Improving access to education and care in Cambodia

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Four years ago, when Cambodia's first diabetes surveys were analysed, they surprised everyone: there were twice as many people with diabetes than had been expected – more than 250,000 people. However, the major donors supporting the country's healthcare sector continue to distribute financial support in unequal shares. The 60,000 people in Cambodia with HIV/AIDS receive 60% of healthcare loans and donations; despite WHO estimates that seven out of 10 deaths in the Western Pacific region are due to non-communicable diseases, including diabetes, these receive just 1% of donor contributions in Cambodia. Chronic non-communicable diseases already represent half of the country's burden of death and disease. Yet by investing wisely, the prevention and management of non-communicable diseases, including diabetes, can be made affordable and effective. Translating this message into timely and appropriate action remains a major task.

In nearly all cases, Cambodian children with type 1 diabetes do not survive. Only around a third of the people with type 2 diabetes, who make up the vast majority of the diabetes population, has been diagnosed. The profile of Cambodian people with type 2 diabetes differs from that of people in wealthier countries, where the condition is more often associated with overweight and obesity. Only half of Cambodians with type 2 diabetes is overweight; one in five is actually underweight.

More than 90% of people with diabetes are 'off the radar'. There may be as many as 15,000 people with type 2 diabetes who cannot survive without insulin. We calculate that there are more than 13,500 hidden people in a life-threatening state. There is a constant turnover in this large group of extremely vulnerable people with type 2 diabetes as large numbers of people die and are replaced by others who develop the condition. A much larger group of missing people with

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diabetes, around a quarter of a million, have uncontrolled diabetes and face premature death from lack of care – in nine out of 10 cases within 10 years.

The Cambodian context

In Cambodia, there is no government provision in terms of subsidies or health insurance programmes to cover essential diabetes medications, including insulin, or other supplies, like test strips. These must be paid for out of pocket by people with the condition and their family. Given that the average Cambodian survives on less than 2 USD per day, only a very small amount is available for personal healthcare; it is almost impossible for most people to cope with their diabetes. Researchers have reported rice farmers with diabetes expressing that they 'wished' they had HIV/AIDS – because care for this infectious disease is heavily subsidized. Indeed, 'I wish I had AIDS' became the title of a report on the struggle to cope with diabetes in Cambodia.

Diabetes is a life-long condition requiring decades of complex management, including pharmacological therapies. Poor people with the condition are therefore extremely vulnerable to financial ruin. Moreover, without adequate education and support, the meagre resources of a family affected by diabetes are often spent on inappropriate or ineffective services and products.

Cambodians normally eat large quantities of white rice – it makes up 80% of a typical meal, even breakfast. White rice is generally considered to have a high glycaemic index, meaning that it is a carbohydrate-rich food that has quite a rapid effect on blood glucose levels. The white rice aside, most traditional Khmer dishes are tasty and healthy, using a range of different vegetables. There are a wide variety of herbal soups. Fish, rather than meat, is often the principal source of protein. Having said this, there is a tendency to add spoonfuls of sugar to many of the dishes. The intake of salt, which is even added to tropical fruit, is also high. Special attention in terms of educational interventions are required in order to build on the healthy elements of the traditional diet and promote healthier culinary habits.

Current public health policy

Acute shortcomings exist in the provision of clinical care for people with diabetes. Public hospitals and health centres do not provide diabetes care.

The Ministry of Health began developing diabetes policies very recently. In 2007, it issued a national strategy for non-communicable diseases. With World Health Organization (WHO) input, this broad framework set out priorities for all non-communicable diseases, including diabetes. Crucially, this has removed the international donors' last remaining excuses for ignoring the growing chronic disease burden: the new strategy allows donors to commit resources for technical assistance and training, preventive initiatives, and infrastructure.

Diabetes care programmes

A number of NGO-managed clinics have been set up – some for chronic diseases in general, others concentrating on diabetes. The Sihanouk Hospital Center of HOPE in the capital, Phnom Penh (a HOPE worldwide chronic disease clinic) provides outpatient and inpatient care for people with long-term diabetes complications, such as kidney disease and cardiovascular problems – often admitted as emergency cases. Many poor people receive care in the outpatient system and are seen every two or three months. All treatment and medications, including insulin, are free of charge.

HOPE worldwide provides education on diabetes and its complications, as well as diet and foot care, in follow-up consultations and group sessions. Médecins Sans Frontières applied a similar model when it established chronic disease clinics that integrate diabetes care with care for people with HIV/AIDS. In 2005, MiCaDO helped set up the diabetes care services in the National Hospital Preah Kossamak in Phnom Penh. The World Diabetes Foundation supported five provincial diabetes clinics, making basic care available at key locations around the country.

No figures are available from the private healthcare sector. Private care is too expensive for most people with diabetes, and, in many cases, of dubious quality.

Peer response

Since 2005, diabetes peer educator networks provide a cost-effective option to reduce the gap between the existing need for services and healthcare system's capacity to provide these services. Through the distribution of urine glucose strips, trained diabetes peer educators are able to identify other people with diabetes and those at risk for the condition in their own community. Fasting blood glucose tests carried out by diabetes peer educators confirm the status of people found to have high urine glucose. Peer educators then provide information and advice on lifestyle changes.

Where necessary, the peer educator helps people with diabetes to make an appointment with an experienced diabetes healthcare professional. Because the peer educator, having identified the person with diabetes, provides counselling and follow-up, the time spent in consultation with a healthcare professional is optimized: the right people are seen at the right time. There are very significant financial as well as health benefits for people with diabetes, who receive relevant and appropriate information from the peer educator on the medications and supplies they will need to manage their condition effectively.

Little wonder, then, that after three years, the peer educator approach has proved popular among people with diabetes and healthcare providers, and effective in improving outcomes and reducing healthcare costs. Early detection and pre-emptive lifestyle changes contribute to the prevention or delay in the serious and debilitating secondary complications that are sadly typical among many people who present for the first time at the regular clinics.

Future challenges

The ostrich attitude towards diabetes must be overcome; burying our heads in the sand will have dramatic and potentially tragic consequences for individuals, communities and entire societies. A commitment in terms of resources is needed urgently to advance the national non-communicable disease strategy in Cambodia. Peer education networks need to be strengthened with the required investment. It is time to act to halt Cambodia's silent epidemic.

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Visit www.mopotsyo.org for more information about MoPoTsyo.

Further reading

- King H, Keuky L, Seng S, et al. Diabetes and associated disorders in Cambodia: two epidemiological studies. *Lancet* 2005; 366:1633-9.