

CHAPTER XII

A HEALTH SERVICE POLICY PROPOSAL FOR SOUTH AFRICA TO ADDRESS CHRONIC DISEASES OF LIFESTYLE

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SITUATIONAL ANALYSES IN SOUTH AFRICA

BACKGROUND

The Restructuring and Development Plan's (RDP)¹ health priorities for South Africa are based on promotion of a healthy lifestyle and on prevention, early detection of risk factors and diseases, and cost-effective treatment with good patient compliance. The primary health care approach with community involvement and intersectoral collaboration is a theme carried throughout the health component of the RDP. The Minister of Health has recently stated that "in a comprehensive primary health care service, a balance should be sought between promotive, preventive, rehabilitative and curative services". This has obvious implications for chronic diseases of lifestyle (CDL), which have now for the first time, been identified to receive specific attention.

The RDP explicitly mentions the importance of Chronic Diseases and the promotion of a healthy lifestyle. The following "priority conditions" have specifically been highlighted under chronic diseases: hypertension, diabetes and cancer of the cervix.

Furthermore, attention is drawn to the following CDL-related issues:

- tobacco control
- substance abuse, such as alcohol abuse
- the establishment of an essential drug list containing excessive drug costs for chronic diseases
- social upliftment programmes, which may impact on Chronic Diseases,

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such as electrification that can lead to the reduction of chronic obstructive lung disease in the community.

The term, chronic diseases of lifestyle, could include many conditions, but this report will focus on the priority areas set out below.

Priority Areas for CDL

Unhealthy Lifestyle

Smoking

Lack of exercise

Over-nutrition and westernised diet*

Risk factors and related diseases

Hypertension

Diabetes

Chronic Obstructive Airway Diseases and Asthma

Rheumatic Diseases

Hyperlipidaemia

Obesity*

Epilepsy[†]

Outcome after decades

Ischaemic heart disease (heart attack)

Cerebrovascular disease (stroke)

Cancer

Geriatric Care[†]

Rehabilitation[†]

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Addressed in the National Programme on Nutrition

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Addressed in the National Programme on Mental Health

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Specific issues of the elderly and needs for rehabilitation are not addressed here

The Burden of Risk and Disease and Status of Health Care for CDL

Mortality, morbidity and risk factors in South Africans

The CDL mortality patterns of South Africans are described in detail in Chapter I. In the Chapters thereafter various risk factors and related conditions, their prevalences and treatment status are described. The major cause of death for all groups of South Africans who have completed the health transition is CDL, and even in the black population there are significant numbers of deaths due to CDL.

In as far as morbidity data for CDL are concerned, other than in annual reports of the larger hospitals and City Council Medical Officers, very little information is available on the CDL morbidity pattern in South Africans. Practical guidelines exist to estimate the number of myocardial infarctions (MI) and cerebrovascular accidents (CVA) that occur in the country. For every one death due to MI and CVA that occur, three people survive these conditions. This estimation indicates that about 60 000 CVA and 39 000 MI occurred in 1990 in South Africa. Of the cerebrovascular accidents 17% and 19% respectively occurred in the Western Cape and Gauteng. For MI 29,7% and 21,6% occurred in the Western Cape and Gauteng respectively. Overall about a quarter of all CVA and about a third of all MI occurred in these two predominantly urban provinces.

The number of South Africans with risk factors is discussed in the particular chapters. Studies by Steyn, *et al.*² showed that 56,5% of all South Africans aged 15-64 years need to change their lifestyle in order to reduce their risk for CDL and 16,5% fall into the high risk category that need to be diagnosed and managed cost-effectively in the emerging health services.

Treatment status of CDL patients

From studies conducted in the Cape Peninsula it is clear that the treatment of conditions such as diabetes and hypertension leaves much to be desired. Levitt, *et al.*'s³ findings from their study of health care received by diabetics attending public sector primary care facilities in the African residential areas in Cape Town clearly illustrates this situation. They reviewed a random sample of 520 patient's records who attended the diabetic clinics at 5 African Day Hospitals in the Western Cape. This reflects a total of 2 583 visits of these patients. They found that the

clinics were largely run by nursing staff who check the patient's urine, blood glucose level and blood pressures. The patients do not see a doctor unless they require a clinical examination, a new prescription or there is an acute problem. Overcrowding was a common problem with 30-50 patients attending each clinic at the larger day hospitals. The nursing complement for the diabetic clinics usually comprised 1 or 2 professional nurses and/or a staff nurse. Only 21,1% of patients had blood glucose levels below 15 mmol/L on at least 50% of visits. At 71,6% of the visits, patients with blood glucose levels above 15,1 mmol/L received no intervention or change of medication. In these records changes in pharmacological therapy were recorded more frequently than dietary advice or specified diabetes education. Most of the patients were obese. Hypertension (blood pressure (BP) $\geq 160/95$ mmHg) was recorded in 53,4% of the diabetics. In 4,4% of patients blood pressure was recorded as $\geq 190/95$ mmHg on more than 3 consecutive visits in the absence of anti-hypertensive therapy. A minimal number of diabetic patients received the appropriate additional care that would be considered acceptable medical practice, such as foot care and eye examinations.

In a cross-sectional study in the coloured population of the Cape Peninsula Steyn, *et al.*⁴ identified that only 41,3% hypertensives were on anti-hypertensive treatment, and only 16% had their BP controlled below 160/95 mmHg. This went up to 48,9% of hypertensives who reported taking daily medication to lower their BP. The concern here is that almost 51% of hypertensives who reported taking their BP medication regularly, still had uncontrolled BPs. Only 5% of these hypertensive patients reported following a diet to control their BP. All of these findings were in the face of 72% hypertensives who had had their BP measured during the previous year.

Findings such as these leave little doubt that the current services for CDL fail to provide adequate care for these important conditions, even if they happened to have been diagnosed early enough.

Promotion of unhealthy lifestyles

An essential part of the prevention and management of all the CDLs is the promotion of a healthy lifestyle, this would include the promotion of non-smoking, eating a healthy diet and leading a physically active life. Such promotion should

involve all media communications and other settings, such as school education curricula and health education at all health facilities. In South Africa this only takes place to an extremely limited extent. In actual fact the promotion of an unhealthy lifestyle seems to be much more extensive in this country than the opposite. The unbridled promotion of tobacco products, particularly in the cities, to the South African public as a whole and to the youth and disenfranchised people of this country in particular, serves as a typical example of the previous government's failure to protect the nation against the promotion of an unhealthy lifestyle. Fortunately tobacco use is now being addressed by South Africa's first antismoking legislation. This legislation is an initial attempt to protect South Africans against smoking, but will have to be extended significantly to really achieve success.

The main problems affecting CDL management in the public sector of the South African health system

In the past, health services in South Africa under the previous regime were fragmented and centrally coordinated, without community participation or an appropriate primary health care system. Cost-effective primary prevention and health promotion or appropriate affordable equitable clinical care for all South Africans was not provided. Lack of communication and collaboration between the governmental, non-governmental and private health care services further eroded the overall health provided in the country.

The preceding information and discussion with health personnel at the primary health care facilities highlights the fact that CDL patients are inadequately diagnosed, poorly managed and do not receive the required health education to enhance treatment compliance or to prevent complications.

The community as a whole is not encouraged by appropriate health promotion to adopt and maintain a healthy lifestyle and is disempowered to make healthy choices by allowing the advertising of disease-inducing agents.

Of major importance is the fact that in busy comprehensive clinics or general practices, CDL seldom present with similar urgency as many other conditions such as a dehydrated child or a patient with severe trauma. Consequently, patients with these conditions are usually inadequately managed and rarely receive the necessary

health education and/or preventive measures to reduce the impact of these diseases. The end result being a slow progression of disease towards premature morbidity or mortality.

The current staff shortages, high level of absenteeism, inadequate and unequal remuneration packages for the level of responsibility carried by the primary health care professional nurses, the extremely difficult working environment, including the lack of personal safety, have lead to the collapse of adequate services for CDL and to the low staff morale at the community health centres.

A number of studies have shown that up to a half of the people in the community attend both public and private services, suggesting a dissatisfaction with both services.

Medical staff are overloaded and have too little time to guide or supervise the primary care nursing sisters. Referrals from academic health centres are usually patients with multiple pathologies and complicated treatment regimens. Management of these patients is time consuming and tertiary care consultants are often impossible to reach by telephone to discuss issues relating to multiple pathology patients. Many of the posts for additional members of the health team, such as those of the occupational therapists and dieticians are frozen and overall there are too few of these posts.

Although continuing medical education (CME) principles are subscribed to, this does not occur for either the medical doctors or the primary care sisters.

No standardised treatment protocols have been adapted from existing consensus guidelines for the various CDL conditions. For this reason the primary care sisters have no clear outline how to manage or when to refer CDL patients.

Communication between personnel at academic complexes, staff and patients in the primary health care setting has been minimal. This results in students being trained without a primary health care orientation. In addition, the personnel in both settings do not benefit from the input that could mutually influence the development towards an ever improving primary health care service for South Africa.

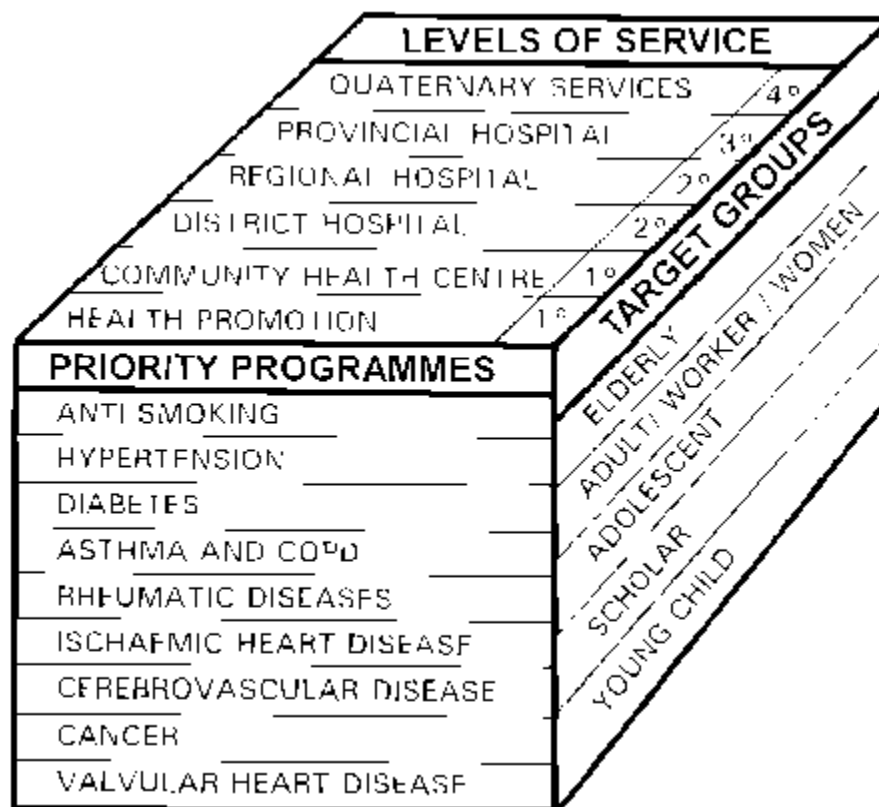
Summary

The consequence of the above is that extensive development of services to manage CDL is required if this health priority, with its major impact on the morbidity and mortality in South Africa is to be addressed in a meaningful way. This chapter will outline a general approach for the management of CDL and will focus on proposals for services at the district level at community health centres.

POLICY PROPOSAL FOR THE MANAGEMENT OF CHRONIC DISEASES OF LIFESTYLE IN THE NEW HEALTH SYSTEM OF SOUTH AFRICA

Matrix Model for CDL Management

Priority programmes to be provided at all levels of service to reach all the target groups



This model is to be part of a comprehensive integrated health care system. It is only in terms of the management and planning that it should have dedicated CDL teams at all levels of care.

Proposal Principles

- An effective health policy for the prevention and management of CDL should have a two-pronged approach. Firstly, a multifaceted health promotion programme directed at the whole population, which prevents or removes the underlying risk factors and is more cost-effective, and secondly, a health service approach for the early diagnoses and cost-effective management and rehabilitation of persons with CDL. The latter approach, however, is more costly as it involves screening and treatment of affected individuals.
- Chronic diseases of lifestyle, which have now been identified as a health priority in this country need recognition to enable the development of cost-effective services. Therefore, management strategies for CDL must be evaluated and adapted regularly to ensure that these conditions are adequately managed, as they form a considerable part of the services at all levels of health care.
- Prevention, treatment and rehabilitation services for CDL can be most cost-effectively rendered by multi-disciplinary teams (doctors, nurses, educators, physio- and occupational therapists, dieticians, administrators, social workers, community health workers and others) fully integrated into a comprehensive primary health care package at the local, district and regional levels.
- Although fully integrated into a comprehensive system, dedicated groups run by clinical professional nurses who have been trained in chronic disease management should be provided at community health centres where CDL patients form a large portion of all patients seen. Appropriate equipment in working order and effective CDL management manuals should be available at these health centres. CDL task forces should form part of the comprehensive teams to focus on the needs of CDL patients at all levels in the health service to ensure that they receive the appropriate care, especially in the case of more acute conditions. These dedicated groups should strive to be patient-centred and not disease oriented. Furthermore, they should not be viewed as part of the ineffective vertical programme approach that was previously found in South African health services.
- Employed people tend to frequent health services far less than other groups in the community. Therefore, apart from providing statutory occupational health needs, the health services should secure CDL screening, routine management, and monitoring at

the workplace. If this is not possible, employees with CDL should be encouraged to attend the local community health centres.

- Guidelines on treatment and referral criteria should be based on recommendations developed by the WHO and locally at South African consensus meetings.

Health Promotion Proposals

Health promotion directed at the entire population

General

Ideally, health promotion should reach individuals at school-going age or younger to ensure the adoption of healthy lifestyle habits in an environment without any conflicting messages. Recommendations should be easy to follow and the norms of the people and facilities in the community should make this possible.

A clear strategy for community involvement, probably through the newly formed community health forums, is essential. This will ensure community ownership of programmes and accurate, appropriate targeting of specific groups. Community involvement must also empower the people to promote and adopt a healthy lifestyle throughout their lives.

Provincial planning of health promotion, directed at the entire population, should be integrated with an effort to contribute to a national health promotion plan. The role of the mass media, particularly television, in health promotion should be greatly expanded, while the promotion of unhealthy behaviour and confusing messages must be curtailed. Mass media health promotion should address unhealthy behaviour patterns by making a healthy lifestyle desirable, and motivate target groups to request required screening procedures and appropriate management when attending health services. All media options should be explored to reinforce messages broadcasted to the community, such as local authority publications, posters, brochures and newsletters. Effective communication methods to reach specific target groups must be identified, developed and evaluated. Specific issues relating to CDL for mass media promotion include:

- the anti-tobacco message
- the healthy diet message
- the message of regular physical activity
- awareness of early signs of disease
- motivating people to request appropriate screening for priority diseases when attending health services.

Priority activities

Health education for the youth

School health curricula in a new unified education system need to be developed. A unified health curriculum planning group, represented by all involved stakeholders and disciplines, needs to be established in order to develop curricula for the current health promotion issues in the country.

With regard to CDL the following objectives will have to be addressed in the health curriculum: the prevention of smoking along with the development of the desirable non-smoking norm; the establishment of a healthy eating pattern; and the importance of regular physical exercise. School-children should develop discernment skills to evaluate the impact of the advertising industry on their lives.

Governmental and legislative role for promoting a healthy lifestyle

The purpose of legislative support must be to protect the population from the promotion and sales of unhealthy products, while encouraging health promotion activities in all sectors of the community.

Smoking:

Local governments should support the national government in promulgating an effective anti-tobacco law, which includes the banning of all cigarette advertising, as well as indirect advertising such as sponsorship of sport and art events by tobacco companies. Although difficult to implement, selling of tobacco products to the youth must be prohibited, along with smoking in all public places. Smoke-free workplaces should be the right of all workers in South Africa. All tobacco products must carry clear visible health warnings and should be heavily taxed. High cigarette prices reduce smoking in the young and the poor. These taxes should be specifically earmarked for a health fund to be used exclusively for health promotion and reducing nicotine addiction in the community. Finally, subsidies of any kind for tobacco-growing agriculture should be replaced by subsidies for agricultural crops not presenting a health hazard.

Healthy diet:

Dietary guidelines for a healthy eating pattern, including a balanced diet without over- or under-nutrition, should be formulated by the Health Departments in the provinces. These guidelines should form the basis for nutrition education programmes and be the measure upon which the effectiveness of a provincial nutrition programme is evaluated.

A national food policy for South Africa must be formulated, involving participants from the health, agriculture and food spheres, as well as economists and provincial representatives.

Legislative control of food labels must be of the nature that consumers can ascertain the relevant information on which to base healthy food choices. All health authorities must support a national effort in this regard.

Workplace services:

The occupational health services are often the only health services frequented by working males, particularly the younger ones. Companies and organisations would be willing to incorporate health services for their workers if tax relief or drug subsidies were made available. The implementation of appropriate occupational health modules for CDL management, developed in collaboration with the Department of Health and/or non-governmental organisations, would make a significant contribution towards preventing these diseases.

Services at the Community Health Centres for CDL (Primary Level)

CDL management at the community health centres

It is proposed that CDL patients could be managed in groups at the community health centres, run by chronic disease-trained clinical nurses. All staff at the community health centres should be oriented to manage CDL, with special emphasis placed on the training of those clinical professional nurses who run the CDL groups. Effective management protocols should be developed to guide their activities and clearly identify referral criteria and routes. Their prescription capacity for drugs on the essential drug lists must be clear. New patients should be diagnosed in the comprehensive clinics and referred to the dedicated CDL groups. Chronic disease patients, who have other complaints, must easily slot into the comprehensive clinics only if the clinical nurse who runs the chronic disease clinic cannot cope. Effective links must exist between the chronic disease groups and facilities at the community health centres or within the community to run smoking cessation groups, healthy nutrition clinics, rehabilitation groups and others. The goal should be set to empower patients in choosing to be active partners in competent CDL management.

Screening

Principle

To use cost-effective screening methods to ensure that CDL and their risk factors are diagnosed and treated early. Elementary methods should be used, such as taking a medical history to first identify high risk persons on whom more costly screening tests can be conducted. The following list is not comprehensive, but serves as an example:

Family history:

- Diabetes
- Breast cancer
- Hypertension
- Osteoporosis
- Heart attack before 50 years of age

Personal medical history:

- Age
- Smoking
- Chest pain on exercise
- Has blood pressure been measured in the last year?
- Signs and symptoms of transient ischaemic attacks (TIA)
- Ethanol use
- Exercise pattern
- In the elderly:
 - activities of daily living
 - dependency needs
 - depression
- Polyuria
- Polydipsia
- Unexplained weight loss
- Eyesight and hearing loss
- Poor healing of wounds
- Foot ulcers
- Complaints of dizziness in patients with hypertension/diabetes to diagnose TIA early
 - hemiparesis
 - aphasia
 - transient visual loss, suggesting carotid territorial symptoms

- bilateral/altering weakness or sensory symptoms suggesting basilar vertebrae territorial symptoms

Essential screening procedures

The relative importance of such measures as well as detailed information in the following table should be available for each screening measure to assess its value in a comprehensive screening package and to ensure its cost-effectiveness.

| Screening test | Best method | Target group (include age) | Frequency of screening | Cost and steps to reduce costs |
|-------------------------------|--|--|------------------------|--|
| Blood pressure | WHO recommendations | <ul style="list-style-type: none"> - All patients with normal BPs - Patients with other CDL risk factors | 2 years 1 year | Train someone with at least 10 years schooling |
| Weight | Anthropometry guidelines | <ul style="list-style-type: none"> - Obese - Heavy ethanol users | 1 year 1 year | Train health workers |
| Pap smear for Ca cervix | | Females > 35 years | Annually | |
| Random blood sugar | Finger prick preferably with glucose meter | Patients with signs and symptoms of diabetes | | Junior nurse can be trained |
| Fasting blood sugar | | <ul style="list-style-type: none"> - Patients > 40 years - Other CDL risk factors | | |
| Urine for protein and glucose | Dipstick | Patients with relevant complaints | | |
| Serum cholesterol | Routine laboratory test | Patients with family history of early IHD or tendon xanthomata | | |
| Blood uric acid | | Patients with family history of gout | Once for the records | |
| Peak flow rate | | Patients with signs and symptoms of asthma | | |
| Carotid bruit | Auscultation | Patients with suggested TIA | | |
| Exclude atrial fibrillation | Feel pulse, heart examination | Elderly patients with IHD | | |
| Visual activity | | Elderly | | |
| Hearing activity | | Elderly | | |

| Screening test | Best method | Target group (include age) | Frequency of screening | Cost and steps to reduce costs |
|---------------------------|------------------|-------------------------------|------------------------|--|
| Breast examination | Self palpitation | From puberty onwards | Annually | Teach patient to do it from an early age |
| | Mammography | Women > 45 years (3 years) | | |
| Skin examination | | Fair haired elderly | | |
| Examine mouth and pharynx | | Smokers > 40 years | | |
| Urinary albumin | Dipstick | Type I diabetes after 5 years | Annually | |

Cost-effective treatment and monitoring

Dedicated CDL groups could cater for CDL patients, who make up a large proportion of the patient load at community health centres, as part of the comprehensive district health services. Conditions such as diabetes, hypertension, asthma and COPD, rheumatic diseases, stable angina, hyperlipidaemia, geriatrics, backache/osteoporosis, incontinence, syncope and dizziness could be managed at these dedicated clinics. To ensure good clinical care and the prevention of complications, well-planned treatment protocols with clear instructions when to consult and refer need to be developed. These manuals must be evaluated and updated regularly.

Specially trained clinical professional nurses must run these CDL groups with the support of clinicians. At larger community health centres, some days can be dedicated to patients with specific conditions, but patients with multiple chronic diseases could have all their chronic conditions addressed by the trained chronic disease clinical nurse on the day of attendance. This clinical nurse should also be able to manage other minor complaints of CDL patients.

Specific health promotion groups, i.e. smoking cessation, nutrition education, weightloss, exercise and osteoporosis/backache groups should be set up by the chronic disease task force. Through the local community health forum and with the aid of NGOs appropriate material could be devised for these groups.

Intervention in collaboration with NGOs, who provide services (e.g.palliative care for cancer patients by the hospice movement) in the community, should be established by the chronic disease task force.

Drug regimens complying with essential drug lists and medication policies, which are clearly defined should be used for CDL patients. These drug regimens should indicate what drugs can be prescribed by the various levels of clinicians who treat CDL patients. Ideally, chronic disease clinic patients should receive their drugs at the clinic instead of queuing at the clinic pharmacy. This practice should be legalised.

Patient empowerment to develop the ability to take responsibility for their conditions should be instituted. Patients should be informed of their chronic diseases and have knowledge of the drugs they are taking and their blood pressure, blood glucose or other levels. It would also help if they understood what good management for their chronic diseases entailed. Patient health cards to record their treatment status, drugs, measurements, next appointment, etc. would help them to understand and know all aspects of their condition. Access to free blood pressure measurement at the community health centres by a trained junior person would also enable them to monitor their own condition.

Identification of **medical emergencies** in patients with chronic diseases is crucial, as are the services to initially manage them before referral to the appropriate emergency or specialised service.

Data collection for good clinical practice must be assured, including the recording of essential data, which is needed for good planning and assessment of services. Ideally, these data should be computerised at the clinic and evaluated for its use in planning and patient care.

Ongoing training for all primary health clinic clinicians (doctors and nurses) and other health personnel is essential for the success of the CDL management programmes, with special emphasis on those who will form the core of such a programme. It is suggested that such training be achieved by bilateral outreach programmes between the primary health care and the tertiary hospitals/academic institutions, including their primary care/family medicine department. Such an arrangement will be of benefit to a variety of priority needs in the provinces:

- Teachers of medical students will be involved in finding solutions for CDL management in the primary health care setting. This will influence the training of medical students towards primary health care issues in CDL management.
- Such an arrangement will fulfil the CME needs of all primary health care clinic staff, will improve morale, and will prevent the vertical compartmentalisation problem

prevailing at present.

- Such collaboration could create meaningful training in primary health care settings for medical and other undergraduate students, and registrars. It should include their involved ongoing management of patients with multiple pathologies for referral to primary health care centres for follow-up. A further likely advantage would be that students become attached to careers in the community health centre.
- Academics will then be encouraged and enabled to focus some of their research activities on issues of CDL management in the primary health care setting.

The staff from the academic health centres and other specialists involved in the outreach programme could also contribute to consulting services at the primary health care clinic for referral of chronic disease patients.

Services to Manage CDL at the Hospital-based (2°) and Specialist (3°, 4°) Levels of Care

Detailed needs for services of CDL are documented in the publications listed in *Addenda A* and *B*. Planning should be done in collaboration with the needs of other health priorities in the provinces.

Secondary level of care at the district and regional hospitals

Patients who could not be stabilised at the community health centres should be referred for further investigation and treatment. Once stabilised they are referred back to the community health centres. Intensive care units should be situated at these district and regional hospitals. These services should also be responsible for CME of clinic staff with the use of tested management protocols.

The regional health services should collate data for the region, also when required from private practices or hospitals, which should be supplied to the individual community health centres and reported to provincial services. To ensure that these services are developed, it would be required to create district teams which focus on CDL management, while being fully integrated in the comprehensive district/regional health service.

Specialist physician level of care (3°) at academic health complexes and provincial

health services

The tasks of these tertiary services in terms of CDL will include:

- The management of patients with complex CDL problems referred from the secondary levels of care. Ongoing care of these patients after stabilisation should be in collaboration with secondary and primary levels of care in bilateral outreach programmes as indicated earlier in the chapter. Services will include radio- and chemotherapy for cancer patients, intensive care for acutely ill patients, renal units, cardiac units and cardiac surgery units.
- The basic training of all health service personnel should be initiated at tertiary care settings, but also offered at secondary and primary health care settings.
- Relevant data collection and collation should be an important function. These data should inform service planning and be communicated to the 2° and 1° levels of care, as well as to the National Department of Health.
- The management of CDL at national and provincial administrative head quarters should be driven in the first instance by the needs at the primary level of care. An integrated, but dedicated CDL task force should be created, which will include a senior health promotion professional to plan and develop the integrated CDL programme in the provinces on the basis of national and WHO guidelines for these diseases. (*Addenda A and B*).
- Links between CDL researchers, service providers and the community must be established at this level to ensure that appropriate research is done and that the results of such research is implemented at district level.

Quaternary services

These services need to be planned nationally to provide centres in one or more provinces that cater for the need of the whole country. This will usually be linked to the academic complexes and provincial hospitals and will also have a research focus. In addition, such services will provide for both the public and private sector patients. These will include services such as organ transplant facilities, genetic screening and tissue typing laboratories.

RESEARCH FOR THE DEVELOPMENT OF THE CDL PROGRAMME

The following issues were identified during discussions around research priorities for developing the CDL programme in South Africa:

- Lack of data, which exists on the morbidity and risk factor patterns for CDL in the country. Such burden of risk and disease needs to be determined if knowledge-based planning is to underpin the development of CDL and appropriate services.
- The tremendous need to develop and evaluate health promotion programmes and education packages, which are used to train the health team at all levels in the province.
- To establish cost-effective screening and management of CDL in South Africa a great deal of ongoing development and evaluation of treatment protocols will have to take place.
- In addition, ongoing basic research that could contribute to the CDL programme will have to be encouraged. CDL research with national importance should also be supported by the provinces.

IMPLEMENTATION OF THE PROPOSED CDL POLICY PLAN

At National Level

To ensure that a national comprehensive policy with the necessary network is formulated for the development of the appropriate CDL services in the country, the following processes and structures are suggested:

General structures

- Create a small National Task Force after the appointment of the Director for the National Programme for Chronic Diseases and Rehabilitation. The members should act as consultants to the Director and should be from the research community, a registered physician and a senior representative from a non-governmental organisation that is involved with CDL. This Task Force with the Director must drive the development of the chronic diseases and rehabilitation Programme of the National Department of Health.

- The necessary network must be developed at the national level with other groups in the Department of Health, such as the health promotion group, the drug policy group, the school health group and relevant other groups. In addition, the necessary links of this national programme with other stakeholders must be created.
- Links with planners of chronic disease services in all the provinces must be forged.
- The necessary data bases and research measures must be ensured so that the development of the Chronic Disease and Rehabilitation National Programme can be developed on the basis of appropriate knowledge.
- The necessary alliances must be created to ensure that an appropriate health promotion programme for chronic diseases as set out below is developed.

Health promotion structures

- Appoint a senior chronic disease health promotion officer in the Chronic Disease and Rehabilitation National Programme, who will collaborate very closely with the directorate of Health Promotion for Chronic Disease health promotion programmes.
- Contract specialist health promotion agencies who have the capacity to develop health promotion programmes directed at the community as a whole through appropriate media. They should also develop material in collaboration with the community health forums and the services, which could be used at the District Health Centres to support clinical staff in the management of CDL patients.

CDL Health Promotion Agencies include:

- the Heart Foundation of Southern Africa
- the Cancer Association of Southern Africa
- the Tobacco Action Group
- the South African Gerontology Association
- Stroke Aid
- the Arthritis Foundation
- the South African Rheumatoid Arthritis Association
- the Osteoporosis Foundation
- the Diabetes Association of South Africa
- Alcoholic Anonymous

These agencies should receive part-funding from the national and provincial governments to support the community to create groups, e.g. smoking cessation groups, cardiac rehabilitation groups, or support groups for cancer patients who do not have access to similar private services.

Meetings between the community health forums and relevant service contributors is the ideal setting to initiate planning around issues where community lobbying and advocacy movements can be initiated.

- A senior health promotion officer at the Head Office of each Health Department in the provinces, with a more junior CDL health promotion officer should be appointed. (The latter will be a member of each province's team responsible for chronic diseases.) Their task should be to collaborate with others in developing a health promotion programme for their province based on successful models from elsewhere. For appropriate health promotion programmes to be suitable for each district, they should be developed at district level.
- The appointment of a National Health promotion ombudsman to monitor advertising and media reporting, which could have a negative effect on health is recommended. The office of this ombudsman must, in principle, be to fulfil a similar role as that of the drug control council regarding safe medication. This would ensure no false or misleading media promotions which could have a negative health impact. The office of the ombudsman would, furthermore, act as a consultancy for the public who may want to confirm the validity of information regarding health.
- It is recommended that the Department of National Health institute formal training in

health promotion at tertiary institutions such as Technicons to create a cadre of health promotion officers who, in future, could provide health promotion services for South Africans.

At Provincial Level

- Appoint a senior official as director, convenor or co-ordinator of the Chronic Diseases programme as well as a task force at the province health department to work with the director.
- At provincial level, appoint a senior official as a health promotion director and reporting to him a dedicated CDL health promotion officer who also works closely with the CDL director. Their task will be to develop CDL health promotion protocols in collaboration with the contracted NGOs.
- A provincial CDL advisory committee who meets regularly with the provincial task force who can advise and also monitor progress. Members: clinical experts, relevant NGO members and community representatives.
- Appoint CDL task forces at regional level to support the development of the CDL programmes in the region.

At Community Health Centre Level

- Request the District Health Manager to appoint a CDL task force to develop and implement the CDL Programme.
- Initially identify 3 to 4 community health centres in co-operation with the training institutions where such mutual outreach programmes can be initiated and function as pilot programmes. Such pilot programmes must be evaluated in detail to ensure that quality services are developed optimally. When efficiently tested and as more resources become available, these programmes can be extended to other centres. These pilot community health centres could potentially become training centres for staff from the primary health care centres to where the service will be extended.
- Introduce a core group of staff at every district health and local clinic centre with community members who operate the service and identify successful or other processes of the CDL Programme. Here the primary health care services for CDL can

be developed in collaboration with the community, the relevant NGO's, the services and the specialists in the region.

- In-service training for both clinical and management skills, could also be achieved by rotating chronic disease clinic staff through chronic disease referral centres at district, regional and provincial services, e.g. the 4-week course in rheumatic diseases presented at Groote Schuur Hospital.
- Ongoing evaluation sessions, at the pilot community health centres with all stakeholders from the community, the services at all levels, relevant NGOs and the research organisations, using available collated data are essential if a viable service and a culture of self-evaluation is to be developed. An overall annual audit of the efficacy of the provinces' CDL programme must be instituted to ensure the ongoing commitment to this major health priority.

Interaction with the Private Sector

- The interaction between private and public services needs to be explored for optimization.
- Departments of Primary Health Care or Family Medicine could contribute to the co-ordination of this development process.

CONCLUSION

In the final analyses it is clear that the time to create the necessary services for CDL in South Africa is now. The health services are being restructured and in the process the creation of a National Programme for Chronic Diseases and Rehabilitation has been included in the overall structure. This is very timely, as these diseases have not yet emerged as the major killers in our black population as in the case of other groups in South Africa. Therefore, primordial prevention is still possible for the black community, while primary and secondary prevention with early detection, cost-effective management and rehabilitation have long been needed for South Africans who suffer from CDL or their preceding risk factors and unhealthy lifestyles. The political will for this development has been shown by the creation of the national programme. It will

hopefully survive and grow when the needs of chronic diseases of lifestyle are balanced against the other pressing health needs also impinging on the limited resources of the Department of Health in South Africa.

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REFERENCES

1. African National Congress. *The Restructuring and Development Programme - A Policy Framework*. Johannesburg: Umanyano Publications, 1994.
2. Steyn K, Fourie J, Bradshaw D. The impact of chronic diseases of lifestyle and their major risk factors on mortality in South Africa. *SAMJ* 1992;**82**:227-231.
3. Levitt D, Bradshaw D, Zwarenstein M, Bawa A, Katzenellenbogen J, Dopfmer, S. The primary care of African diabetics in the public sector in Cape Town, part 1. Submitted to *SAMJ*
4. Steyn K, Jooste PL, Fourie JM, Parry CDH, Rossouw JE. Hypertension in the coloured population of the Cape Peninsula. *SAMJ* 1986;**69**:165-169.