Editor's Focus

A snapshot of noncommunicable disease profiles and their prescription costs at ten primary healthcare facilities in the western half of the Cape Town Metropole[1]

In 2005, the World Health Organization estimated that noncommunicable diseases (NCDs) caused an estimated 35-million deaths, representing 60% of global deaths. In addition, the burden of NCDs is increasing in both the rural and urban areas of South Africa, being foremost in poor people living in urban areas. Isaacs AA et al were motivated by the rapid increase in the prevalence of NCDs globally. Therefore, they conducted a cross-sectional study to determine the disease profile and cost of treating patients at 10 primary healthcare facilities in the western half of the Cape Town Metropole. Hypertension was the most prevalent chronic condition (58.96%) in the sample of 4 184 patients, followed by arthritis (21.8%), diabetes (19.67%), and asthma and chronic obstructive pulmonary disease (12.14%).

In addition, the average cost of a prescription script for an acute condition [R15.43, standard deviation (SD) ± R20.13] was significantly cheaper than that for a chronic condition (R61.01, SD ± R83.84), and this was statistically significant (p-value < 0.001). However, the cost of the prescription increased with the number of co-morbidities. Sixty-five per cent of the patients with chronic conditions had co-morbidities. It was concluded that most adults who were seen in the western half of the Cape Town Metropole had chronic diseases with co-morbidities, and that the cost of treating them was significantly greater than that of treating acute conditions. The implications of the study findings highlight the importance of population-based interventions, as well as healthy lifestyle choices, in reducing the prevalence of NCDs, i.e. tobacco cessation, exercise, a healthy dietary intake and a reduction in diets that are high in refined sugar and flour. Since the public health sector is the main provider of health care for the masses, it is important to reduce the burden of NCDs, so as to reduce the budgetary costs of managing chronic conditions in the community.

Hearing loss within a marriage: perceptions of the spouse with normal hearing[2]

Loss of hearing in a spouse later in life, after relationship patterns have been established, may cause anger, anxiety, depression, resentment, guilt and withdrawal in the spouse with normal hearing. In addition, arguments between the couple may occur more frequent owing to communication inadequacies. Govender NG et al conducted a descriptive survey using a self-reported questionnaire adapted from The Significant Other Scale for Hearing Disability. The aim of the study was to determine the perceptions of a spouse with normal hearing on the influence of his or her partner's hearing loss on their relationship. Thirty-five individuals who reported experiencing no hearing difficulties, and who were married to a person with acquired hearing loss, contributed data to the study.

Seventy-one per cent of participants expressed concern for their hearing-impaired partners, and specifically with regard to fear for their safety. The majority identified a range of communication-related difficulties within their marriage, such as repeating themselves extensively in conversation with their hearing-impaired partners (97%), having to raise the volume of their voices (83%), and needing to maintain face-to-face contact with their spouse (74%). In addition, 69% reported feeling frustrated because of difficulties experienced in respect of their partner's hearing impairment. The authors concluded that although negative experiences were cited across a range of various categories, communication difficulties and the subsequent changes necessitated by the hearing-impaired partner's disorder greatly impacted on the quality of a married couple's relationship.

The prevalence of suicidal behaviour and associated risk factors in grade 8 learners in Durban[3]

Youth suicidal behaviour is now an increasingly serious public health problem globally. Less is known about the epidemiology of suicidal behaviour in developing countries. The only source suicide mortality data in South Africa were obtained in 2008, and indicated that nearly 70% of suicide victims were mainly young adults. In her study on 100 grade 8 learners, Vawda N demonstrated that those who reported suicidal behaviour experienced higher levels of depression, perceived stress, hopelessness and anger than those who did not report suicidal behaviour. The prevalence of suicidal behaviour was 33.8% in her study. Strong predictors of personal suicidal behaviour in this sample of learners were alcohol use, perceived stress, depression and a friend's suicidal thoughts. Such stressors can be identified and addressed by healthcare providers before the situation worsens. However, management of young people with suicidal behaviour is poorly understood. Usually, they are sent from one healthcare provider to another, owing to inadequate training. Early identification and treatment of depression should not be left to psychiatrists and psychologists only. With adequate training and various interventions, such as stress management techniques and the prevention or moderation of alcohol use, the prevalence of suicidal behaviour can be reduced in young people. Family physicians have a role to play in the training of nurses and medical students through the detection and management of depression in such people in order to reduce suicidal behaviour.

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References

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