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HOW SOUTH AFRICA CAN STRENGTHEN ITS FIGHT AGAINST DIABETES

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AS WE mark World Diabetes Day today, we cannot ignore that South Africa faces a rapidly escalating public health crisis.

Type 2 diabetes has become the country's second leading cause of death and is spreading within a health system historically designed for short-term, episodic illness rather than the lifelong demands of chronic disease. Without decisive reform, diabetes will continue to erode both the well-being of citizens and the sustainability of public health expenditure.

South Africa's dual burden of disease, in which non-communicable diseases (NCDs) now overshadow HIV and tuberculosis, has increased the pressure on an already overstretched primary health care (PHC) system.

In 2018, the direct public-sector costs of diabetes were estimated at R2.7 billion for diagnosed cases and R21.8 billion for undiagnosed ones, with projections suggesting an increase to R35.1 billion by 2030.

Alarmingly, nearly half of this cost is attributed to preventable complications arising from inadequate management of blood sugar levels.

Yet diabetes care across the country remains largely confined to facilities that function reactively rather than preventively. People with diabetes are expected to attend follow-up appointments during standard working hours, a structural obstacle that undermines adherence to treatment and continuity of care.

Services for chronic disease are often limited to specific clinic days, restricting accessibility even further. Compounding these challenges, Africa's regional health-worker density averages only 2.9 per 1 000 population which is far below the World Health Organization's recommended threshold of 13.4. The resulting capacity gap emphasises the urgent need to re-orientate PHC toward integrated, community-responsive, and preventive models of care.

In a study published recently in the African Journal of Primary Health Care & Family Medicine, we focused on the Chiawelo Community Practice (CCP) in Soweto that adopted a community-orientated primary care (COPC) approach to confront these systemic weaknesses. This model blends clinical medicine with public health by embedding care within the social and household context of the community and integrating clinical teams with ward-based outreach workers.

EXPERTS say South Africa must reorient primary healthcare towards prevention and community care to tackle the country's growing diabetes crisis. | FILE

Our study evaluated adults with type 2 diabetes managed through the COPC framework at the CCP against those treated under standard care at the neighbouring Community Health Centre (CHC). We found that there were clear advantages for patients enrolled in the community-based model across nearly all measured indicators.

The blood sugar levels of those receiving COPC-based care were managed significantly better compared to CHC patients. Adherence to proven treatment standards was also much stronger. More CCP patients had their body mass index measured, had their urine tested using a dipstick, and their kidney function checked regularly than CHC patients.

Preventive screenings revealed even sharper contrasts. Sixty-one percent of CCP patients received annual foot checks — a critical safeguard against diabetic ulcers and amputations — compared to just 1% at the CHC.

Thirty-eight percent of CCP patients had their eyes tested for diabetes-related eye problems and none at the CHC. Furthermore, there were more discussions around sticking to prescribed treatment at the CCP. Collectively, these results indicate that COPC enhances not only health outcomes but also the comprehensiveness and following of guidelines of diabetes management.

The implications extend far beyond a single community. The evidence challenges long-standing assumptions that chronic disease care in communities with fewer resources must be anchored within fixed facilities.

Conventional models, though administratively straightforward, often disregard the social and economic realities confronting patients who face transport costs, unstable employment, and a limited understanding of health information. The COPC approach redefines healthcare as a continuous, collaborative, and preventive process rather than a series of disjointed medical visits.

Within the Chiawelo practice, interprofessional teams, comprising family physicians, clinical associates, nurses, and community health workers (CHWs), engage in ongoing case discussions, quality improvement cycles, and direct household follow-ups. This structure facilitates continuity of care and long-term monitoring of health outcomes. By situating CHWs within both healthcare facilities and communities, the model effectively shifts the focus from the facility to the community. In doing so, it builds trust, strengthens patient engagement, and ensures earlier intervention.

Ultimately, these findings provide empirical support for a patient-centred health system in which chronic disease management revolves around people rather than institutions. By embodying the principles of prevention, integration, and equity, COPC illustrates a practical route for PHC reform in the era of non-communicable disease dominance.

For South Africa to realise the vision of its National Health Insurance reforms and National Strategic Plan for NCDs, we must move from facility-based to population-focused care.

Real change requires structural and managerial shifts at district and facility levels, not merely rhetorical endorsement.

Scaling COPC must be adapted to local contexts. Rural districts face geographical isolation and workforce shortages, while urban areas contend with population density and mobility. Implementation should therefore be flexible, guided by local needs, supported through adequate training, supervision, and community partnerships.

Sustained investment is equally vital. The success of COPC depends on consistent funding for CHW development, digital tools for patient tracking, and intersectoral initiatives that tackle the broader social determinants of health.

The Chiawelo study delivers compelling evidence that COPC can yield markedly better diabetes outcomes than traditional, top-down facility approaches. By embedding services within communities, promoting interdisciplinary teamwork, and prioritising prevention, the model offers a viable and scalable framework for transforming South Africa's PHC system.

In a country where diabetes continues to drain lives and resources, this is not merely an alternative approach but a necessary evolution. Re-anchoring PHC within communities represents a decisive step toward achieving universal health coverage and building a system that is equitable, resilient, and responsive to the chronic disease realities of the 21st century.