as President and this had been met with support across member associations from all regions.

But it should also be mentioned that a couple of member associations and associate members who already were active in the education area and whilst doing a good work, were also charging fees which in many instances were felt to be too high and which was not something people living in developing countries be they LIC or MIC countries could afford. Moreover with the changes in the laws governing how people could not take the help of money from companies especially pharmaceutical companies, such as the “Sunshine Laws” etc., it was becoming more and more difficult for people not only in LIC and MIC countries to attend education meetings for face to face lectures but this was being felt even in many developed countries.
A brief history of the International Diabetes Federation

Speaking as President-Elect in Vancouver, he told the General Assembly the rationale for concentrating on the various aspects of education. “In 2011 when the 5th edition of the IDF Atlas came out, it had a significant amount of data but one stood out. One person died of diabetes related complications every SEVEN seconds! Then in 2015 when the 7th Edition came out, it showed that one person died of diabetes related complications every SIX seconds!

In the four years in between, almost every association had come out with new Guidelines and Consensus Statements, new knowledge had been published in a myriad of Journals and spread out in many Conferences and meetings, also new medications had come in the market.....BUT...for our people with diabetes, “life” had become worse!

All the knowledge and medications seemed to be of no use in improving the lives of our people with diabetes which should be our main aim and focus. It was time for the IDF to come out of the Ivory towers of Academia and look at the ground reality. It had to spread the knowledge to the main medical care givers, especially the Primary Care Physicians (PCPs) and General Physicians, diabetes educators and our people with diabetes. Not only would education and knowledge lead to better prevention and management of the diabetes for the people.

We ask everyone to be advocates for our people with diabetes and Unite for Diabetes” (although he said that the slogan should have been “Unite Against Diabetes”) but how would this be possible if most of them were not aware of the aspects of diabetes especially the medical, but as importantly the socio-economic consequences not only for the people with diabetes and their families, But to society and the national at large!

If we were to wage, and win, a war against diabetes, we had to realise that this was not a modern day war where one could bomb the “enemy” or use drones to fight the war. This was like the old days when troops faced each other. The front line troops in our war against diabetes were our Primary care and general physicians as well as diabetes educators, and these had to be backed by the support of our people with diabetes.

Our “troops” had to be well armed to fight the war and in this it was Education which was the best weapon. It was education which would empower them so that they were better able to fight this scourge. Diabetes education was our weapon and must become a central theme in our fight against diabetes. It had to become a key area of focus for the IDF”.

With the support given by the General Assembly and the new Executive Board being on “board” especially the support of the President Elect Prof. Nam Cho, the IDF set up an International School of Diabetes which was online and had a significant amount of education material as well as certified courses in various aspects of diabetes education, prevention and care. The total content was generic and the IDF maintained total control of the material on the website, especially in the certified courses.

Almost 85% of the website was open access and available for free and dealt with education and information for people with diabetes as well as the care givers.

A science section was be available which discussed and explained in a suitable format all the latest advances as well as IDF Position Statements on various aspects of diabetes care and also the IDF Position Statements on any ongoing Controversy so that all were “on the same page”.

There was an open forum for discussion such as D-Net and links to other sites, and e-library and a section where patients and care givers could ask questions which would be answered in a time bound manner by the faculty.

There were certified courses for Physicians, both Specialists, as well as General and Primary Care Physicians, and for Diabetes Educators. These certificate courses were in a continuing education format so that those taking part in these courses would be able to update their knowledge for a specific period of time. Some of the courses were tutorial type and had access to Tutors/Mentors from their region if required.

Those undergoing the certificate course as well as others, dependent on their expertise, would be eligible to be Fellows of the IDF School of Diabetes or belong to other categories.
A brief history of the International Diabetes Federation

The certificate courses charged a nominal fee in order to ensure that the School would be financially stable within a couple of years.

The fee structure was:

- Diabetes Educators: 9 modules 300 E
- General Physician and Primary Care Physicians: 10 Modules 500 E
- Specialists: 12 Modules 800E

The courses were initially in English but were soon to be available also in French, Spanish, Russian, Chinese and Arabic.

People from LIC countries were offered a 75% concession in the fees and those from MIC countries were given a discount of 50%. In certain deserving cases, the Management Committee waived all charges. All people working in Government health care centres would have their fees waived off if the health Ministry of the country and the WHO so recommended. Dr. Sadikot made it very clear to the members of the Executive Board that the purpose of the School was not to make a large amount of money but to spread education and knowledge. At the same time, some finances had to be generated in order to keep the School financially solvent and running.

Keeping this in mind, the fee structure for the certified courses were decreased still further

The fee structure was:

- Diabetes Educators: 9 modules 50 E
- General Physician and Primary Care Physicians: 10 Modules 150 E
- Specialists: 12 Modules 400E

The School did not offer degrees or diplomas but only certified that the people had undergone training in their field. It was felt that the IDF was not legally eligible to offer diplomas and degrees and this was the rule in many countries and the IDF did not want to do anything illegal and have their certificates misused as falsely certifying people to treat patients and become “doctors”!

The School also had a category for becoming Fellows of the IDF School of Diabetes.

The administration of the School consisted of Deans (Prof. George Alberti and Prof. Paul Zimmet agreed to serve as Co-Deans) and a Board of Directors consisting of people from all the regions in order to cater to the diversity of the regions.

The day to day administration was looked after by a small Board of Management and there was a Science Audit group which vetted the content especially of the certified modules as well as were responsible for the scientific correctness and the updates.

Faculty was available in every region as also IDF certified Centres of Education as well as IDF Centres of Excellence in Diabetes Care which were to be available for face to face training and hands on training if thought necessary.

The IDF School of Diabetes would also be associated with IDF Centres of Education, IDF Centres of Excellence in Diabetes Care and also would support a Best of IDF a face to face teaching and education Initiative.

IDF School platform link: https://www.idfdiabeteschool.org

The soft launch of the School was done on World Diabetes day 2016 and the platform is regularly being updated and upgraded.

IDF CENTRE OF EDUCATION AND IDF CENTRES OF EXCELLENCE IN DIABETES CARE

These Centers would be integral to the functioning of the E – School. The Executive Board was explained the rationale for having these Centres.

IDF CENTRES OF EDUCATION

These would have a spread across all the regions and the applications were opened late in 2017. The selected Centres were evaluated before being accepted but keeping in mind that circumstances and needs could be different in different areas, the criteria were not made very rigid but one of the requirements was that the facilities at the Centre should allow face to face education and interaction during training if required.

The IDF Centres of Education would offer education facilities especially for people who have taken the
IDF School of Diabetes courses but would also like a face to face training or interaction. It was decided that in order to spread education as far and as widely as possible, the Centres of Education would be allowed to use a special IDF logo and call itself an IDF Centre of Education.

Whilst there would be no bar to hosting medical conferences and meetings, if it was to use the IDF logo or the name of IDF Centre of Education, the topics would have to be within the acceptable standards of medical care and prior permission from the IDF Office would need to be taken. In most circumstances, the Centres would be asked to utilize the education initiative “Best of the IDF”.

**IDF CENTRES OF EXCELLENCE IN DIABETES CARE**

These too would be spread all over and the applications for this were opened in 2017. The Centres were independently evaluated before being accepted had to meet a high standard in the treatment of people with diabetes. Whilst it would also be used as an IDF Education Centre, as above, it would cover the full diabetes management for people with diabetes. The chosen Centre could use the special IDF Logo and also the term IDF Centre of Excellence in Diabetes Care. A nominal annual fee would have to be paid but this could be decreased for LIC countries if necessary.

Both the types of Centres would be a part of the IDF Disaster Response initiative.

**THE BEST OF IDF**

As an extension of the education initiatives which were so important to halt the rising pandemic of Diabetes and to improve the lives of our people with diabetes, Dr. Sadikot and the Executive Board felt and reiterated again that it was essential and within the responsibilities, of the IDF that all that could be done to educate the health care givers and the people with diabetes, must be done.

Although the reponse to the Online School of Diabetes was tremendously positive, some members informed the President that whilst online education was the way, in some countries, it would be good to have the option for face to face interaction also. Keeping in mind that the IDF was there for all members and not only for some from the developed countries, the IDF initiated a program called “The Best of the IDF”.

All MAs, organisations, other associations, companies, medical groups, Universities, including primary care Physicians, Diabetes Educators, Dieticians and Nutritionists and even patient groups could utilise this excellent initiative in addition to the education materials available on the IDF School of Diabetes website.

The Hosts of such a proposed meeting would contact the IDF Office and depending on the areas of interest of the organisers, the Office would facilitate by giving permission to use the title “The Best of the IDF” provided that the topics are widely acceptable and meet the current good Standards of Care. The Office would also provide a list of Speakers who meet the areas where the host organisers were interested or give them a list of IDF Speakers along with their areas of expertise for the hosts to choose the faculty for their meeting.

Whilst the IDF would charge a fee, this was again much less than was being charged by some other associations.

The IDF received many inquiries about this initiative and the first meeting was held in India in September 2017 within a month of the launch!

**BLUE CIRCLE VOICES**

Shaukat Sadikot in his address to the General Assembly in Vancouver in 2015 had said that the aim of the IDF should be to do whatever was needed to better the lives of our people with diabetes and try and “bring a smile on the face of our people with diabetes especially the most poor and vulnerable”. But how could this be done unless the International Diabetes Federation which termed itself as the voice of the people with diabetes, put in place a way by which the voice of the people with diabetes could be heard. If one did not know what was really troubling the people with diabetes at the ground level, all advocacy as well as many initiatives could be irrelevant to the needs! The efforts of the IDF, including advocacy, needed to be legitimized by having an ear to the ground where one could come to know of the major areas which the people with diabetes felt needed looking into and improving.
Unless this was done, the efforts of the IDF could be a waste of time, efforts and money.

It was with the aim of understanding what the views and needs of our people with diabetes whom the IDF is there to help and support to the extent it can, that the Blue Circle Voices (BCV) initiative was put in place and launched in mid 2016 to represent the interests of people living with, or affected by, diabetes, through a worldwide network of members and other stakeholders. The network draws upon the experiences of people with diabetes, acts as their global voice and provides them with an opportunity for expression. This network focuses on a variety of issues and challenges that people with diabetes encounter in our world today.

The network included adults living with diabetes, as well as those living with complications of diabetes, of all ages and from all IDF regions. The BCV network includes individuals with

- Type 1 diabetes
- Type 2 diabetes
- A less common type of diabetes (such as monogenic or secondary diabetes)
- A history of gestational diabetes
- A child, close relative or loved one with diabetes
- A high profile within his/her community (such as a local celebrity, a journalist, blogger, etc.)

IDF established the Blue Circle Voices network to represent the interests of people living with, or affected by, diabetes, through a worldwide network of members and other stakeholders. The network would draw upon the experiences of people with diabetes, act as their global voice and provide them with an opportunity for expression.

The intention was that “hearing” the Blue Circle Voices became an integral part and focus of many of the IDF initiatives, to add legitimacy to the claim that IDF is truly the global voice of diabetes.

The key BCV objectives continue to provide their national/regional perspective to issues of concern for IDF, participate in IDF consultations on key topics (access to care, discrimination, etc.), provide their testimonies for IDF website and specific projects and support IDF advocacy activities. The network would also strengthen IDF’s presence in global forums and bring both better awareness and credibility to diabetes prevention, care, access and rights issues.

The BCV network in the first year with all its teething troubles grew to 125 people living with diabetes (August 2017), with a good geographical spread and across all types of diabetes, albeit with a bias towards T1D.

Key activities initially were:

The consultations to date, together with informal discussions with members of the network, were enabling IDF to better understand the priorities of the network.

A key strategic objective, the voice of people with diabetes had started to be raised both through in-person interventions (such as during the IDF side event in Geneva) and communications activities. For example, individual video testimonies by members of the network were promoted on the IDF website and through social media channels every week, and a bimonthly newsletter had been published and sent to the entire IDF network in English, French and Spanish. Advocacy activities were underway, such as the promotion of specific policy recommendations to improve access to diabetes care in Brazil, South Africa and Russia. BCV members were engaged in the support of IDF’s call to action ahead of the UN High Level Review in 2018, as well as in specific activities around Eye Health and CVD initiatives which had been launched by the International Diabetes Federation.

Efforts were being continuously made to increase the numbers and thereby the “voice” of our people with diabetes.

**YOUNG LEADERS IN DIABETES (YLD) PROGRAMME**

The Young Leaders in Diabetes (YLD) programme was
started by the International Diabetes Federation taking into consideration the need of the younger of our people with diabetes to be heard and their opinions respected. Moreover there was a distinct need felt that many of the youngsters, all over, but especially those living in LIC countries and in remote places needed to be educated and have knowledge of the various aspects associated with their type of diabetes and its management. Unless they had a clear understanding of their health care aspects, how would they be able to become valid advocates for others living with their types of diabetes and in later years become advocates for all people with diabetes.

IDF Young Leaders at the IDF Congress in Vancouver in 2015

The idea of the Young Leaders in Diabetes (YLD) Programme originated in 2010, when IDF launched a survey amongst its Member Associations to inquire about the involvement of youth in their associations and its activities and see if they were interested in increasing youth involvement in their work. The response was overwhelmingly positive, and many national associations already had national youth programmes of their own.

This encouraging feedback led to the establishment of the YLD Programme in 2011, which aimed to empower young people living with diabetes to become advocates for themselves and others living with diabetes worldwide. The overall objectives of the YLD Programme as decided in 2011 were:

1. To bring together young people from around the world to discuss living with diabetes;
2. To encourage the sharing of experiences and to create opportunities to learn from one another;
3. To encourage young people with diabetes to become actively involved in their diabetes associations and take lessons learned back to these associations;
4. To eliminate discrimination (e.g. societal, educational) and to ensure equity of access to structured patient-centered healthcare.

IDF Member Associations were to nominate the “Young Leaders”, who became part of the YLD network and benefited from the educational activities prepared for them by IDF. One of the key activities in each two-year period was the YLD Training programme, which was organised along with the IDF Congress. The objective of this Training programme was to bring them together to share experiences and learn from each other. Education was to be an integral part of the Training Course.

The first YLD Training event took place during the IDF 2011 Congress in Dubai (UAE). Around 70 young people attended the programme, whilst the second YLD Training programme took place during the IDF 2013 Congress in Melbourne (Australia). Some 140 young people participated in this Training, which also served as a platform for the new members to learn from the 2011 Young Leaders, and get inspired by the projects they had developed with the support of their national associations in their respective countries.
The third YLD Training programme was hosted during the IDF 2015 Congress in Vancouver (Canada). Some 129 young people, including Young Leaders from 2011 and 2013, as well as new members of the YLD Programme, participated in it. This Training event supported again the exchange of ideas between different “generations” of Young Leaders.

At the same time, it was increasingly felt that the YLD programme was not being spread out as much as it should amongst the various regions and that many of the faces seen in these Training Programmes were the same as before. It was also felt that the advocacy associated with the YLD programme should be such that it not only raised awareness but efforts were also made by the YLDs to try and see how the lives of the youngsters who were still not a part of the YLD network could be improved. It was felt by quite a few members that one area which should have had some focus was to work closer with the IDF and many of the LIC member associations in their regions not only to advocate but try and raise funds, through social media crowd funding, to get finances to access medications such as insulin and monitoring equipment for the youngsters with little or no access to these life saving care in the less developed and LIC countries, and for IDF initiatives such as the Life For a Child programme, which was facing an imminent financial crunch.

In order to spread the IDF YLD programme to many more countries, when Dario Rahelic became the Chair of the IDF YLD Programme, he and the IDF-YLD Steering Group decided that delegates coming to the Training Course would be equally divided between the regions. Moreover, delegates would not attend the Training Course for the third time in a row. Every region could nominate two YLDs who had participated in the previous Training Programme who could be delegates but would have to show how they had utilized their training in the previous Course for advocacy and how they had helped their MAs to improve the lives of their people with diabetes in their country and regions.

Finances also played a role in the IDF having to do this, as with the new laws of pharmaceutical company involvement in Conferences, financial support had become tight.

Education and training about advocacy would not be restricted to face to face meetings every two years but would be put online so that this could be accessible to people and youngsters all over.

The fourth YLD Training would take place along with the IDF 2017 Congress in Abu Dhabi (UAE). Around 70 participants spread equally from the seven regions would attend this Training programme which, for the first time, would be filmed and uploaded to the IDF website – so that the YLD Programme members not attending this meeting as well as others could still benefit from the education modules, training master classes and workshop sessions.

To date, the YLD Programme had shown significant success in raising awareness of diabetes in many countries where the members lived and they were involved with and helped their member associations in reaching many of the objectives for which this programme was started. At the same time a lot was still needed to be done to help out others with diabetes especially where the resources for health care in general and diabetes in particular is scarce.

But the work goes on and the lives of our people with diabetes will be made better.

WOMEN AND DIABETES’ INITIATIVE

This initiative was launched in 2017 during the Presidency of S. Sadikot and was also the theme of the World Diabetes day that year. The associated slogan was “Our right to a healthy future”.

It generated a lot of interest especially amongst women, many member associations, partners and especially the World Health Organisation which was always involved in the WDDactivities. It was made clear to the people that this would be an ongoing initiative and would not end the day after the WDD.

This was an initiative which was very close to the heart of the President and had a lot of support in the Executive Board. As Sadikot said, when introducing the initiative, “I have always believed that women play, and can, and will play a major role in helping us in our fight against diabetes. Unfortunately they do not get, in most instances, the credit they deserve for all that they do, as well as the support which they should get from many of us. With this initiative, we would like them to come to the forefront and getting
credit for the work they do!"

Led by the International Diabetes Federation (IDF), the campaign aimed to promote the importance of affordable and equitable access for all women, and their families, at risk for or living with diabetes to the essential diabetes medicines and technologies, self-management education and information they require to achieve optimal diabetes outcomes and strengthen their capacity to prevent type 2 diabetes.

In the 7th IDF Atlas, released in 2015, it was estimated that there were 199 million women living with diabetes and this total was projected to increase to 313 million by 2040.

Diabetes was the ninth leading cause of death in women globally, causing 2.1 million deaths each year. As a result of socioeconomic conditions, girls and women with diabetes experienced barriers in accessing cost-effective diabetes prevention, early detection, diagnosis, treatment and care, for themselves as well as their families, particularly in developing countries.

Two out of every five women with diabetes were of reproductive age, accounting for over 60 million women worldwide. Women with diabetes had more difficulty conceiving and were more prone to have poor pregnancy outcomes.

Approximately one in seven births was affected by gestational diabetes (GDM), a severe and neglected threat to maternal and child health. A significant number of women with GDM went on to develop type 2 diabetes resulting in further healthcare complications and costs.

Women and girls had to be empowered with equitable access to knowledge and resources that would strengthen their capacity to prevent or delay the onset of type 2 diabetes, and influence the adoption of healthy lifestyles to improve the health and well-being of themselves, as well as their families, and future generations.

The IDF set up an International Board, but more importantly there were Regional Boards and many of the member associations set up Committees in their own countries to take things further.

The initiative had the following focus.

1. Education about diabetes. The IDF School of Diabetes which was open access and online would be very important for this.
2. Gestational Diabetes Mellitus
3. PREVENTION and Management of DM in children and adolescents. The onus usually fell on the mother.
4. Lifestyle Management for prevention and treatment, which in most if not all over the world, was in the hands of women.
5. Access to Medicines, with a special focus on socioeconomic status.
6. Management of diabetes in the elderly. In most parts of the world elderly people were looked after by the family, and usually by the women in the family.

The IDF had a Central Board with 2 Chairpersons and members looking after each section. The Regions had the same as did member associations. Member associations who had not formed the committees were asked to do so as soon as possible.

Sadikot asked that the members be women as far as possible. Some male members were not happy about this but were told that not being on the committee did not mean that they should or would not be a part of this. Was it not possible for them to help in carrying out the initiative without being on “committees”! This silenced a lot of “gender” dissenters.

PARLIAMENTARIANS FOR DIABETES GLOBAL NETWORK (PDGN)

Diabetes is a growing epidemic that affects every country in the world, with no exceptions. For a long time, IDF had recognised the need for strong policies both at a global and national level to address diabetes prevention, diagnosis, care and treatment. Hence the critical need to enrol the help of policy makers in reversing the current tide in order to achieve the 0% increase in diabetes prevalence and the 80% access to essential medicines and supplies by 2025.

Michael Hirst, when he was President, promoted the creation of the Parliamentarians for Diabetes Global Network (PDGN) with the objective of bringing together parliamentarians from around the world to share best practices in their respective countries and to discuss how to move forward together to reach the international diabetes and NCD commitments.
PDGN was officially launched in December 2013, when the first PDGN Forum took place in Melbourne (Australia) on occasion of the IDF Congress. Parliamentarians from 55 countries attended this meeting and presented national reports of the situation of diabetes in their respective countries. The Forum culminated in the adoption of the Melbourne Declaration, a document that outlined the following objectives:

- Eliminate discrimination against people with diabetes;
- Encourage governments to take comprehensive action to meet the WHO NCD targets;
- Establishment of a platform for dialogue, to work towards urgent action through the exchange of views and seeking of further knowledge.

The second PDGN Forum, focused on the human, social and economic impact of diabetes.

ST. VINCENT DECLARATION

Representatives of Government Health Departments and patients organizations from all European countries met with diabetes experts under the aegis of the Regional Offices of the World Health Organisation and the International Diabetes Federation in St. Vincent, Italy on October 10-12, 1989.

They identified some aspects which had to be undertaken in order to reduce the burden of diabetes both on the affected individual as well as the society at large. They unanimously agreed upon the following recommendations called the St. Vincent Declaration and urged that they should be presented in all countries throughout Europe for implementation.

Full text of the 1989 St. Vincent Declaration:

Diabetes mellitus is a major and growing European health problem, a problem at all ages and in all countries. It causes prolonged ill-health and early death. It threatens at least ten million European citizens. It is within the power of national Governments and Health Departments to create conditions in which a major reduction in this heavy burden of disease and death can be achieved. Countries should give formal recognition to the diabetes problem and deploy resources for its solution. Plans for the prevention, identification and treatment of diabetes and particularly its complications - blindness, renal failure, gangrene and amputation, aggravated coronary heart disease and stroke - should be formulated at local, national and European regional levels. Investment now will earn great dividends in reduction of human misery and in massive savings of human and material resources. General goals and five-year targets listed below can be achieved by the organised activities of the medical services in active partnership with diabetic citizens, their families, friends and workmates and their organisations; in the management of their own diabetes and the education for it; in the planning, provision and quality audit of health care; in national, regional and international organisations for disseminating information about health maintenance; in promoting and applying research.

**General goals for people - children and adults - with diabetes**

**Sustained improvement in health experience and a life approaching normal expectation in quality and quantity.**

**Prevention and cure of diabetes and of its complications by intensifying research effort. Five-year targets**
Elaborate, initiate and evaluate comprehensive programmes for detection and control of diabetes and of its complications with self-care and community support as major components.

Raise awareness in the population and among health care professionals of the present opportunities and the future needs for prevention of the complications of diabetes and of diabetes itself.

Organise training and teaching in diabetes management and care for people of all ages with diabetes for their families, friends and working associates and for the health care team.

Ensure that care for children with diabetes is provided by individuals and teams specialised both in the management of diabetes and of children, and that families with a diabetic child get a necessary social, economic and emotional support.

Reinforce existing centres of excellence in diabetes care, education and research. Create new centres where the need and potential exist.

Remove hindrances to the fullest possible integration of the diabetic citizen into society. Implement effective measures for the prevention of costly complications.

Reduce new blindness due to diabetes by one third or more.

Reduce numbers of people entering end-stage diabetic renal failure by at least one third. Reduce by one half the rate of limb amputations for diabetic gangrene.

Cut morbidity and mortality from coronary heart disease in the diabetic by vigorous programmes of risk factor reduction.

Achieve pregnancy outcome in the diabetic woman that approximates that of the non-diabetic woman.

Establish monitoring and control systems using state of the art information technology for quality assurance of diabetes health care provision and for laboratory and technical procedures in diabetes diagnosis, treatment and self-management.

Promote European and international collaboration in programmes of diabetes research and development through national, regional and WHO agencies and in active partnership with diabetes patients organisations.

Take urgent action in the spirit of the WHO programme, “Health for All” to establish joint machinery between WHO and IDF, European Region, to initiate, accelerate and facilitate the implementation of these recommendations.

The Saint Vincent Declaration was driven by informed and empowered people with diabetes and those who care for them, as individuals and in national and regional Associations. Their key role, in partnership with health professionals and health politicians, constituted a guarantee of the effective use of limited health care resources.

As a follow up to the St. Vincent Declaration, a meeting was held in Athens in 1995 which led to the “Acropolis Affirmation”. Representatives of people living with diabetes, and representatives of the health care professions, governments and industry, at the Athens meeting for the Implementation of the St Vincent Declaration:

While recognizing:

• that the purpose of the St Vincent Declaration initiative is to achieve a fuller and healthier life for all people with diabetes in Europe;
• that the principles and targets of the St Vincent Declaration remain valid and attainable;
that governments have formally endorsed the Declaration at regional world health assemblies, and agreed to work for its implementation;
• that many individuals with diabetes, many health care professionals, WHO/EURO, IDF (Europe), governments, funders, and industrial partners, have already contributed their time and effort with enthusiasm and dedication;
• that many tools and systems for developing and implementing quality diabetes care have been devised and tested under auspices of the St Vincent initiative.

Now call upon all concerned to resolve:

• that WHO/EURO and IDF (Europe) actively promote collaborative and practical strategies with diabetes associations, health care providers, government, the European Union, other healthcare programmes, health care funders, and industrial partners, to bring into full use the tools and methods now developed;
• that the use of a planned strategy, together with structured information for monitoring and evaluation, is essential for progressive improvement in the quality of diabetes care; that special attention be given to further development.

This along with the Lisbon Declaration in 1997 tried to create a continuing momentum to see the tenets of the St. Vincent Declaration move ahead. But it had to be admitted that one had not been able to achieve and fulfill all the goals with follow up meetings in Istanbul in 1999 and Glasgow a decade later in 2009 re-enforcing this.

20 years down the line only 13 of the EU’s 27 member states had developed and put in place a national framework or plan to help effectively manage diabetes and reinforcing that the strategies agreed at St Vincent. An editorial at this time, in the British Journal of Diabetes and Vascular Disease that ‘despite the progress made following the St. Vincent Declaration and the UN Resolution, significant gaps still exist and urgent action is needed to stem this rising epidemic.

Although the meeting leading to the St. Vincent Declaration could be said to have been the first regional partnership between the WHO and the IDF, to deal with the emerging pandemic of diabetes, this lead to other similar partnerships: the Declaration of the Americas or DOTA (1996), the Western Pacific Declaration on Diabetes (WPDD 2000), and the Declaration and Diabetes Strategy for Sub-Saharan Africa (2006). Most importantly, these initiatives fostered the development of national diabetes programs in their respective regions.

Incidently whilst the St Vincent’s, Western Pacific and Africa initiatives remained fully in force, DOTA was discontinued as a joint venture of PAHO/WHO and IDF after two 5 year planning and implementation periods. Since then, PAHO had built instead on the CARMEN network of integrated national NCD initiatives, conceived in 1995 and implemented in 1997, and the Pan American Forum for Action on NCDs (PAFNCDs), launched in 2009. Both initiatives included diabetes in a set of major non-communicable diseases.

UNITED RESOLUTION ON DIABETES (UNR 61/225)

In 2003, it was realised based on the IDF Atlas that every 10 seconds a person died of diabetes. In the same 10 seconds two more people were diagnosed with diabetes. There were then over 246 million people living with diabetes. Within a generation, this number was predicted to reach 380 million if action was not taken to curb the pandemic. The International Diabetes Federation (IDF) issued a call to action and made the world aware that to do nothing was not an option.

Diabetes was of significance because of the social, economic and health burden it placed on countries, and on individuals and their families. Costs of diabetes were manifested in both direct and indirect costs that put pressure on individuals, societies and governments. Direct costs included medical costs for long-term care and complications; indirect costs accounted for losses in productivity, coping mechanisms, and the costs of quality of life, which affected individuals and families and was immeasurable. In many countries, the cost of insulin and diabetes supplies far exceeded annual incomes, leaving people with diabetes unable to properly manage their condition, and susceptible to complications in the long-term. Treatment of complications was more expensive than prevention or control, and studies had shown that health care expenditure for people with diabetes was five times
higher than for people without diabetes. As an example, in low income populations in urban India, annual income spent on diabetes-related health care increased from 24.5% in 1998 to 34.0% in 2005, 93.6% of which was out-of-pocket.

The challenge of achieving a United Nations Resolution on Diabetes (UNR) was firstly considered soon after the 2003 International Diabetes Federation (IDF) Congress in Paris.

The IDF rationale to seek a UNR on Diabetes was to:

- Elevate the existing WHO/IDF World Diabetes Day to a United Nations World Diabetes Day
- Educate governments to view diabetes as a worldwide epidemic
- Emphasise the immensity of the global human, social and economic burdens of diabetes
- Emphasise that 80% of worldwide diabetes burden affects people in developing countries
- Empower and “bond” Member Associations as part of a “diabetes world”.

The first steps were taken between 2003-2005 when the draft proposal for a campaign on the UNR on Diabetes was presented at multiple Regional and Member Associations conferences. Each time the “business plan” for the campaign was strengthened and with each improvement, the draft proposal gradually gained acceptance as an achievable goal.

In July 2005, the Australian Minister of Health and the Office of the Australian Minister of Foreign Affairs were approached to see if Australia would act as the sponsor at the UN, but at that stage no commitment of support or opposition was provided.

In August 2005, senior leadership of the American Diabetes Association (ADA) were approached and enthusiastically offered ADA’s support of IDF’s proposal for a UNR campaign.

In December 2005 IDF, together with ADA’s support, organised a meeting in Washington DC to determine the level of support by pharma companies and other organisations. The outcome was not only widespread support, but included commitments of significant funding for the proposed campaign.

However, following the successful December 2005 meeting in Washington DC, the Australian Ambassador to the UN in New York advised the IDF that Australia’s position was that diabetes should remain a WHO health issue and that Australia would not sponsor the Resolution at the UN. Furthermore, Australia indicated that it would actively work against the issue at the UN General Assembly.

The next major step occurred in March 2006 after the IDF President-Elect Martin Silink presented the Ibrahim Oration at the Golden Jubilee of the Bangladesh Diabetes Association (BDA) at which he provided a vision of the UNR on Diabetes. Subsequently the Trustees of the BDA arranged a meeting with the Foreign Minister which led to Bangladesh agreeing to sponsor the UN Resolution on Diabetes at the UN.

In the meantime, opposition to a proposed UNR on Diabetes had gathered at the UN where the UK was appointed to speak on behalf of the 25 European Union Nations. The EU, as a bloc, agreed to oppose the proposed UNR on Diabetes. In addition to the opposition by the European Union bloc, Australia’s own negative position had been joined by New Zealand and Canada. Furthermore, USA agreed to support EU’s position, whilst Japan agreed to join USA’s position.

By June 2006, virtually all the developed countries at the UN were against a UNR on Diabetes.

The rationale given for the opposition was that it was best to keep diabetes in the World Health Organisation realm.
After receiving this negative news, Martin Silink, an active Rotarian, approached the Rotarians in New York in February 2006 for guidance. The Rotarians who served as RI Representatives to the UN proved to be invaluable in providing insights into UN processes and identified the steps which would be needed to gain the support of the majority of the 192 nations of the UN Assembly.

Against this opposition, IDF began a worldwide campaign to convince other nations to vote for the UNR and to try and reverse the opposition against the UNR. This campaign involved a pincer strategy of educating and informing all national Ministers of Health and Ministers of Foreign Affairs, whilst their Ambassadors at the UN were provided with similar information on the diabetes epidemic.

Officially launched in June 2006, the IDF-led “Unite for Diabetes” campaign aimed to:

- Place diabetes on the global agenda
- Increase awareness of the disease and patient education
- Address poverty as a main obstacle to access to quality healthcare and insulin
- Pass a UN Resolution on Diabetes, which calls on all governments to create national plan for the prevention, treatment and cure of diabetes.

The Unite for Diabetes campaign was an unprecedented success and proved a catalyst for uniting the global diabetes community. It brought together the largest ever coalition of diabetes stakeholders.

Diabetes organizations from around the globe, including all IDF Member Associations, the majority of the world’s global scientific and professional diabetes societies, and industry partners, as well as many charitable foundations and service organizations with an interest in diabetes, all joined together to call for a UN Resolution.

Similar to the way in which red ribbons promote AIDS awareness and recognition as a public health priority, the IDF Public Relations Committee developed the Blue Circle as a logo to represent the unity of the diabetes world in the challenge of preventing and curing diabetes. Hundreds of thousands of blue circles were proudly worn as lapel pins and the logo was added to all letters and advertisements.

At the UN, Bangladesh, on reaching out to the other Missions and finding opposition from the developed countries, recognised the need for the support of the UN G77 Committee, which was compromised of the 133 nations from the developing world.

At the same time, the IDF campaign began to involve Member Associations in all seven IDF Regions to communicate with their national Ministers. Centrally, IDF Committees were established to provide relevant information and resources to assist these education and information campaigns. Willing volunteer experts established committees which provided information on diabetes in Children and Adolescents, the Elderly, Pregnancy, Indigenous Peoples, whilst other committees were established on Economics, Statistics and Public Relations. Important contributions from volunteers with direct and indirect links to politicians were able to strengthen political support at national levels in many countries.

By November 2006, two major events occurred that eventually led to the success of the UNR campaign. The first was Bangladesh’s success in receiving the support of the 133 nations in the G77 Committee.

The second important factor was the unexpected support by Portugal’s Prime Minister following direct contact by Portugal’s Diabetes Association. The political support by Portugal divided the previous EU opposition. This was followed by Germany’s support and soon after by the whole EU bloc. The combined approval by the 133 developing countries in the G77 and the 25 countries of the EU led to USA and Japan providing their support, followed by Australia and New Zealand. Other nations joined and in the end only Canada remained in opposing a UNR on Diabetes. Its opposition was that diabetes should remain a WHO issue. However, this was finally reversed after WHO gave its support for diabetes to be recognised as an issue worthy of a UN Resolution.

On 20 December 2006, during the 61st session of the United Nations General Assembly, the First Secretary of the Permanent Mission of South Africa to the UN, Ms Laoura Lazouras, introduced the draft Resolution on World Diabetes Day on behalf of the Group of 77 (a coalition of developing countries) and China. The following countries were listed as co-sponsors:
A brief history of the International Diabetes Federation

Armenia, Bosnia and Herzegovina, Croatia, Monaco, Austria, Georgia, Malta, Portugal, and Ukraine.

In her speech to the Assembly, the First Secretary spoke of the potentially devastating impact of the silent pandemic of diabetes. She highlighted the disproportionate threat to life and wellbeing in low- and middle-income countries and warned of the huge increase in the number of people affected by diabetes that is expected over the coming decades. The UNR on diabetes was formally adopted by all 192 countries at the General Assembly on 20th December 2006.

The UNR on Diabetes is Resolution 61/225 which “designates November 14th as a United Nations Day to be observed each year from November 2007”. The Resolution recognizes “that diabetes is a chronic, debilitating and costly disease associated with severe complications, which poses severe risks for families, Member States and the entire world” and encourages “Member States to develop national policies for the prevention, treatment and care of diabetes”.

The achievement of the UNR on Diabetes was remarkable in many ways. It was the first time that the UN recognized a non-communicable disease as a risk to the entire world. It was also remarkable in achieving a UN Resolution in just over 12 months. It was even more remarkable that it was achieved by the hard work of thousands of volunteers from the whole “diabetes world”, all working together towards a common goal.

The UNR on Diabetes can be viewed as an important resource from which further advocacy could start to work towards IDF’s vision of a world without diabetes!

WORLD DIABETES DAY (WDD)

World Diabetes Day (WDD) was established by the International Diabetes Federation in 1991 to call attention to growing concerns about the escalating health threat posed by diabetes. The date of Nov. 14 was chosen to honor Dr. Frederick Banting, co-discoverer of insulin back in 1921.

WDD is celebrated along with the World Health Organization.

WHO collaboration on WDD

The World Diabetes Day campaign aims to:

- Be the platform to promote IDF advocacy efforts throughout the year.
- Be the global driver to promote the importance of taking coordinated and concerted actions to confront diabetes as a critical global health issue.

The 1st WDD was celebrated in 1991 and the date coincided with the holding of the IDF Congress in Washington D.C. and was launched the world over becoming the largest single worldwide public awareness effort ever undertaken for those with diabetes. A news conference in Geneva marked the beginning of the activities leading up to World Diabetes Day. Dr. Chigan of Russia, who was then the Director of the Non-Communicable Diseases Division of the World Health Organization, participated. News conferences and other activities relating to World Diabetes Day took place throughout the world. Over 55 different countries had confirmed their participation in these activities.

At the same time it must be mentioned that a day devoted to diabetes, but not really a World Diabetes day as is seen now, was first done on 1971 as a result of the close working relation which the International Diabetes Federation had with the World Health Organization resulted in the World Health Day on April 7 being devoted to diabetes and the release of a special issue of World Health (the WHO magazine), with the subtitle ‘A full life despite diabetes’.

In the years after 1991, the activities and interest in the WDD picked up significantly especially in
A brief history of the International Diabetes Federation

the activities of the IDF member associations but it really took off after 2006 when the IDF successfully advocated for the United Nations to issue a resolution on it and World Diabetes Day became an official United Nations Day in 2006 with the passage of United Nation Resolution 61/225.

With the passage of the resolution, every year on WDD is joined by the United Nations in keeping the focus on improving for the better making the lives of the people with diabetes. Here is a message from the Secretary-General of the United Nations.

“Let us focus both on prevention and strengthening health services so that everyone who has this debilitating disease can receive the support he or she needs.” UN Secretary-General, Ban Ki-Moon

It was decided by the International Diabetes Federation and the World Health Organization that in view of the multiple aspects associated with diabetes including the prevention, good care and avoidance of complications, there would be one key theme for the WDD and that education, information and focus would be on that subject for that years WDD.

World Diabetes Day Themes

• 2014-15: Healthy living and diabetes
• 2009-13: Diabetes education and prevention
• 2007-08: Diabetes in children and adolescents
• 2006: Diabetes in the disadvantaged and vulnerable
• 2005: Diabetes and foot care
• 2004: Diabetes and obesity
• 2003: Diabetes and kidney disease
• 2002: Diabetes and the eye
• 2001: Diabetes and cardiovascular disease
• 2000: Diabetes and lifestyle
• 1999: The costs of diabetes
• 1998: Diabetes and human rights
• 1997: Global Awareness - Our Key To A Better Life
• 1996: Insulin for Life!
• 1995: The Price of Ignorance
• 1994: Diabetes and Growing Older
• 1993: Growing Up with Diabetes
• 1992: Diabetes: A Problem of All Ages in All Countries
• 1991: Diabetes Goes Public

The BLUE CIRCLE

Although this is often taken to be the emblem associated with the World Diabetes Day, it was in reality an emblem that was developed as a universally acceptable symbol for the “Unite for Diabetes” Campaign during the efforts to get the UN Resolution passed. It was now becoming more and more a symbol for Diabetes and used significantly in WDD celebrations. The International Diabetes Federation had made it the official logo of WDD.

The stories around its development are interesting and discussed in the section dealing with the IDF Logos.
In spite of the growing popularity of the WDD celebrations, the International Diabetes Federation closely monitors its impact. The IDF measures the effectiveness of a campaign in terms of the number of people who request, translate, reproduce or purchase the IDF materials and merchandise, visit the IDF website, follow the Federation on social media and organize activities using the key messages and visuals of the campaign.

It has been seen that most member associations adopt the blue circle in some form in their awareness activities and that many other diabetes-related groups and individuals have embraced the symbol. Evidence supporting this is the number of requests that the IDF and its member associations receive to use the symbol and the many visual examples of how the symbol is used in relation to diabetes around the world.

The few countries where the WDD and the Blue Circle symbol did not take off and still has a long way to go include the USA and Canada. There the JDRF has been by far the most supportive of the big organizations in promoting the symbol (and celebrating World Diabetes Day), although the IDF recognized that it has not been embraced like in other countries. Encouragingly, in recent years there has been an increase in requests to use the symbol from smaller diabetes groups and health professionals in the US. Other IDF campaigns, such as the IDF Pin a Personality campaign, seemed to have helped in engaging Americans to recognize the symbol.

One reason for this could also be that the American Diabetes Association (ADA) celebrates November as the Diabetes Month and possibly its focus is on the myriad of activities which they promote throughout the month.

As discussed at the General Assembly at the Dubai Congress, World Diabetes Day was well-established in many countries but it would be hard to be definite about effective the campaign had been in changing public awareness of and attitudes towards diabetes, which was and is the ultimate goal. But there was no doubt that awareness was on the rise in terms of the exposure that World Diabetes Day and the blue circle were receiving but work still needed to be done in terms of getting the campaign firmly recognized in the mainstream.

The work needs to go on but as Shaukat Sadikot reported to the Executive Board and the member associations, the feedback that the IDF had received from the WHO, many member associations, our partners and others about the theme of the 2017 WDD “Women and Diabetes” was extremely encouraging.

**IDF LIFE FOR A CHILD (IDF-LFAC)**

During her tenure as President, Maria de Alva came across the terrible situation that youngsters with T1DM faced in many places around the world especially in LIC countries. At one point, in a meeting, a boy not more than 16 years old stood-up and declared “Mrs. de Alva, we all know here that we will never reach adulthood”. She felt outraged that people could not have access to insulin even 75 years after its discovery. She felt that the IDF should have a program where they would be able
to help needy youngsters in poor and developing countries. Unfortunately this was not easy. The IDF Office did not have enough personnel on its own to carry out this program and moreover the finances were a problem. She traveled and spoke to many member associations as well as asked for funding from pharmaceutical companies but none of this was forthcoming at that time. Moreover, the majority of the IDF Board was not in favour of concentrating all the resources on this as they had other areas which they felt one should focus on. The majority felt that this was beyond the IDF raison d’etre. Moreover she was coming close to the end of her tenure. It so happened that Martin Silink who was a member of the board and Chair of the IDF Consultative Section on Childhood and Adolescent Diabetes at that time, felt otherwise and with the help of Diabetes Australia felt that we could take this further. The Executive Board of the IDF endorsed this in 1999.

Maria de Alva asked Martin Silink to help develop her dream “Sponsor a Child with Diabetes”. With the support of the members of the Consultative section on Childhood and Adolescent diabetes, Industry partners who supported this concept and dream and put in the start up capital. ISPAD, World Vision Australia, Graham Ogle, the Regional Director of HOPE Worldwide and Dr. John Galtorne of Anderson Consulting firmed up the concept. Tremendous support was given by Diabetes - New South Wales and Diabetes Australia National.

Thus, in 2000, the International Diabetes Federation Life for a Child Program was established in response to the desperate situation facing many young people with diabetes in less-resourced countries.

Vision

No child should die of diabetes

Mission

To support the provision of the best possible health care, given local circumstances, to all children and youth (under 26 years of age) with diabetes in less-resourced countries, through the strengthening of diabetes services in these countries.

Martin Silink asked Dr Graham Ogle to help him establish the program as Graham was a paediatric endocrinologist who had worked for some years in Papua New Guinea and Cambodia. A brainstorming workshop was held at the headquarters of Diabetes NSW & ACT in Sydney in March 2000. Diabetes NSW & ACT and HOPE worldwide provided in-kind support.

The IDF LFAC program commenced support in late 2000, with pilot work in three countries in the Western Pacific - Philippines, Fiji, and Papua New Guinea. Following the success of this work, the program expanded to India and Bolivia in 2002, and then beyond, growing to supporting around 1,000 children and adolescents by 2009.

In that year, a meeting was held in London entitled “From one to ten thousand”. By 2012 this target had been achieved and then exceeded. This was made possible in-kind support from Eli Lilly, Trividia, LifeScan, Becton Dickinson and others, and financial support from the Fondation de l’Orangerie, the Harry B and Leona M Helmsley Charitable Trust, Diabetes NSW & ACT, Diabetes Australia, as well as many other sources.

Timeline for the work of the IDF LFAC programme

• 1999 President Maria de Alva proposes program
• 2000 IDF LFAC is established
• 2000 Program piloted in three Western Pacific countries 2002 India, Bolivia enrolled
• 2004 Support extended to African countries
• 2007 First academic partnership (University of Pittsburgh)
• 2008 Supporting over 1,000 children in 19 countries. London meeting held “From 1,000 to 10,000”
• 2009 Eli Lilly and then other companies begin in-kind support – large-scale provision of insulin commenced
• 2011 34 countries, 5,000 children and youth
• 2012 41 countries, 10,000 children and youth. Large-scale provision of blood glucose meters and strips, syringes, and HbA1c supplies commenced (support from Trividia, LifeScan, Becton Dickinson)
• 2011 Education website launched, Leona M and Harry B Helmsley Charitable Trust begin support
• 2012 Pocketbook Guidelines launched
• 2013 Four countries enrolled including Malawi, Syria and North Korea
• 2015 Camp guidelines launched, 46 countries, 18,000 children and youth
• 2016-7 Extensive research agenda underway in epidemiology, access, cost of care, impact, social aspects and other areas

As of 2017, the program is supporting the care of over 18,000 young people in 42 countries. Four countries have graduated from the program, as their governments now provide the support.

Most partners are member associations of the IDF, and various member associations support the work. Incidentally at the present, 25 Member Associations are recipients and 5 are donors.

Type of support provided

• Insulin
• Blood glucose meters and strips Syringes
• HbA1c testing Complications screening
• Education – patient resources and staff training
• Other support as possible Mentoring relationships
• Research
• Technical advice and capacity building
• The range and quantity of support depends on needs of the recipient centre, and the resources at LFAC’s disposal.

THE RELATIONSHIP BETWEEN THE INTERNATIONAL DIABETES FEDERATION (IDF) AND THE WORLD HEALTH ORGANIZATION (WHO)

The relationship goes a long way back.

It was also at the General Council meeting in Cambridge in 1955 that a small committee was formed which had the task of collaborating and interacting with the WHO and its subsidiaries as well as the World Medical Association. The members consisted of Profs. Rambert and Martin and Dr. H. Root.

In 1957, the Executive Board of the World Health Organization (WHO) decided to establish relations with the International Diabetes Federation. This was the start of a long and continuing journey.

In 1961, one of the first task undertaken by the newly elected President Howard F. Root was to interact with the World Health Organisation and deliver a resolution passed by the General Council of the International Diabetes Federation (IDF) urging the WHO to recognise diabetes as a condition of worldwide importance and asked them to actively formulate a programme to meet this development.

As a direct consequence, the WHO Expert Committee on Diabetes was set up and it was from these initial steps that the present close collaboration between the IDF and the WHO has been seen.

Continuing the close interaction between the IDF and the WHO, one of the members of the IDF, Bernard Rilliet (Switzerland) in 1964 was appointed as the Liaison person between the two bodies and continued to do so for many years, attending meetings on behalf of the IDF.

The relationship between the IDF and the WHO was already on a good footing and the Expert Committee on Diabetes had met and its Report published in November 1965.

In 1971 this close working relationship with the WHO resulted in World Health Day on April 7 being devoted to diabetes and the release of a special issue of World Health (the WHO magazine), with the subtitle ‘A full
Meeting in 1970 at Buenos Aires, the General Council was pleased that the World Health Day in 1971 would be devoted to diabetes. They passed the following Resolution: “The International Diabetes Federation noted that the first meeting of the WHO Expert Committee on Diabetes had noted the need to carry out epidemiological studies in various countries, and the General Council on behalf of the IDF urged the World Health Organisation to set up an International Reference Centre to coordinate the epidemiological studies on random population samples in various countries in the world”.

Looking forward to continue with this active collaboration, in New Delhi, in 1976, the General Council noted that it was very pleased with the willingness of the WHO to continue the active collaboration with the IDF in the fight against diabetes. The WHO Technical Report No.310 had been published and members wanted to know what the views of the governments and the member associations were about the Report. It was also hoped that if a new Expert Committee was convened, the IDF would be more closely consulted regarding its composition.

A resolution was put before the General Council and unanimously adopted.

“In view of the growing prevalence of diabetes mellitus and its resultant chronic complications which affect so many people around the world, and taking into account the considerable advances in scientific knowledge over the past twelve years since the publication of the WHO Technical Report No 310 was published, The INTERNATIONAL DIABETES FEDERATION requests the WORLD HEALTH ORGANISATION to convene a new Expert Committee on Diabetes Mellitus to consider the present state of knowledge of the disease and its clinical, epidemiological and public health aspects which would be applicable at national and international levels”.

Once again as a rider it was stressed that it was important for the IDF and the WHO working together to decide the composition of any such Expert Committee.

With increasing interactivity there was a need for more active collaboration and in a first active collaboration between the IDF and the WHO, in 1978, the first ever Pan-African Course on Diabetes was held in Kenya. This was widely seen as providing proof that the IDF was very focused on providing health education programmes even between its Congresses.

During the General Council held along with the Nairobi Congress in 1982, Philippe Assal who was the Liaison Officer between the IDF and the WHO, reported the greatly increased collaborative activities between the IDF and the WHO in the past 3 years. The WHO Expert Committee had met soon after the Vienna Congress and had come up with a report that made 10 specific recommendations:

Health care for the diabetic should be incorporated into the community based health care systems with appropriate additional facilities available at all levels of care;
The availability of insulin must be assured for diabetics everywhere by national guarantee;

Establishment of special centres in developing countries to promote care, learning and research on diabetes;

To organise educational activities aimed at the patient as well as the health care personnel;

International standardisation directed towards diagnosis, classification and treatment of diabetes (insulin, learning aids and materials for global use);

Primary prevention should be vigorously explored with particular reference to high risk people and to environmental factors;

To reduce the burden of complications by improving the quality of diabetes care and metabolic control through such measures as patient education, self monitoring, early diagnosis and treatment of diabetic eye disease;

To investigate further traditional methods of diabetes mellitus control; To establish national and local registers of diabetics;

That WHO should make every effort to promote these recommendations.

Following these recommendations a Joint WHO/IDF Executive Committee was established to monitor and facilitate the implementation of the recommendations. It was highly recommended by Assal, and many members of the General Council, that all delegates at the General Council and also those attending the Nairobi Congress should be made aware of these recommendations of the WHO Expert Committee and actively pursue them in their regions and countries.

Many epidemiology, research as well as education initiatives in diabetes had been supported by the WHO and co-funded by the IDF and WHO. This was a continuing action.

Eli Lilly & Co. agreed to sponsor financially a IDF/Lilly Fellow who would work within the WHO organisation but be funded and supervised by the IDF.

Moreover the IDF was privileged to be a NGO in official relations with the WHO but the appointment of its Liaison Officer was not a permanent sinecure.

In 1988, further proof of the active collaboration came with the agreement with the World Health Organization wherein it was agreed that its Collaboration Centres could be seen as an integral part of the IDF Educational Foundation Centres.

Practically all the countries of the world are members of the World Health Organization. WHO's governing body is the World Health Assembly which meets annually in Geneva. Like many governmental organizations, the World Health Assembly tends to deal with generalities rather than specifics, especially when it comes to specific diseases. But on May 19, 1989, the World Health Assembly passed a resolution on the Prevention and Control of DiabetesMellitus.

After recognizing that “diabetes mellitus is a chronic, debilitating and costly disease,” and noting that WHO is “aware of the support of the International Diabetes Federation,” the Resolution requests the Director-General of the WHO to “strengthen WHO activities to prevent and control diabetes,” and to “foster relations with the International Diabetes Federation . . . with a view to expanding the scope of joint activities.”

The story continues in 1989. In October a joint meeting between the WHO Regional Office for Europe and the member association of the IDF who came from Europe was held at St. Vincent, Italy where many stakeholders came together under one roof. People with diabetes, healthcare givers, scientists, politicians, people from various health ministries, economists and industry representatives met to discuss the scourge of diabetes. It was at this meeting that the St. Vincent Declaration was released aiming to improve and prolong the lives of the people living with diabetes. It set goals and targets for diabetes care with the aim to reduce the major diabetes complications and led to a flurry of activities across many countries in Europe to improve the quality of care of people with diabetes.

The conference produced the Saint Vincent Declaration, which pointed out that, “It was within the power of national Governments and Health Departments to create conditions in which a major
reduction in the heavy burden of diabetes disease and death could be achieved.”

The Saint Vincent Declaration included several specific goals. One general goal summed them all up. The Saint Vincent Declaration called for

“Sustained improvement in health experience and a life approaching normal expectations in quality and quantity.”

And the Saint Vincent Declaration included precise recommendations about how this general goal and the Declaration’s more specific goals could be met using knowledge that was available at that time.

IDF was a bridge between the WHO and the Health Ministries of Europe and representatives of the private system that were trying to put in place the structures to achieve the goals of the Saint Vincent Declaration.

Although the meeting leading to the St. Vincent Declaration could be said to have been the first regional partnership between the WHO and the IDF, to deal with the emerging pandemic of diabetes, this lead to other similar partnerships: the Declaration of the Americas or DOTA (1996), the Western Pacific Declaration on Diabetes (WPDD 2000), and the Declaration and Diabetes Strategy for Sub-Saharan Africa (2006), amongst others.

Most importantly, these initiatives fostered the development of national diabetes programs in their respective regions.

It was in 1991 under the Presidentship of Wendell Mayes Jr., the first non medico to be President, and the father of a son with diabetes, who was instrumental for the launch of the 1st World Diabetes Day at the 14th IDF Congress held at Washington DC. This was the first year that the World Diabetes Day was celebrated. It was the largest single worldwide public awareness effort ever undertaken for those with diabetes. A news conference in Geneva marked the beginning of the activities leading up to World Diabetes Day. Dr. Chigan of Russia, who was the Director of the Non-Communicable Diseases Division of the World Health Organization, participated. News conferences and other activities relating to World Diabetes Day took place throughout the world. Over 55 different countries had confirmed their participation in these activities.

The World Diabetes day (WDD) activities are a joint effort between the IDF and the WHO and have become the most visible annual international events and campaigns raising awareness about diabetes.

Since the World Health Assembly passed that resolution a little over two years ago in 1989, the World Health Organization had:

Established a section on diabetes.

Produced, and distributed to all the Health Ministers of the world, Guidelines for the Development of a National Program for Diabetes Mellitus.

And had joined with the International Diabetes Federation and the Centers for Disease Control of the United States in sponsoring a course on Planning and Delivery of Diabetes Health Care.

In his triennial address, Wendell Mayes Jr. spoke of the increasing collaboration with the WHO and the interactions with them at the World Health Assemblies and during the executive Committee meetings of the WHO. He reported that from then onwards the World Health Organisation would also be co- sponsoring the World Diabetes day celebrations.

The Joint IDF/WHO Working Group was set up in 1997.

The collaboration between the IDF and WHO continued in many areas in the following years.

It was also in 2003 that Diabetes Action Now (DAN) was launched as a joint initiative between the WHO
A brief history of the International Diabetes Federation

The objectives of DAN were summed up as “The increasing severity of the diabetes epidemic worldwide is clearly recognised by WHO and the IDF. It is widely accepted, however, that there is considerable apathy and ignorance, as well as serious misconceptions. This is probably particularly so in countries and regions where the epidemic is a relatively recent phenomenon. Evidence is now available, from randomised controlled trials as to how the onset of type 2 diabetes can be prevented or delayed and similarly firm evidence is now to hand regarding the effective clinical prevention of complications. The translation of these research findings into practice requires action directed at the lay public, people with diabetes and their families, health professionals and health care decision makers and is one of the most significant challenges in global public health. WHO and IDF have complementary roles and functions to comprehensively address prevailing misconceptions about diabetes, its determinants and control. The expected outcomes are an increased awareness of diabetes and its consequences and the delivery of health care more appropriate to diabetes”.

The Objectives were:

1. To achieve a “quantum leap” in awareness about diabetes and its complications amongst the lay public, people with diabetes and their families, health professionals and healthcare decision makers;
2. To support regions and countries in the reorganization of their health services in response to the diabetes epidemic by developing coordinated programmes for the primary prevention of type 2 diabetes and the promotion of effective management of people with diabetes;
3. To contribute to the evidence base for these activities globally and in regions and countries by continuing to provide good quality epidemiological data on the burden of diabetes and its complications, completing a review of the rationale for diabetes prevention, accumulating baseline information on public and professional awareness and knowledge about diabetes and its complications, disseminating this information and evaluating the effects of this initiative.

The project ended in 2010 and the impact was significant, as summed up in the joint WHO and IDF statement, “There is increased awareness of diabetes and NCDs globally resulting in increased pressure for action. There is now a UN resolution on diabetes, several governments have strongly voiced calls for action to reduce the public health and economic impact of NCDs, and a UN Summit on NCDs will take place in September 2011. These are major advances. How to contribute to the evidence base for these activities globally and in regions and countries by continuing to provide good quality epidemiological data on the burden of diabetes and its complications, completing a review of the rationale for diabetes prevention, accumulating baseline information on public and professional awareness and knowledge about diabetes and its complications, disseminating this information and evaluating the effects of this initiative. The precise impact of this project on its own is difficult to quantify, but the joint voices of WHO and IDF are likely to have substantially contributed to the current state of attention demanded by diabetes and related NCDs”.

During the International Diabetes Federation Congress in Paris in 2003, the IDF took up the challenge of achieving a United Nations Resolution on Diabetes (UNR). Initially there was support for this amongst many of the member associations but the aim was to get support amongst the health Ministers, Foreign Affairs Ministries and National Governments if the UN Resolution had any chance of being passed.

In July 2005, the Australian Minister of Health and the Office of the Australian Minister of Foreign Affairs were approached to see if Australia would act as the sponsor at the UN, but at that stage no commitment of support or opposition was provided.

In August 2005, senior leadership of the American Diabetes Association (ADA) were approached and enthusiastically offered ADA’s support of IDF’s proposal for a UNR campaign.

In December 2005 IDF, together with ADA’s support, organised a meeting in Washington DC to determine the level of support by pharmaceutical companies
and other organisations. The outcome was not only widespread support, but included commitments of significant funding for the proposed campaign.

However, following the successful December 2005 meeting in Washington DC, the Australian Ambassador to the UN in New York advised the IDF that Australia’s position was that diabetes should remain a WHO health issue and that Australia would not sponsor the Resolution at the UN. Furthermore, Australia indicated that it would actively work against the issue at the UN General Assembly.

Whilst there were other countries willing to sponsor the UN Resolution, a major setback occurred in Europe. In the meantime, opposition to a proposed UNR on Diabetes had gathered at the UN where the UK was appointed to speak on behalf of the 25 European Union Nations. The EU, as a bloc, agreed to oppose the proposed UNR on Diabetes. In addition to the opposition by the European Union bloc, Australia’s own negative position had been joined by New Zealand and Canada. Furthermore, USA agreed to support EU’s position, whilst Japan agreed to join USA’s position.

By June 2006, virtually all the developed countries at the UN were against a UNR on Diabetes. The major argument by these countries against the UNR was that health should remain in the WHO realm.

But things changed dramatically in favour of the UNR on Diabetes and one of the main reasons was possibly the IDF working closely with the WHO which gave its support for diabetes to be recognised as an issue worthy of a UN Resolution.

It is quite possible that although the UNR may have cleared the UN, it would not have been passed unanimously had it not been for the relationship between the IDF and the WHO.

Further proof of the collaboration between the IDF and the WHO can be seen in the editions of the IDF Atlas. The President of the IDF would write the Foreword and the Introduction would be someone from the WHO. In the 2nd Edition of the Atlas in 2003, Derek Yach, Executive Director Non Communicable Diseases and Mental Health Cluster, WHO, wrote about how WHO and IDF continued their partnership in the fight to improve the wellbeing of people with diabetes. This aspect was again reiterated in the Introduction to the 3rd Edition of the IDF Atlas by Robert Beaglehole, Director Department of Chronic Diseases and Health Promotion, Noncommunicable Diseases and Mental Health Cluster, WHO, “Diabetes presents major challenges to patients, health systems and national economies. The World Health Organization together with the International Diabetes Federation is working to raise awareness of diabetes worldwide along with improving the quality of care.”

As was the norm, Ala Alwan Assistant Director-General World Health Organization in his Introduction to the 4th Edition of the IDF Atlas in 2009, “WHO is currently working with the International Diabetes Federation and other partners to establish an agenda to enhance international collaboration to promote and support the multi-dimensional and multisectoral research needed to strengthen the evidence base for prevention.” And “The Ministerial Declaration adopted at the 2009 session of the High-level Segment of the United Nations Economic and Social Council recognized the need to address this important health problem. The Declaration also called for urgent action to implement the Global Strategy and its Action Plan. Diabetes has many faces — but very few voices. And that is why I am so grateful to the International Diabetes Federation for taking such a strong leadership role in giving a voice to the challenges faced by the millions of people with diabetes.”

“The last two years, since the publication of Diabetes Atlas 2009, have witnessed strengthened joint work and coordination between WHO and IDF in the areas of diabetes as well as other major NCDs. Further collaboration between WHO and IDF on harmonizing the methodology for generating diabetes estimates is a desirable further step in improving their accuracy and reliability. Joint efforts to build country capacity
for surveillance and for implementing prevention and health care interventions will also help in providing a solid basis for an effective global campaign to reduce the diabetes burden and its adverse health and socio-economic consequences”. This was in the Introduction to the 5th Edition 2011, by Dr Ala Alwan, Assistant Director General, World Health Organization.

Incidently, in 2016, the WHO with technical inputs from the IDF came up with a Global Report on Diabetes. On the occasion of World Health Day 2016, WHO issued a call for action on diabetes, drawing attention to the need to step up prevention and treatment of the disease.
ANNEX
## IDF Boards
### (1950-2017)

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A brief history of the International Diabetes Federation

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<td>J.S. Bajaj</td>
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<td>H. Keen</td>
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### A brief history of the International Diabetes Federation

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**National Association**

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ANNEX 2

IDF HISTORY TIMELINE

1949
The seeds for the formation of an international federation of diabetes associations were sown in Brussels

1950
The International Diabetes federation was officially formed on 23rd September in Amsterdam. To ensure administration, it was decided to elect an Executive Board consisting of a President, Vice Presidents and a Secretary-Treasurer. President: Dr. R.D. Lawrence (U.K); Vice Presidents: Dr. J.P. Hoet (Belgium); Mr. Maurice Paz (France); Dr. Howard Root (USA); Secretary-Treasurer: Dr. F. Gerritzen (The Netherlands). Prof. Charles Best (Canada) and Prof. Elliot Joslin (USA) appointed Hon. Presidents.

1952 –1955
The 1st IDF Congress was thus held in Leiden, the Netherlands, in 1952; Dr. R.D. Lawrence continued as the President; A sub-Committee to draft the first constitution was formed and the draft constitution was ratified by the 16 member associations. Thirteen of these, Belgium, Denmark, Finland, France, Germany, Italy, Norway, The Netherlands, Portugal, Spain, Sweden and the United Kingdom, were from Europe and they were joined by Australia, Canada, Uruguay and the USA.

1955 – 1958
The 2nd IDF Congress was held in Cambridge, UK in 1955; Dr. R.D. Lawrence continued as the President; A Committee on Education was set up to hold Postgraduate courses; a small committee was formed which had the task of collaborating and interacting with the WHO and its subsidiaries as well as the World Medical Association; in 1957, WHO agrees to officially work with the IDF;

1958 -1961
The 3rd IDF Congress was held in Dusseldorf, Germany in 1958; As would be the norm, the incoming President Prof. J.P. Hoet assumed the Presidency from Dr. R.D. Lawrence at the end of the General Council meeting; Dr. R.D. Lawrence the outgoing President would be the President of the ongoing Congress, till its end; All new applicants for membership would have to be sponsored by two existing member associations; French was added to English as the official language of the IDF; If finances permitted translations, Spanish would also be available but only during the Conference; Presidents who had served their terms would be appointed as Honorary Presidents; Prof. Bernardo Houssay from Argentina and R.D. Lawrence were elected as Honorary Presidents;

1961-1964
The 4th IDF Congress was held in Geneva, Switzerland in 1961; Prof. Howard Root assumed the Presidency from Prof. J.P. Hoet, who presided over the Congress; it was decided that instead of electing individuals as Vice Presidents, Member Associations would be appointed to the Executive Board;

1964 - 1967

The 5th IDF Congress was held in Toronto, Canada in 1964; Prof. Howard Root was re-elected President for a second term and also presided over the Congress;

1967 – 1970

The 6th IDF Congress was held in Stockholm, Sweden in 1967; Dr. Richmal Levine assumed the Presidency from Prof. Howard Root, who presided over the Congress; it was decided that they would elect an individual as Vice President along with the election of the President, but member Associations continued to be on the Executive Board; for the first time, the concept of disaffiliation of a member association was discussed and became a part of the IDF Constitution;

1970-1973

The 7th IDF Congress was held in Buenos Aires, Argentina in 1970; Dr. Frank Young assumed the Presidency from Dr. Richmal Levine, who presided over the Congress; a representative of the WHO, Dr. Chopra was invited as an Observer, a sign of increasing collaboration between the IDF and the World Health Organisation;

1973 -1976

The 8th IDF Congress was held in Brussels, Belgium in 1973; Prof. R. Luft assumed the Presidency from Dr. Frank Young, who presided over the Congress; a totally new innovation was The Commission for the Teaching Programme which held a seven day refresher course on diabetes; The Commission for Socio-Medical Programme was also established under Prof. G. Verdonk to specifically look into the programmes for lay attendees; In 1974, at the meeting in Israel, it was decided that there was a need for a revised Constitution;

1976 - 1979

The 9th IDF Congress was held in New Delhi, India in 1976; Prof. R. Luft was re-elected President for a second term and also presided over the Congress; the existing 1967 Constitution was formally repealed and the new Draft Constitution and By-laws were adopted unanimously by the General Council; the following became Hon. Presidents: Prof. V. Foglia; Prof. F. Gerritzen; Dr. Alexander marble; and Mr. Maurice Paz; at a meeting between Congresses held in Geneva in 1977m it was decided to take the IDF Congress to Africa and the application from Kenya to hold a Congress in Nairobi was accepted for hosting the 1982 IDF Congress.

1979 - 1982
The 10th IDF Congress was held in Vienna, Austria in 1979; Dr. Albert Renold assumed the Presidency from Prof. R. Luft, who presided over the Congress; member associations were no longer on the Board but members of the Board were elected in their individual capacity; there was a feeling that the prevailing state of affairs needed to be thoroughly reviewed, and to plan for future strategies that would accelerate the progress and facilitate the fulfillment of the Federation objectives. Dr. Luft was made the Chair of the Special Review Committee along with Drs. Bajaj, Pfeiffer, Krall and Mr. Decker; in these days of apartheid, it was also decided that all IDF Congresses would only be held in countries where all the IDF Member Associations and nationals of that country were freely admitted and accepted as members of the IDF member association; Rolf Luft became the 1st Hon. Member of the IDF

1982 -1985

The 11th IDF Congress was held in Nairobi, Kenya in 1982; Prof. Leo Krall assumed the Presidency from Dr. Albert Renold, who presided over the Congress; restructuring of the IDF with the formation of seven regions was accepted; the formation of a Board of Management to look after the day to day administrative aspects was passed; the formation of a Nominating Committee was also passed by the General Council; the “Secretariat” would henceforth be known as the “Executive Office”; members from S. Africa were not allowed to enter Kenya and could not attend the Congress due to apartheid laws;

1985-1988

The 12th IDF Congress was held in Madrid, Spain in 1985; Prof. J. S. Bajaj assumed the Presidency from Prof. Leo Krall, who presided over the Congress; it was decided to shift the IDF Executive Office permanently to Brussels, Belgium in 1985; one main topic of discussion was the financial status of the IDF;

1988-1991

The 13th IDF Congress was held in Sydney, Australia in 1988; Prof. J. J. Hoet assumed the Presidency from Prof. J. S. Bajaj, who presided over the Congress;

1991 - 1994

The 14th IDF Congress was held in Washington DC, USA in 1991; Wendell Mayes Jr., the first lay person to become President, assumed the Presidency from Prof. J. J. Hoet, who presided over the Congress; 14 new associations were welcomes as full members. The disaffiliation of non paying members was kept on hold till the 1994 Congress; the World Health Assembly Resolution 42.35 had lead to the setting up of the Diabetes Unit within the WHO; the IDF long range Plan (1988 – 1994) was laid out; the 1st Official World Diabetes day was held and celebrated in 1991 and every year thereafter; Prof. J.J. Hoet and Prof. H. Keen were elected Hon. Presidents; Task Force on Diabetes Health Economics - established in 1994, disbanded in 2016 (Chairs: Rhys Williams; Jonathan Brown; Andrew Palmer); Task Force on Finance and By-laws - established in 1994, disbanded in 2001 (Chair: Henry Rivera); Task Force on Revenue Generation - established in 1997, disbanded in 2001 (Chair: Donald Chisholm);

1994 – 1997
The 15th IDF Congress was held in Kobe, Japan in 1994; Prof. Jak Jervell assumed the Presidency from Wendell Mayes Jr., who presided over the Congress; the International Diabetes Federation was spreading and becoming stronger throughout the world. It now had 130 member associations from 108 countries; increasing collaboration with the WHO; Who would also co-sponsor the WDD celebrations although this would remain basically an IDF initiative; setting up of the IDF Education Foundation; Consultative sections on Childhood and Adolescent Diabetes as well as one on Diabetes education had been formed as well as Task Forces on NIDDM and Insulin Distribution; Prof. Harold Rifkin and Prof. S. Baba were elected Hon. Presidents and Archbishop Trevor Huddleston was elected as Hon. Member of the IDF; Consultative Section on Childhood and Adolescent Diabetes - established in 1995, disbanded in 2013 (Chairs: Martin Silink; Francine Kaufman; Johnny Ludvigsson); Consultative Section on Diabetes Education - established in 1994, disbanded in 2016 (Chairs: Trisha Dunning; Marg McGill; Sue McLaughlin); Task Force on Appropriate Technology - established in 1995, disbanded in 2000 (Chair: Sir George Alberti); Task Force on Clinical Practice Guidelines - established in 1997, disbanded in 2017 (Chairs: Philip Home; Stephen Colagur; Pablo Aschner); Task Force on Insulin - established in 1994, disbanded in 2016 (Chairs: Jean-Claude Mbanya & Earl Bell; Larry Deeb); Task Force on Member Association Development - established in 1994, disbanded in 2004 (Chair: Bjornar Allgot); Task Force on Regional Development - established in 1995, disbanded in 2001 (Chair: Sterling Tucker);

1997 – 2000

The 16th IDF Congress was held in Helsinki, Finland in 1997; Ms. Maria de Alva assumed the Presidency from Jak Jervell, who presided over the Congress; focus was laid on the Regional Development Plan; an IDF/WHO Working group had been formed; the Bulletin was now published in three languages; a By-Law was passed granting the Federation some, or all, of the fiscal and operational responsibility of its Congresses; reports on the work of the Special Committees and task Forces were presented; The Diabetes Voice had become a full colored magazine, printed in three languages, English, French and Spanish in 1999; IDF website had been launched in 1999; Wendell Mayes Jr., Lorna Mellor, Manuel Serrano Rios and S. Shera were elected as Hon. Presidents; Aladin Alwan, James Jackson, Hilary King, Rudolf Korec, Eric Mngola, Z. Skrabalo, Meng Tan and K. Staer-Johanson were elected as Hon. Members; Consultative Section on the Diabetic Foot - established in 2000, disbanded in 2016 (Karel Bakker; Kristien van Acker); Task Force on IDF Review - established in 2000, disbanded in 2003 (Chair: Jak Jervell); Task Force on Epidemiology and Prevention - established in 2000, disbanded in 2013 (Chairs: Paul Zimmet; Sir George Alberti); Task Force on Cardiovascular Disease - established in 2000, disbanded in 2006 (Chair: Clive Cockram);

2000 – 2003

The 17th IDF Congress was held in Mexico City, Mexico in 2000; Sir George Alberti assumed the Presidency from Maria de Alva, who presided over the Congress; 50th Anniversary of the formation of the IDF; that the IDF had grown significantly from the 16 member associations at the start in 1950 to 176 members from 136 countries; focus on making the regions stronger; major restructuring of the IDF Executive Office; IDF Global taking over the organization of the Congress; launch of the 1st edition of the IDF Diabetes Atlas; start of the IDF Life For A Child programme; Jak Jervell and John Turtle elected as Hon. Presidents; Mr Neil Decker, Mr. Thorbjorn Jagland, Prof. Thomas Johnson, Prof. Michiel Krans, Sir A. McIntyre, Sir K. Ramdanee, Prof. S. Tandhanand and Mr. Ray Williams as Hon. Members; Consultative Section on the Diabetic Foot - established in 2000, disbanded in 2016 (Karel Bakker; Kristien van Acker); Task Force on IDF Review - established in 2000, disbanded in 2003 (Chair: Jak Jervell); Task Force on Epidemiology and Prevention - established in 2000, disbanded in 2013 (Chairs: Paul Zimmet; Sir George Alberti); Task Force on Cardiovascular Disease - established in 2000, disbanded in 2006 (Chair: Clive Cockram);
2003 – 2006

The 18th IDF Congress was held in Paris, France in 2003; Prof. Pierre Lefebvre assumed the Presidency from Sir George Alberti, who presided over the Congress; continuing restructuring of the IDF Executive Office; IDF Office assuming control of the organization of Congresses; increasing communication activities including Diabetes Voice and Diabetes Atlas; strengthening of regional offices; continuing collaboration with the WHO; first thoughts on getting the United Nations Resolution; growing activities of the IDF Education Foundation which ended in 2006; The passing of the United Nations Resolution in 2006; Ms. Maria de Alva elected as Hon. President; Task Force on Diabetes Awareness - established in 2003, disbanded in 2007 (Chair: Rhys Williams); Task Force on Insurance - established in 2003, disbanded in 2007 (Chair: Wim Wientjens); Task Force on Position Statements - established in 2003, disbanded in 2007 (Chair: Martin Silink);

2006 – 2009

The 19th IDF Congress was held in Cape Town, S. Africa in 2006; Prof. Martin Silink assumed the Presidency from Prof. Pierre Lefebvre, who presided over the Congress; Passing of the United Nations Resolution61/225; Sir George Alberti elected as Hon. President; The Journal DRCP becomes the official medical journal of the IDF; Task Force on National Diabetes Policy and Action - established in 2007, disbanded in 2013 (Chair: Ruth Colagiuri);Strengthened IDF infrastructure and governance with the appointment of IDF’s first Chief Executive officer 2008. Strengthened infrastructure by appointments of IDF Diabetes Education Manager 2008, IDF Epidemiologist 2008, IDF Health Economist 2009; Appointed first IDF Centres of Education 2008; Launched community awareness program for Early Diagnosis of DKA in children on WDD 2007;Celebrated First United Nations World Diabetes Day, Nov 14, 2007 at UN; Celebrated WDD internationally by having more than 250 buildings and landmarks lit in blue in 2007 and more than 2000 in 2008.

2009 – 2012

The 20th IDF Congress was held in Montreal, Canada in 2009; Prof. Jean-Claude Mbanya assumed the Presidency from Prof. Martin Silink, who presided over the Congress; Pierre Lefebvre was elected as Hon. President; The 1st issue of DRCP as an IDF Journal launched; The IDF Congress would be held every two years from 2009 onwards; The terms of the Boards would also be 2 years from 2016; Task Force on Global Advocacy - established in 2010, disbanded in 2013 (Anne-Marie Felton); Task Force on Science - established in 2010, disbanded in 2016 (Massimo Massi-Benedetti, Akhtar Hussain); The 21st IDF Congress was held in Dubai, UAE in 2011; Prof. Jean-Claude Mbanya continued with his Presidency which would be complete at the end of 2012; Major restructuring of the Articles of Association; Prof. Paul Zimmet was elected as Hon. President; Prof. Linda Simeniero, Prof. Azad Khan and Mr. Brian Wentzell were elected as Hon. Members;

2012 – 2015

Sir M. Hirst assumed the Presidency from Prof. Jean-Claude Mbanya; The 22nd IDF Congress was held in Melbourne, Australia in 2013; The IDF-PGDM programme started; The 23rd IDF Congress was held in Vancouver, Canada in 2015; Shaukat Sadikot assumed the Presidency from Sir M. Hirst, who presided over the Congress; Martin Silink and Jean-Claude Mbanya were elected as Hon. Presidents under the new Guidelines for Hon. Presidency;
2015-2017

The 23rd IDF Congress was held in Vancouver, Canada in December 2015; Prof. Shaukat Sadikot assumed the Presidency from Sir M. Hirst, who presided over the Congress; The IDF School of Diabetes established online. 80% of education material having free access. Three certified Courses for Specialists, General and Primary Care Physicians and the third for Diabetes Educators. In six languages, English, French, Spanish, Russian, Chinese and Arabic; Started appointments of IDF Centres of Education and IDF Centres of Excellence in Diabetes Care; Best of IDF Initiative for face to face started; The IDF-PGDN programme terminated; The IDF-YLD programme spread all over the regions and education material and master classes put online so that they could be accessed by youth all over; The IDF Disaster Management Response Plan initiated and working along with Medecins sans Frontieres and ICRC; Collaboration with WHO strengthened; Regional Development put on a firm footing; Clinical Recommendations for management of T2DM, T1DM in elderly and Foot Recommendations published and put in online in three languages, English, Spanish and French; WDD theme Women and Diabetes, an initiative which would be continued for the next five years; IDF Lifetime Achievement Awards and IDF Outstanding service to Diabetes and the IDF in the recent years to be presented at the Abu Dhabi Congress in December 2017;
# IDF Congress 1952-2017

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<th>Region</th>
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<td>Fernando Lavalle</td>
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<td>24-29 Aug 2003</td>
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<td>Anne-Marie Felton</td>
<td>Sir Michael Hirst, UK</td>
</tr>
<tr>
<td>4 – 8 Dec 2017</td>
<td>Abu Dhabi, UAE</td>
<td>MENA</td>
<td>Monira Al Arouj</td>
<td>Sha.ukat Sadikot, India</td>
</tr>
</tbody>
</table>
ANNEX 4

IDF Members

Africa (AFR)

1976
Diabetes South Africa (South Africa) Society for Endocrinology, Metabolism and Diabetes of South Africa (South Africa)

1978
Diabetes Kenya Association (Kenya)

1982
Diabetes Association of Nigeria (Nigeria)

1985
Ethiopian Diabetes Association (Ethiopia)
National Diabetes Association (Ghana)
Uganda Diabetes Association (Uganda)

1991
Diabetes Association of Zanzibar (Tanzania)
Cameroon Diabetes Association (Cameroon)
Diabetes Association of Zambia (Zambia)
Zimbabwe Diabetic Association (Zimbabwe)

1994
Gambian Diabetes Association (Gambia)
Tanzania Diabetes Association (Tanzania)

1997
Association Malienne de Lutte contre le Diabète (Mali)
Association Sénégalaise de Soutien aux Diabétiques (Senegal)
Diabetic Society of Seychelles (Seychelles)

2000
Association des Diabétiques de Côte d’Ivoire (Côte d’Ivoire)
Association Guinéenne d’Education et d’Aide aux Diabétiques (Guinea) Association Togolaise du Diabète (Togo)

2003
Eritrean National Diabetic Association (Eritrea)

Lesotho Diabetes Association (Lesotho)
Association Rwandaise des Diabétiques (Rwanda)

2006
Burundian Diabetes Association (Burundi)
Association Vaincre le Diabète au Congo (Democratic Rep of Congo)
Diabaction-Congo (Republic of Congo)

2009
Association Burkinabe d’Aide aux Diabétiques (Burkina Faso)

2011
Association Malgache contre le Diabète (Madagascar)
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2011
Diabetes Association of Malawi (Malawi)
Association Mauritanienne de Lutte contre le Diabète (Mauritania)

2013
Diabetes Association of Botswana (Botswana)
Association des Diabétiques du Congo (Democratic Rep of Congo)

2015
Diabetes Swaziland (Swaziland)

Europe (EUR)

1950
Association Belge du Diabète (Belgium)
Diabetes Liga (Belgium)
Diabetesforeningen (Denmark)
Finnish Diabetes Association (Finland)
Fédération Française des Diabétiques (France)
Associazione Italiana per la Difesa degli Interessi dei Diabetici (Italy)
Norges Diabetesforbund (Norway)
Svenska Diabetesförbundet (Sweden)

1952
Diabetesvereniging Nederland (The Netherlands)
Diabetes UK (United Kingdom)

1958
Associação Protectora dos Diabéticos de Portugal (Portugal)

1958
Israel Diabetes Association (Israel)
Schweizerische Diabetes-Gesellschaft
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IDF Members

(Switzerland)
Turkish Diabetes Association (Turkey)

1970
Magyar Diabetes Tarsasag (Hungary)

1976
Österreichische Diabetes Gesellschaft (Austria)
Hellenic Diabetes Association (Greece)

1979
Societa Italiana di Diabetologia (Italy)

1982
Cyprus Diabetic Association (Cyprus)
Association Luxembourgeoise du Diabète (Luxembourg)
Maltese Diabetes Association (Malta)

1985
FAND Associazione Italiana Diabetici (Italy)

1988
Ceska Diabetologicka Spolecnost (Czech Republic)

1991
Shoqata E Diabetit Ne Shqiperi (Albania)
Samtök Sykursjúkra (Iceland)
Polskie Stowarzyszenie Diabetyków (Poland)
Swedish Society for Diabetology (Sweden)

1993
Slovenska Diabetologicka Spolocnost (Slovakia)

1994
Bulgarian Society of Endocrinology (Bulgaria)
Hrvatski savez dijabetickih udruga (Croatia)
SVAZ Diabetiku Ceske Republiky (Czech Republic)
Estonian Diabetes Association (Estonia)
Georgian Union of Diabetes and Endocrine Associations (Georgia)
Diabetes Federation of Ireland (Ireland)
Lithuanian Diabetes Association (Lithuania)
Zveza Drustev Diabetikov Slovenije (Slovenia)

1995
Polskie Towarzystwo Diabetologiczne (Poland)

1997
Diabetes Association of the Republic of Kazakhstan (Kazakhstan)
Sociedade Portuguesa de Diabetologia (Portugal)
Turkish Diabetes Foundation (Turkey)
Ukrainian Diabetic Federation (Ukraine)

2000
Azerbaijan Diabetes Society (Azerbaijan)
Hellenic Diabetes Federation (Greece)
Associazione Medici Diabetologi (Italy)
Diabetes & Endocrinological Association of Kyrgyzstan (Kyrgyz Republic)
Macedonian Diabetes Association (Macedonia)
Russian Diabetes Federation (Russia)
Sociedad Española de Diabetes (Spain)
Societatea Romana de Diabet, Nutritie si Boli Metabolice (Romania)

2003
Belarussian Humanitarian Organisation Children’s Diabetes (Belarus)
Diabetes Association of Serbia (Serbia)
Serbian Association for the Study of Diabetes (Serbia)
ZVAZ Diabetikov Slovenska (Slovakia)

2006
Diabetesfelag Foroya (Faroe Islands)
National Federation of Hungarian Diabetics (Hungary)
Latvian Diabetes Association (Latvia)
Latvian Diabetes Federation (Latvia)
Prodiab (Moldova)
Endocrinological and Diabetes Association of Uzbekistan (Uzbekistan)

2009
DiabetesDE (Germany)
Associazione Nazionale Italiana Atleti Diabetici (Italy)

2011
Armenian Association of Diabetes (Armenia)
Bulgarian Diabetes Association (Bulgaria)
Federatia Romana de Diabet, Nutritie, Boli Metabolice (Romania)

2013
Panhellenic Federation of People with Diabetes (Greece)
Diador (Slovakia)
International Diabetes Association of Ukraine (Ukraine)
Tashkent Charity Public Association of the Disabled and People with DM “UMID” (Uzbekistan)

Middle East and North Africa (MENA)

1967
Diabetic Association of Pakistan (Pakistan)

1969
Iranian Diabetes Society (Iran)

1975
Egyptian Diabetes Association (Egypt)

1985
Saudi Diabetes and Endocrine Association (Saudi Arabia)

1994
Bahrain Diabetes Society (Bahrain)

1997
Iraqi Diabetes Association (Iraq)
Jordanian Society for the Care of Diabetes (Jordan)
Kuwait Diabetes Society (Kuwait)
Lebanese Diabetes Association (Lebanon)
Libyan Diabetic Association (Libya)
Syrian Diabetes Association (Syria)

2000
Emirates Diabetes Society (UAE)
2006
Afghanistan Diabetes Association (Afghanistan)
Oman Diabetes Society (Oman)

2009
Sudanese Diabetes Association (Sudan)
Yemen Diabetes Association (Yemen)

2013
Arabic Association for the Study of Diabetes & Metabolism (Egypt)
Upper Egypt Diabetes Association (Egypt)
Chronic Care Center (Lebanon)

2015
Libyan Pediatric Diabetes Society (Libya)
Diabetes Palestine (Palestine)
Saudi Charitable Association of Diabetes (Saudi Arabia)

North America and Caribbean (NAC)

1950
American Diabetes Association (USA)

1954
Canadian Diabetes Association (Canada)

1970
Sociedad Mexicana de Nutrición y Endocrinología (Mexico)

1976
Sosiedat Kurasoleno di Diabetiko (Curaçao)

1980
Federación Mexicana de Diabetes (Mexico)

1982
Bermuda Diabetes Association Bermuda
Diabète Québec (Canada)

1991
Diabetes Association of Jamaica (Jamaica)
Diabetes Association of Trinidad and Tobago (Trinidad and Tobago)

1994
Diabetes Association of Barbados (Barbados)
Belize Diabetes Association (Belize)
British Virgin Islands Diabetes Association (British Virgin Islands)
Cayman Islands Diabetes Association (Cayman Islands)
Dominica Diabetes Association (Dominica)
Grenada Diabetes Association (Grenada)
Guyana Diabetic Association (Guyana)
Fondation Haïtienne du Diabète et des Maladies Cardiovasculaires (Haiti)
St Kitts Diabetes Association (St Kitts & Nevis)

1997
Bahamas Diabetic Association (The Bahamas)

2000
Aruba Diabetes Foundation (Aruba)

2003
Anguilla Diabetes Association (Anguilla)
Antigua and Barbuda Diabetes Association (Antigua and Barbuda)

St Lucia Diabetes and Hypertension Association (St Lucia)

2006
Diabetes Foundation of Sint Maarten (Sint-Maarten)
Diabetes Vereniging Suriname (Suriname)

2009
Montserrat Diabetes Association (Montserrat)

2011
American Association of Diabetes Educators (USA)

South and Central America (SACA)

1950
Asociación de Diabécticos del Uruguay (Uruguay)

1958
Sociedad Cubana de Diabetes (Cuba)

1968
Sociedad Argentina de Diabetes (Argentina)

1976
Liga Argentina de Protección al Diabético (Argentina)

1979
Sociedade Brasileira de Diabetes (Brazil)
Sociedad Chilena de Endocrinología y Diabetes (Chile)
Sociedad Paraguaya de Diabetología (Paraguay)
Sociedad Puertorriqueña de Endocrinología y Diabetología (Puerto Rico)

1982
Sociedad Venezolana de Endocrinología y Metabolismo (Venezuela)

1985
Asociación Nacional Pro Estudio de la
Diabetes, Endocrinología y Metabolismo (Costa Rica)
Instituto Nacional de Diabetes, Endocrinología y Nutrición (Dominican Republic)
Sociedad Dominicana de Diabetes (Dominican Republic)
Asociación de Diabetes del Peru (Peru)

1988
Asociación Panameña de Diabeticos (Panama)

1991
Fundación Diabetes Juvenil de Chile (Chile)
Sociedad de Diabetología y Nutrición del Uruguay (Uruguay)

1997
Sociedad Boliviana de Endocrinología, Metabolismo y Nutrición (Bolivia)

2000
Associação de Diabetes Juvenil (Brazil)
Federação Nacional de Associações e Entidades de Diabetes (Brazil)
Federación Diabetológica Colombiana (Colombia)
Federación Ecuatoriana de Diabetes (Ecuador)
Asociación Salvadoreña de Diabetes (El Salvador)
Fundación Pro Ayuda a Enfermos Crónicos (Nicaragua)
Fundación Paraguaya de Diabetes (Paraguay)
Asociación de Diabéticos Juveniles del Perú (Peru)
Asociación Puertorriqueña de Diabetes (Puerto Rico)
Asociación Puertorriqueña de Educadores en Diabetes (Puerto Rico)
Federaición Nacional de Asociaciones y Unidades de Diabetes (Venezuela)
Asociación Colombiana de Diabetes (Colombia)

2009
Federación Argentina de Diabetes (Argentina)
Fundación Nicaraguense para la Diabetes (Nicaragua)

2011
Asociacion de Padres de Ninos y Jovenes Diabeticos de Nicaragua (Nicaragua)

2013
Asociación para El Cuidado de la Diabetes en Argentina (Argentina)
Fundación Santandereana de Diabetes y Obesidad (Colombia)
Asociación Costarricense Lucha contra la Diabetes (Costa Rica)
Fundación Aprendiendo a Vivir con Diabetes (Ecuador)
Fundacion Los Fresnos "Casa de la Diabetes" (Ecuador)

2015
Asociación de Diabeticos de Chile (ADICH) (Chile)
Asociación Nacional de Diabeticos de Honduras (ANADIH) (Honduras)
Fundación de Diabetes Juvenil del Ecuador (Ecuador)

2006
Asociacion Civil de Diabetes Argentina (Argentina)
Vivir con Diabetes (Bolivia)
South East Asia (SEA)

1959
Diabetic Association of Bangladesh (Bangladesh)

1962
Diabetic Association of India (India)

1982
Mauritius Diabetes Association (Mauritius)

1985
Diabetes Association of Sri Lanka (Sri Lanka)

2000
Nepal Diabetes Association (Nepal)

2002
Diabetes Society of Maldives (Maldives)

2009
Faridpur Diabetic Association (Bangladesh)

2013
Eminence (Bangladesh)
Research Society for the Study of Diabetes in India (India)

Western Pacific (WP)

1958
Japan Diabetes Society (Japan)

1967
Diabetes New Zealand (New Zealand)
Diabetes Philippines (Philippines)

1970
Diabetes Association of Thailand (Thailand)

1972
Korean Diabetes Association (South Korea)

1976
Diabetes Fiji (Fiji)
Diabetic Society of Singapore (Singapore)

1979
Diabetes Australia (Australia)

1985
Chinese Diabetes Society (China)
Diabetes Malaysia (Malaysia)

1988
Hong Kong Society of Endocrinology, Metabolism and Reproduction (Hong Kong)
Chinese Taipei Diabetes Association (Taiwan)

1991
Diabetic Association of Papua New Guinea (Papua New Guinea)

1994
Persatuan Diabetes Indonesia (Indonesia)

1997
Tonga Diabetes Association (Tonga)
2000
Diabetes Hongkong (Hong Kong)
Macau Diabetes Association (Macau)

2003
Cambodian Diabetes Association (Cambodia)

2006
Mongolian Diabetes Association (Mongolia)
Vanuatu Diabetes Association (Vanuatu)
Vietnamese Association of Diabetes & Endocrinology (Vietnam)

2009
Japan Association for Diabetes Education and Care (Japan)
Taiwanese Association of Diabetes Educators (Taiwan)

2011
Youth Diabetes Action (Hong Kong)
Association of Diabetes Educators Singapore (Singapore)

2013
Diabetes Committee of Hospitals Association of Korea (North Korea)
Resolution adopted by the General Assembly

[without reference to a Main Committee (A/61/L.39/Rev.1 and Add.1)]

61/225. World Diabetes Day

The General Assembly,

Recalling the 2005 World Summit Outcome ¹ and the United Nations Millennium Declaration,² as well as the outcomes of the major United Nations conferences and summits in the economic, social and related fields, in particular the health-related development goals set out therein, and its resolutions 58/3 of 27 October 2003, 60/35 of 30 November 2005 and 60/265 of 30 June 2006,

Recognizing that strengthening public-health and health-care delivery systems is critical to achieving internationally agreed development goals, including the Millennium Development Goals,

Recognizing also that diabetes is a chronic, debilitating and costly disease associated with severe complications, which poses severe risks for families, Member States and the entire world and serious challenges to the achievement of internationally agreed development goals, including the Millennium Development Goals,

Recalling World Health Assembly resolutions WHA42.36 of 19 May 1989 on the prevention and control of diabetes mellitus³ and WHA57.17 of 22 May 2004 on a global strategy on diet, physical activity and health,⁴

Welcoming the fact that the International Diabetes Federation has been observing 14 November as World Diabetes Day at a global level since 1991, with co-sponsorship of the World Health Organization,

Recognizing the urgent need to pursue multilateral efforts to promote and improve human health, and provide access to treatment and health-care education,

1. Decides to designate 14 November, the current World Diabetes Day, as a United Nations Day, to be observed every year beginning in 2007;
2. *Invites* all Member States, relevant organizations of the United Nations system and other international organizations, as well as civil society, including non-governmental organizations and the private sector, to observe World Diabetes Day in an appropriate manner, in order to raise public awareness of diabetes and related complications, as well as its prevention and care, including through education and the mass media;

3. *Encourages* Member States to develop national policies for the prevention, treatment and care of diabetes in line with the sustainable development of their health-care systems, taking into account the internationally agreed development goals, including the Millennium Development Goals;

4. *Requests* the Secretary-General to bring the present resolution to the attention of all Member States and organizations of the United Nations system.

83rd plenary meeting
20 December 2006
A brief history of the International Diabetes Federation

Federazione Internazionale del Diabete

Fédération Internationale du Diabète

International Diabetes Federation

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