The 2012 SEMDSA Guideline for the Management of Type 2 Diabetes

Much has been written recently about the burden of noncommunicable diseases (NCDs), and the recent United Nations High Level Summit on Non-Communicable Diseases in September 2011 served to highlight a call to action globally. One hundred and ninety-three Member States, with 34 Heads of State (including our own President), adopted the historic Political Declaration on Non-Communicable Disease Prevention and Control. This is the first ever Political Declaration on NCD, and includes 22 commitments to which governments worldwide must now be held accountable. Importantly for people with diabetes mellitus (diabetes), the Declaration commits governments to increasing access to affordable, safe, effective and quality-assured medicines and technologies. Diagnostics are equally as important as medicines for people with diabetes. Crucially, the Declaration commits governments to improve diagnostic services, including by increasing capacity of laboratory services, and collaboration with the private sector to improve affordability, accessibility and maintenance of diagnostic equipment and technologies. The central role that people with diabetes and NCDs play is made clear in the Declaration. It commits governments to a nationally driven and comprehensive response to NCDs, with the full and active participation of people living with the diseases. It also acknowledges the importance of health literacy and patient empowerment in care, and the role of patient organisations in the provision of NCD services.

The International Diabetes Federation (IDF) estimated that, in 2011, 366 million people worldwide were living with diabetes, and that 80% of these individuals live in low- and middle-income countries. It is projected that, by 2030, the number would have risen to 552 million. According to the IDF, the estimated diabetes prevalence for South Africa is 6.46% for adults aged 20-79 years (approximately 1.9 million of 30 million adults). The self-reported rate of known diabetes (type 1 and 2) in the South African Second Demographic and Health Survey of 2003 was unchanged from 1998 (6.5% of persons older than 15 years). However, it must be noted that 50-85% of diabetes sufferers (especially in rural areas) remain undiagnosed. The high prevalence of diabetes (and other NCDs) is closely linked to rapid cultural and social changes, ageing populations, increasing urbanisation, unhealthy eating and reduced physical activity. How are we to stem the tide?

Type 2 diabetes is not a particularly well-managed disease, with fewer than 50% of patients meeting glycaemic targets, even in developed countries. More disturbingly, fewer than 10% achieve glycaemic, lipid and blood pressure targets, despite evidence that multifactorial interventions are extremely effective at improving morbidity and mortality outcomes. Limited local data suggest that more than two thirds of type 2 diabetes patients in South Africa have a glycated haemoglobin (HbA1c) level above the generally recommended target of 7%.

The need for a guideline to manage the high burden of disease that is type 2 diabetes is therefore quite obvious. It provides a framework for training healthcare professionals, helps guide rational management decisions and limits wastage of scarce resources on treatments and technologies that are outdated or dangerous. Importantly, a guideline also assists the funders of health care to plan ahead and formulate strategies for the future. Government departments and health insurers need to take cognisance of the standards of care that need to be provided for the citizens of our country, and need to be held accountable for failures when these occur. A national guideline removes ignorance as a defense against lack of service delivery.

The last SEMDSA type 2 diabetes Guideline was revised in 2008 and published in this journal in 2009. That Guideline was entitled “SEMDSA Guidelines for Diagnosis and Management of Type 2 Diabetes Mellitus for Primary Health Care – 2009”, with the emphasis on “primary health care”. Unfortunately, it was misconstrued, particularly by the funders of health care (both public and private), and applied as a definitive guideline at all levels of care. We hope that this does not recur. It is also noteworthy that interventions mentioned in that Guideline are still not accessible to the majority of our patients in South Africa. Referrals to dietitians and diabetes educators and measurement of HbA1c, serum creatinine and microalbumin are simply not available or accessible for many, if not most, of our patients.

Since the publication of the 2009 Guideline, there have been many new developments that needed updating in the current Guideline. HbA1c has now been validated as a diagnostic tool and accessibility to internationally standardised assays is improving, new data have emerged with regard to glucose, blood pressure and cholesterol....
target levels, and the risks of hypoglycaemia for cardiovascular events and death are being recognised. Additionally, the dangers of older therapeutic agents (glibenclamide and thiazolidinediones) have come to light, and the potential benefits of other agents (incretins and alpha-glucosidase inhibitors) for avoiding weight gain and hypoglycaemia are now being appreciated. These and other developments have necessitated the rewriting of large sections of the 2009 Guideline.

The purpose of the Guideline is to improve healthcare delivery, and ultimately to translate into improvements in quality and quantity of life for our patients. To achieve this goal a number of simultaneous initiatives will be necessary:

• The Guideline must be accepted by all stakeholders (healthcare professionals, regulators of health care and patients) as a minimum standard of care for type 2 diabetes.

• Regulators and funders of health care must ensure that facilities and resources are made available for the practical implementation of these guidelines.

• Non-governmental organisations (NGOs) and lobby groups must take up the challenge of holding regulators and funders of health care accountable for failure to implement the care processes outlined in the Guideline. The newly formed alliance in the United Diabetes Association (SEMDSA, Diabetes South Africa (DSA) and the Diabetes Educators Society of South Africa (DESSA)) will play a pivotal role here.

• The Guideline must be disseminated widely and systems must be in place to ensure that even practitioners in the most remote parts of our country have access to it and understand how to use it in daily practice. A short summary version of the guideline will be published soon to improve its practical day-to-day usage. Structured CME programmes, coordinated by SEMDSA and the Association of Clinical Endocrinologists, should be used to oversee this process.

• A method for measuring the impact of the Guideline on healthcare delivery and outcomes needs to be established. This should be the responsibility of SEMDSA, the Department of Health and the funders of health care.

Finally, some introspection on the part of SEMDSA is appropriate. There is no doubt that SEMDSA (including academic training units and the Association of Clinical Endocrinologists) is and ought to be caretaker for diabetes in South Africa. Yet we are all confronted, on a daily basis, with patients where we can speak not of the standard of care but the standard of neglect; patients whose first serum creatinine is measured at the time of end-stage renal failure, patients needing amputations who have never had their feet examined, or patients with deplorable glycaemic control where no therapeutic adjustments have been made for years. I believe that change will come from empowering our patients. Through education and publicity we must empower them to demand the services and levels of care that are set out in this guideline, and to hold us all (funders, government, doctors, nurses etc.) accountable when the system fails them. Someone needs to answer to every case of amputation, blindness and renal failure. If we sit back and continue to accept the diabetes disasters that confront us daily, without informing our patients of the failures in the system, then we are guilty of colluding with the system and reneging on our Hippocratic Oath. The words that brought change to our country will also bring change to diabetes.

Amandla! Power to the people!

Aslam Amod
Chairperson: SEMDSA and the Association of Clinical Endocrinologists of South Africa

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References


