Dear All,

It is with great pleasure that I welcome you into this new year of 2013. A year that seems to be looking quite busy, with almost something going on in Paediatric endocrinology all over the world right from ASPAE 2013, Durban, SA from 20-22nd of March 2013 till November.

I wish to thank all those who through their activities and support have allowed this young but rapidly growing society (ASPAE) to become a formidable society that has been recognized all over the world as the society that represent the African Paediatric Endocrinologist interest.

We still have a lot of rivers to cross and the only way we can cross all the obstacles, cliffs, gorges etc on the way is by cooperating, listening, communicating and supporting strongly all our plans so that all our program for the year will turn out successful.

My prayer is that everyone achieve their dream for the year.

Long live the continent of Africa, long live ASPAE

Professor Abiola Oduwole
President of ASPAE
As an organization, we are the pioneers in the field of paediatric endocrinology in Africa, and we have indeed charted the uncharted territory.

MESSAGE FROM THE EDITOR

Dear Friends and Colleagues,

The year 2012 has come and it is now gone. This is leaves us with a moment of reckoning as to what the year 2013 has for us. We have witnessed a number of activities and winds of change blowing across the field of paediatric endocrinology in Africa. From our 3rd annual conference in Lagos, Nigeria in March 2012 to the launch of the 1st Africa Diabetes Summit in Arusha, Tanzania and the launch of the 1st ASPAE-ISPAD post-graduate training course in Durban, South Africa, indeed the year 2012 was year full of activities. As an organization, we are the pioneers in the field of paediatric endocrinology in Africa, and we have indeed charted the uncharted territory.

In this edition of the newsletter, we give you the highlights of the 1st ASPAE-ISPAD Post-Graduate Training Course in Paediatrics and Adolescent Diabeties, the 1st Africa Diabetes Summit as well as endocrinology services across 2 countries in Africa, namely Senegal in West Africa and Kenya in East Africa. We also give you some information about the paediatric registries in Africa as well the launch of the textbook of Practical Paediatric Endocrinology in resource limited setting.

Our role as the Editorial Team is to provide you with the best quality news reflective of the major events occurring in the field of paediatric endocrinology across Africa. We would like to take this opportunity to wish a happy and prosperous new year.

We hope to see you all in Durban, South Africa on the 20th-22nd March 2013 for the 4th ASPAE Scientific Conference.

May god bless you all.

Please let us know of your ideas on what you expect of the newsletter to make it even better! Feel free to send us your comments at apsalms@yahoo.com.

Dipesalema Joel MRCPI
Editor
The 1st ASPAE-ISPAD Post-graduate training in Paediatrics and Adolescent diabetes was held in Phumula Beach Hotel Resort, in Kwa-Zulu, Natal in South Africa from the 04th to the 06th December 2012. The course was attended by 29 delegates from 9 countries namely Botswana, Cote D’voire, Nigeria, Kenya, Senegal, South Africa, Sudan, Tanzania and the United Kingdom.

Following the brief opening remarks by the ASPAE President, Professor Abiola Oduwole and the ISPAD President Professor Stephen Greene, delegates were given the opportunity to present the organization of care in their countries. There is marked variation in the amount of resources which various African governments input in their health care system. Currently, some governments in Africa invest as low as US$36 per person in their health expenditure while on the other hand other governments invest up to US$648 per person in their health expenditure. As a consequence of this variation in the resources allocated to care in different countries, access to health care for children with diabetes is a challenge in some countries in Africa.

The training also covered an in-depth review of intensive insulin therapy, barriers to intensive therapy in Africa as well as the challenges faced by the low-income countries in insulin delivery and storage. In the absence of modern refrigerators, the traditional methods of cooling things like the use of clay pots have been used successfully in some low income countries.

The other aspects of diabetes care which were covered included acute management of diabetes ketoacidosis, hypoglycaemia, prevention of diabetes ketoacidosis and the sick day rules. The psychosocial support as well as the dietary management in children and adolescent with diabetes were also covered in details.

The training came to a conclusion with a group discussion on the challenges and the progress made so far in the establishment of the paediatric diabetes registries in Africa. Dr Kuben Pillay gave a vote of thanks on behalf of organizers and
On the 25th -28th July 2012, the ASPAE delegates attended the 1st African Diabetes Summit in Arusha, Tanzania. The aim of the summit was to present scientific papers and to disseminate knowledge about diabetes care in Africa. The conference was preceded by other activities like African Diabetes Youth Leadership programme and training of the healthcare professionals in managing diabetes in childhood more especially in areas where the Changing Diabetes in Children (CDiC) programme will be implemented. The youth leaders were later joined by their counterparts from the International Diabetes Federation (IDF) Youth Leaders, who are based in different countries around the globe. Among the ASPAE delegates who attended the pre-conference programmes were Dr. Edna S Majaliwa who was one of the organizers for the youth leadership programme as well as the trainer in both the Youth programme and CDIC programme, Dr. Kandi C Muze who was one of the faculty in the Youth and CDIC programmes, Dr. Levina Msuya and Rahim Damji who were the trainers in the Youth Leadership programme. Dr. Renson Mukwana who is a faculty in the Paediatric Endocrinology Training Centre for Africa(PETCA) in Nairobi, Kenya then joined the group for the meeting.
AN UPDATE COURSE IN PAEDIATRIC ENDOCRINOLOGY HELD IN UNIVERSITY COLLEGE HOSPITAL, IBADAN. NIGERIA HELD ON 9TH -10TH JULY 2012

A two day update course in Paediatric endocrinology was held in Ibadan at the department of Paediatrics in the University College Hospital (UCH). This was jointly organised by the West African College of Physicians (WACP) and the National Postgraduate Medical College of Nigeria (NPMCN). The facilitators of that seminar were the members of the Society of Paediatric and Adolescent Endocrinology of Nigeria (SPAEN). Paediatric endocrinology is fast making an in-road in the field of medicine in Nigeria as a leading sub-specialty in Paediatrics and being able to have a joint sponsorship of an update course by the 2 most powerful medical colleges in the West African sub-region was a great land mark achievement.

There were about 37 participants that registered for the update course. These were mostly resident doctors from across the length and breath of Nigeria. Also present were resident doctors from the West African coast and Australia.

It was coordinated by our indefatigable colleague Dr Tokunbo Jarret, supported by our dynamic President, Professor Abiola Oduwole.

Participants were inundated with lectures covering a wide range of topics in paediatric endocrinology like Diabetes mellitus in children, Growth, puberty, thyroid, calcium and vitamin D metabolism. Also covered were endocrine emergencies, Adolescent health issues and sessions in imaging studies. Practical sessions on growth and DKA were covered and pre and post tests were done. Resource persons were mainly from the newly trained paediatric endocrinologist in Nigeria from PETCA. We were glad to have Professor Ze'ev Hochberg from Haifa, Israel who is ever supportive on development of Paediatric endocrinology in Africa.

The course was generally well planned, well organised and well delivered. It was also a refreshing time for us as we enjoyed the clement weather and serene environment of Ibadan-a city known for its ancient history in arts and culture and harboured the first premier university and teaching hospital in Nigeria. From all indications this is going to be a yearly event as Paediatric endocrinology has now carved out a niche in the medical arena of Nigeria.

Dr Maryann Ugochi Ibekwe, Associated Editor of ASPAE Newsletter
Consultant Paediatrician/Paediatric Endocrinologist, Ebonyi State University, Abakaliki, Nigeria
ESTABLISHING PAEDIATRIC DIABETES REGISTRIES IN DEVELOPING COUNTRIES – AN IMPORTANT STEP TOWARDS DECREASED MORBIDITY AND MORTALITY

By Johnny Ludvigsson MD PhD, Professor of Pediatrics, Linköping University, Sweden; Chairman of IDF Task Force for Diabetes in Children and Adolescents.

It has been said that the most common cause of death in Type 1 diabetes is lack of insulin. That may be true, but it can also be so that the most common cause is lack of diagnosis! All over the world, where reasonably reliable statistics exist, the incidence of diabetes in children and adolescents is increasing rapidly. There is an epidemic, in some areas with mainly Type 1 diabetes, in other areas probably mainly Type 2 diabetes. However in many countries the information is scarce or almost completely lacking. This is the case in large parts of Sub-Saharan Africa.

Awareness of diabetes in children is too low! We can fear that many patients die before diagnosis. Those who are diagnosed usually come with keto-acidosis, many of them seriously ill. And then they meet lack of insulin in many places. Why? Lack of resources, but not least lack of information good enough to convince healthcare decision makers to plan for what is needed, to organize a care which has a minimal standard.

All efforts have to be made to increase awareness both in the general population and health care system through the provision of information by, for example; posters/pictures like Fig 1 put up at markets, in towns and villages, and also through advertisements in television. Perhaps also messages in mobile telephones could be used. Then all cases of diabetes in children have to be registered. This will give a clear picture of the problem, what resources are needed, how much insulin is needed, what devices are needed. If incidence would be ten times lower than in Sweden, that is much lower than eg in Sudan, then this should mean at least some 5000 new cases of diabetic children per year in a country like Nigeria! If these children got adequate treatment there should then be at least 50 000 registered children! You can yourself calculate how many you should have in your own country with an incidence of 5/100 000 children in a year! And the incidence may be higher!!

There may be jurisdical and cultural problems with registration. Large registries may also need a computer, and time from somebody. But to start simple at a hospital or healthcare centre does not take very much time. You will not meet SO many new diabetic patient!. Every physician, even working hard, with small resources, has the possibility to write down some simple facts about every new diabetic patient. Table 1 shows a proposed example of registry of new cases (incidence register) and an example of a prevalence register. Anybody can write down this type of register and fill in those facts available and leave the rest. Already in a year you can see how many diabetic patients you have and their phenotype. With this information it is much easier to call for resources, ask for help from outside if you do not have it at home eg insulin from Insulin Foundation, Life for a child (supported by IDF and by Lilly), or help with education of Staff from ISPAD (International Society for Pediatric and Adolescent Diabetes), or from Changing Diabetes (Novo Nordisk). And in some cases clinical work can develop into interesting research for those who wish.

Please report to me (Johnny.Ludvigsson@liu.se) or to IDF how you proceed! Good Luck!

Fig 1; A poster showing the signs and symptoms of diabetes in children

DIABETES IN CHILDREN AND YOUNG ADULTS

KNOW THE WARNING SIGNS

TEXT SECOND LANGUAGE

Fig 1: A poster showing the signs and symptoms of diabetes in children
Table 1: Incidence register of new diabetes cases in children and youth below 21 years of age.

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<tr>
<th>Patient number</th>
<th>Record number</th>
<th>Reporting borough</th>
<th>Birthdate</th>
<th>Sex</th>
<th>Date of diagnosis</th>
<th>Needs insulin</th>
<th>On oral agents</th>
<th>Diabetes type</th>
<th>Date of most recent measure</th>
<th>Status</th>
<th>Male</th>
<th>Female</th>
<th>Weight (kg)</th>
<th>Height (cm)</th>
<th>Albuminuria</th>
<th>Other complications</th>
<th>Other comments</th>
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Table 2: Prevalence register of new diabetes cases in children and youth below 21 years of age.

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<th>Patient number</th>
<th>Record number</th>
<th>Reporting borough</th>
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Table 3: Prevalence register of existing diabetes cases before the register started.

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<th>Patient number</th>
<th>Record number</th>
<th>Reporting borough</th>
<th>Birthdate</th>
<th>Sex</th>
<th>Date of diagnosis</th>
<th>Needs insulin</th>
<th>On oral agents</th>
<th>Diabetes type</th>
<th>Date of most recent measure</th>
<th>Status</th>
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SERVICES IN PAEDIATRIC ENDOCRINOLOGY ACROSS AFRICA

REPUBLIC OF SENEGAL
By Dr Niang Babacar, Fellow in Paediatric Endocrinology
Paediatric Endocrinology Training Centre for West Africa, Lagos, Nigeria

Senegal is a country in West Africa with a population of over 12 million people. Around 44% of the population is less than 14 years of age. It covers an area of 196,190 square kilometers. According to the World Bank, Senegal is a low income country with a nominal GDP of US$1,033.91 per capita income. Senegal expend 5.66% of its national GDP in health and that translates to US$58.50 per person per year on health expenditure. The infant mortality rate stands at 48 per 1000 births and the under 5 mortality rate stands at 69 per 1000 births.

There are currently 2 Paediatric Endocrinologists in the whole country and they are based in the National Children’s Hospital, Alberta Royer in Dakar-the capital city of Senegal. In addition to the 2 Paediatric Endocrinologists, Dr Niang Babacar from Dakar, enrolled in the Paediatric Endocrinology Fellowship run by the Paediatric Endocrinology Training Centre for West Africa in Lagos, Nigeria in June 2012. The number of children with diabetes mellitus is unknown as there is currently no diabetes registry available.

However, there is some evidence that the prevalence of diabetes in children in Senegal may have increased over the last 34 years. Data from the National Children’s Hospital Albert Foyer in Dakar indicates that among all the hospitalized children in the year 1976, diabetes accounted for 0.08% of all the hospitalized cases. That figure increased to 0.22% in 1992, 0.28% in 2006 and 0.42% in the year 2010. Also, the figures from the National Adult Diabetes Centre at Abbass Ndao Hospital in Diedhiou shows that, out of 17,600 diabetic patients who attended the centre between 2000 and 2010, there were 234 children aged less than 20 years.

In Senegal, the diabetic children pay for all their health care needs including insulins, glucometers, glucometer strips, consultations, transportations and hospitalizations. There are very few people who have medical insurance. Currently the human regular insulin is available at a cost of US$5 per 100 IU/10 mLs. The NPH insulin and the Pre-mixed bi-phasic insulin 30/70 are available at a cost of US$12 per 100 IU/10 mLs each. The insulin analogues eg Insulin Glargine, Detemir etc, are not available in Senegal and they have to been ordered from France. It is very rare for children to use the insulin pens as they are quite expensive and many patients cannot afford them. Virtually every diabetic child uses the insulin syringe for injection and it comes at a cost of US$0.20 per syringe. The pump therapy is not available at all in Senegal.

The glucometers which are available are Onetouch and Accu check glucometers, at a cost of US$50-75 each. The strips cost US$20 per packet of 50 strips.

Besides the support and the care given to the diabetic children and their families by the doctors, no other forms of care like psycho-social support are available. There exist a number of barriers to the care of children with diabetes which includes abject poverty, high cost of health care including insulins, a high number of lost to follow up at around 22%, lack of a dedicated paediatric diabetology and endocrinology team, delayed/mis-diagnosis of diabetes mellitus due to inadequate staff training, and non-availability of insulin analogues and pumps.

Further to the above mentioned barriers to care, other challenges include the absence of data/diabetes registries to enable health care providers to gauge the magnitude of the problem, and the absence of a secure and reliable funding from the government.

However, despite all these challenges, Paediatric Diabetology and Endocrinology in Senegal is set to grow as more manpower is trained in this field and we are looking forward to a better future for children with diabetes and other endocrine disorders in Senegal.

In Senegal, the diabetic children pay for all their health care needs including insulins, glucometers, glucometer strips, consultations, transportations and hospitalizations. There are very few people who have medical insurance.

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<th>Health data</th>
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<tr>
<td>Health expenditure (% of GDP)</td>
<td>5.66% ($ 58.5 per person)</td>
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<tr>
<td>Health expenditure (private)</td>
<td>2.52%</td>
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<tr>
<td>Health expenditure (public)</td>
<td>3.14%</td>
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<tr>
<td>Physicians per 1000 people</td>
<td>0.06</td>
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<tr>
<td>Hospital beds per 1000 people</td>
<td>0.34</td>
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<tr>
<td>Infant mortality rate</td>
<td>48 per 1000 births</td>
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<tr>
<td>Under 5 mortality rate</td>
<td>69 per 1000 births</td>
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<tr>
<td>Immunization, DTP (% of children between 1-2 years)</td>
<td>70%</td>
</tr>
<tr>
<td>Immunization, measles (% of children between 1-2 years)</td>
<td>60%</td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td>58.95 years</td>
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The Republic of Kenya is home to over 40 million multi-ethnic inhabitants and it covers an area of 582,650 square kilometres in East Africa. About 42% of the population are under 14 years of age. It is a low income country with a nominal GDP per capita of US$794.77 per person.

Kenya’s health expenditure amounts to 4.75% of its national Gross Domestic Product (GDP), which translates to US$36.85 per person per year. The infant mortality rate stands at 50.1 per 1000 births and the under 5 mortality stands at 76.1 per 1000 births. The life expectancy at birth is 56.5 years.

Kenya has 8 board certified Paediatric Endocrinologists and 250 General Paediatricians. Out of these 8 Paediatric Endocrinologists, 6 of them are the alumni of the Paediatric Endocrinology Training Centre for Africa (PETCA) program which started in Nairobi in 2007. Besides their routine work in clinical care for children with diabetes and other endocrine disorders, they also serve as tutors for PETCA Fellows from various African countries.

The number of children with diabetes Kenya is unknown due to lack of data. However, the Paediatric Diabetes Registry is currently under development to generate data which will in the future help to inform decisions.

The Kentyan health care system is financed through the government subsidy (Health Insurance Fund) to the patients, the private medical insurance and through patient self finance. All types of insulins—regular human insulin, NPH insulin, Pre-mixed biphasic 30/70 insulin and the insulin analogues are available in Kenya. The cost of insulin at a government subsidized facility is US$5 per 100 IU vial while at the private health care facilities, it cost US$9-20 per 100 IU vial/cartridge.

All forms of glucometers including the ketone metres are available in Kenya at a cost of US$20-95 per glucometre. The government does not provide the glucometers and the strips and therefore the patient have to finance their own glucometers and strips. The pump therapy is also available at a cost of US$2400 per pump and the patient have to finance all the cost and the maintenance of the pump therapy.

Other aspects of paediatric diabetes care like the psychosocial care are not well established. The other barriers to the care of children with diabetes include lack of universal outpatient insurance cover for the public, lack of awareness/education about paediatric diabetes care among the health care providers, lack of experience with care, and the lack of public awareness of the existence of of diabetes in children.
THE LAUNCH OF A BOOK OF PRACTICAL PAEDIATRIC ENDOCRINOLOGY IN A RESOURCE LIMITED SETTING

By Prof Margaret Zacharin, Consultant Paediatric & Adult Endocrinologist
University of Melbourne, Royal Children’s Hospital, Melbourne, Australia

This book of practical paediatric endocrinology in a resource constrained setting was conceived after I had made a number of visits to countries where busy paediatricians were engaged in teaching other young staff to manage endocrine care of the child and adolescent, whilst simultaneously being heavily committed to a host of urgent daily tasks. The need for a practical guide to assist with management of a vast array of highly complex and diverse endocrine conditions seemed necessary, for those starting a new career, to offer the experience of those who have years of clinical experience to a broad array of personnel who will be practicing in areas where material resources may be limited and where clinical skills are paramount in providing viable and acceptable management plans for families and children. The Paediatric Endocrinology Training Centre for Africa (PETCA) is responsible for a fellowship program that aims to provide training in clinical endocrine practice for paediatricians within Africa. Some practical support seemed to be a valuable adjunct to this excellent initiative.

The book is a guide to practice and is not intended to take the place of a standard text, to be used in collaboration with more extensive material to be found in those books. Many eminent endocrinologists worldwide have contributed to its creation. Most of the chapters have a strong clinical base, outlining management plans for those working in a resource constrained environment. Each chapter is formatted in a style to provide a clinical setting, with general considerations for assessment of any patient, a methodology and plan for diagnostic approach and rationale for management. Information has been provided as to how to prioritize investigations that will prove useful without the need for expensive and often unavailable technological backup. In particular we have emphasized consideration of financial constraint for families and tried to limit the expenditure in coming to a workable diagnosis. Suggestions have also been made as to how to go about seeking sophisticated confirmatory testing, if required.

To complement the clinical chapters, we have also provided a brief chapter on how to design clinical research so that those involved in clinical practice may enhance their skills and inform their practice management and offer better opportunities for future planning. Well planned clinical research will also provide an opportunity to engage with fellow practitioners and will provide evidence as a base for future, locally sourced funding and support, within their own country.

A chapter summarizing basic requirements for a current understanding of molecular biology has been included, to enhance critical judgment when reading the literature.

The book covers all the main areas of endocrinology with particular emphasis on the importance of providing evidence of normal growth and implications of variations of growth pattern, the range of normal and abnormal puberty and disorders of sexual development in a resource limited setting. Thyroid and adrenal disease, bone and mineral metabolism, disturbances of salt and water are covered, along with the emerging problems of obesity and bone health in any society. Specific areas of paediatric and adolescent gynaecology and endocrine dysfunction in the neonatal period are also included. A chapter by Professor Stuart Brink, specifically for management of type 1 diabetes mellitus has been included, as an adjunct to his larger text book on the subject, for use in a resource constrained setting.

We hope that the text book of Practical Paediatric Endocrinology in a Limited Resource Setting is able to provide information and guidance to paediatricians throughout the African continent.
The true prevalence of congenital hypothyroidism is unknown in Nigeria and many African countries. Many sporadic cases have been reported but there are many African countries lacking the national newborn screening program. The causes of congenital hypothyroidism are protean, and in countries with screening programmes, organic defects with low or no thyroid hormone production have been reported. Unfortunately, symptoms and signs of CH do not appear until the period when damage to the developing brain has occurred. It is for this reason that newborn screening is mandatory, especially as the cost of treating is also inexpensive.

Nigeria has areas of iodine deficiency, and despite Government effort to legislate and support iodine fortification of salt, some regions still use uniodinized salt for cooking, as it is cheaper to do so. Report also shows that the decline in endemic goiter may be matched with decline in cretinism. Severe cretinism will show in later life, with a child who has very reduced intelligent quotient. Physical development may be normal, but mental capacity will be considerably reduced.

The society for Paediatric and adolescent endocrinology in Nigeria, and the African Society for Paediatric and Adolescent Endocrinology decided to collaborate with Charité Universitätsmedizin, Berlin, and the Institute of Maternal and Child Health, Port Harcourt, in developing a pilot study to screen for CH in newborns, in 12 centers spread across Nigeria. These centers are located in the 6 geopolitical zones and have paediatric endocrinologists who will monitor and evaluate the progress of the study.

Training of doctors and midwives on education and sensitization of the public, obtaining informed consent, collecting cord blood samples, and eventually sending to the research laboratory in Berlin, was conducted in two centers, and for two days. The participants were highly motivated and had several inputs on the methodology, bringing out difficulties and loopholes and offering solutions to these with enthusiasm and sense of ownership. Many nurses described scenarios of difficulties and we arrived at consensus towards achieving perceived and real objectives and goals.

Dr. Oliver Blankenstein, Paulina Aleksander and Iroro Yarhere conducted the symposium, in that order. Oliver delivered a 10 minute lecture on CH, pathophysiology, epidemiology, symptoms and signs, while Paulina took the audience through the practical aspects of obtaining cord blood samples, type of filter paper used, labeling and cut off point for diagnosis. Iroro Yarhere went through the logistics of sample labeling, center and sample identification, preservation of the samples, and transportation of samples to research laboratory. He also discussed the technicalities with recall of all positive cases and how they will be managed thereafter. The symposium ended with a practical session where placentae from labour wards of the two centers were used to demonstrate cord blood sampling on filter paper. Participants acknowledged the difficulty in this and also suggested the heel prick for samples that cannot be taken due to such technical problems.

There was light refreshment at the end of the training session and participants went home with one filter paper to familiarize themselves with it. The participants all decided to take the project as their pet project and some promised it would be their goal to see that every child is screened within their jurisdiction. The facilitators showed appreciation to the trainees, and went on a tour of facility with the Chief Medical Director of University of Port Harcourt Teaching Hospital, Prof. Aaron Ojule.

The visitors had a tour of other health facilities in Rivers state before they traveled back to Berlin. They visited DHL, who is partnering with the scientists, by delivering samples to Berlin, from the birth centers at reduced cost.
The 3rd ASPAE Meeting in Lagos, Nigeria, March 2012

ASPAE delegates at the 51st ESPE Meeting in Leipzig, Germany, September 2012

Prof Mohammed Abdullah being conferred the Lastradet Award at the 38th Meeting of ISPAD in Istanbul, Turkey, October 2012

Global diabetes walk to commemorate world diabetes day in Abakaliki, Nigeria, November 2012

Post graduate training in Paediatrics and Adolescent Diabetes, Phumula Beach, Kwazulu-Natal, South Africa, December 2012

The social programme of the post-graduate training course in Paediatrics and Adolescent Diabetes, Phumula Beach, Kwazulu-Natal, South Africa, December 2012
Special thanks goes to all those who contributed to the write up of this newsletter. I would like to specifically acknowledge the contribution made by the following people; Edna Majaliwa, Johnny Ludvigsson, Margaret Zacharin, Iroro Yarhere, Maryan Ugochi Ikewke, Renson Mukhwana, Niang Babacar, Abiola Oduwole and Tokunbo Jarrett.

Special thanks to our President, Professor Abiola Oduwole, who is also a Consultant Paediatric Endocrinologist in the College of Medicine, University of Lagos and Lagos University Teaching Hospital, Lagos, Nigeria for her visionary leadership and guidance throughout.

Special thanks goes to Worldscor Communications, Nairobi, Kenya and Gertrude Children’s Hospital, Nairobi, Kenya, for formatting the design and the graphics outlook of the newsletter.

To all ASPAE Executive Committee members and to all ASPAE members who have contributed in anyway possible to this newsletter, we all appreciate all your contributions.

To my wife Violet and my son Lefika, thanks for giving me time to write this newsletter and finally to my employer, The Botswana-Baylor Children’s Clinical Centre of Excellence in Gaborone, Botswana, all I can say to you is that I highly appreciate the time you gave me to write this newsletter.

**IMPORTANT DATES AND FUTURE MEETINGS**

- The 4th Scientific Meeting of the African Society for Paediatrics and Adolescent Endocrinology (ASPAE); 20th-22nd March 2013, Durban, South Africa
- The 5th Scientific Meeting of the African Society for Paediatrics and Adolescent Endocrinology (ASPAE); 26th-28nd March 2014, Dar es Salam, Tanzania
- The 6th Scientific Meeting of the African Society for Paediatrics and Adolescent Endocrinology (ASPAE); 25th-27nd March 2015, Khartoum, Sudan
- The 7th Scientific Meeting of the African Society for Paediatrics and Adolescent Endocrinology (ASPAE); 30th March to 01st April 2016, Gaborone, Botswana
- The 9th Joint Meeting of the Pediatric Endocrinology involving the European Society for Pediatric Endocrinology (ESPE), Pediatric Endocrine Society (PES), Australiasian Paediatric Endocrine Group (APEG), Asia Pacific Paediatric Endocrine Society (APPES), African Society for Paediatrics and Adolescent Endocrinology (ASPAE), Japanese Society for Paediatric Endocrinology (JSPE), Sociedad Latinoamericana de EndocrinologiaPaediatrica (SLEP); 19th-22th September 2013, Milan, Italy
- The 39th Annual Meeting of ISPAD; 16th-19th October 2013, Gothenburg, Sweden
- The International Diabetes Federation world diabetes congress; 02nd-06th December

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