Dialogue Summary

On

Strengthening Integrated Diabetes Care in

Cambodian Primary Health Care

This Policy Dialogue convenes key policymakers and stakeholders to capture contextual information, tacit knowledge, views and experiences including potential recommendation to address high priority issues.

The Dialogue was informed by a pre-circulated Briefing Note to allow for focused discussion among policymakers and stakeholders.

Acknowledgements

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The views expressed in the dialogue summary are the views of the dialogue participants and should not be taken to represent the views of the authors of the dialogue summary.

Dialogue

The policy dialogue about Strengthening Integrated Diabetes Care in Cambodian Primary Health Care was held on 23 October 2020 at the Phnom Penh Hotel, Phnom Penh, Cambodia. The policy dialogue was facilitated by Prof. CHHEA Chhorvann, the director of the NIPH.

Citation

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Preamble

The NIPH Policy Dialogue, hosted 19 diverse stakeholders including representatives from:

- Policy and Decision-making departments under Ministry of Health (MoH) including Department of Planning and Health Information (DPHI), Department of Preventive Medicine (DPM), and National Centre of Health Promotion (NCHP), and Ministry of Economic and Finance (MoEF) including General Secretariat of National Social Protection Council (GS-NSPC), and National Social Security Fund (NSSF).
- International non-governmental organizations include Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), and the NGOs forum.
- Community-based organization include MoPoTsyo and the Korea Foundation for International Healthcare (KOFIH).
- Research Institute include University of Health and Science (UHS)
- Provincial level includes Siem Reap, Pursat and Battambang Provincial Health Department (PHD).
- Other institutions include National Hospital (Calmette) and National Diabetes Centre

The policy dialogue was facilitated by Prof. CHHEA Chhorvann, the Director of the National Institute of Public Health (NIPH).

Background to the Policy Dialogue

The Policy dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action.

Key features of the dialogue were:

Identifying and selecting a relevant topic according to predefined criteria

1. Presenting an issue currently being faced in Cambodia;
2. Focus on different underlying factors of the problem;
3. Focus on four recommendations of an approach for addressing the policy issue;
4. Informed by a pre-circulated briefing note that synthesized both global and local research evidence about the problem, recommendations and key implementation considerations;
5. Informed by a discussion about the full range of factors that can inform how to approach the problem and possible recommendation of an approach for addressing it;
6. Brought together many parties who would be involved in or affected by future decisions related to the issue;
7. Ensured fair representation among policymakers, stakeholders, and researchers;
8. Engaged a facilitator to assist with the deliberations;
9. Allowed for frank, off-the-record deliberations by following the Chatham House rule: “Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed”; and
10. Did not aim for consensus. Participants’ views and experiences and the tacit knowledge they brought to the issues at hand formed key input to the dialogue. The dialogue was designed to spark insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue and by those who review the dialogue summary.

Deliberations about the problem

The participants of the dialogue discussed the overall framing of the problem regarding the lacking access to primary health care of diabetic patients in Cambodia and the need to strengthen integrated diabetes care in Cambodian primary health care. Participants admitted that it is indeed a problem and agreed on the need to address the underlying factors leading to the problem.

Participants also recognized the importance of solving the problem as soon as possible to address the need for strengthening the diabetic care at the primary health care.

The participants agreed on the data that shows the increase in the prevalence of deaths attributable to diabetes and the higher number of patients not being treated and a lack of blood glucose control. Many participants also mentioned the complications that will occur if the problem is not solved. They also suggested that in order to solve the problem, both Non-Government Organizations (NGOs) and Ministry of Health (MOH) should work together.

One of the participants agreed and shared that there are a lot of diabetic patients with complications such as end-stage renal disease which needed dialysis byadmission to clinic, and foot ulcers. These complications cost the patients a large amount of money, low quality of life, and a high mortality rate, so it would be the best solution if primary health care could work on primary prevention.

Participants also stressed the need to train and educate health professionals, especially nurses who were allocated at the health center.

Deliberations about underlying factors

Participants then movedto discuss the underlying factors of the problem. Most participants agreed on the approach to the problem at the governance, health service delivery, health financing, health information system and cultural and socioeconomic factors and lifestyle among patients. There is a suggestion from one participant that we should look at the details problem as a system. For

example, the level of healthcare at which the patient should get the screening, the place to refer the patient after screening, and the lack of human resources.

Governance arrangements

Logistics of drug supplies were stressed more in detail. One participant raised the discussion on the system of requesting Anti-diabetic medicines and the way the drugs were provided to each health center. The problem is that both systems do not link and work together. For example, the one who requested the drugs to the Centre of Medical Storage (CMS) does not even know which health center needs the drugs; they only knew the number of drugs needed, and then passed the request to the Provincial Health Department (PHD) and then to the ministry (MOH). After that, the MOH will provide the drugs, which will lead to an unequal drug distribution to each health center.

Another participant stated that there are Anti-diabetic medicines in the essential drug list that are provided. However, the amount is limited, and if the amount of Anti-diabetic medicines increases, there will be a shortage of the other drugs, so the hospital and the health center should use the 30% funds that they have to solve the problem of this shortage. He added that the health facility should manage to know how to manage the drug shortage. Another participant also pointed out that there is still a lack of human resources and their capacity.

One participant suggested that NIPH should conduct research on the assessment (supply, demand, drug utilization) of Diabetes on the ground and at the national level.

Health service delivery arrangement

The discussion started with the system of the service providers, whether it is acceptable for nurses at the primary health care level to prescribe the Anti-diabetic medicines to the patients, or should it be the doctor. However, this would be a challenge at facility level. One participant suggested that the doctor should still be the one who prescribes drugs, and the health center staff should work as a primary health care for diabetic patients by helping the doctor with screening and follow up with the patients after getting the diagnosis. This way will help lessen up the travel expense of the patients as well as having enough time to give education to the patients. Another participant added that the primary health care level should focus on pre-diabetes, education on lifestyle more than clinical treatment.

Health financing arrangement

One participant clarified that there are two sources of funds in health care, the National Social Security Fund (NSSF) and Health Equity Funds (HEF). He also mentioned that there are a lot of Anti-diabetic medicines on the essential drugs list already. However, after the meeting with the national hospital level, National Social Security Fund will cover the Anti-diabetic medications (besides the drugs in the essential drugs list). One participant stated that NSSF and HEFs help a lot of patients. Another participant suggested that the treatment of the disease should be set according to the stage of the disease, and the health center level should only focus on pre-diabetes and glucose monitoring. This idea was supported by one of the participants that the treatment should be set accordingly to the type of Diabetes (Diabetes with complications and non-complication). One participant added that the organizations and Ministry of Health (MOH) should raise the shortage problem of drugs, and they should work together to set an exact price for a Diabetic care package for the patients.

Health information system

Most participants agreed that it is hard to find the mechanism to revise or set up a health information system to cover all facilities as different models have been implemented right now. One of the participants mentioned related to the database that it has been set Patient Management Registration System (PMRS) number as a case identifier.

Cultural and socioeconomic factors and lifestyle among patients

Most participants seemed to agree on the challenges from patients themselves so that education is still important.

Deliberations about the Recommendations

Deliberations about the Recommendations for Addressing the Problem

All participants discussed all the recommendations and strategies laid out in the briefing note. However, regarding each recommendation, it should highlight the level at which the issue will be resolved, namely national or facility level (HC, OD, PHD).

Recommendation 1: Strengthen the role and capacity of health care organization

Most participants agreed on this section as it has to be a multidisciplinary team work. There should be a team formed of both health center and hospital to manage the diabetes care and use it as a model for the other chronic care of NCDs. A participant mentioned that primary prevention is a really good point to prevent all of the complications and consequences of diabetes, and these should be done at the Health Center level. Also, diabetes educators and dietitians should be considered, so there should be a multidisciplinary team. Few participants agreed at adding doctor into facilities in the next 10 years, stating it would be hard to achieve. We agreed and should reconsider of skill-mix as nurse practitioner if we follow PEN.

Another suggestion is to highlight more clearly the issues of the finding and then link it to the recommendations to solve each problem. Some strategy in this recommendation is too broad. They suggested to use the exact word, for instance provide training or supervision or support instead of strengthening the capacity and make it shorter, therefore more useful to convince policymakers. One participant suggested that we should reconsider the point on integrated the revolving drug fund scheme of MoPoTsyo into the public health facilities. This case, it may be impossible, but we can find another way to find to secure the access of Anti-diabetic drugs. But the team could find at the level of financing structure such as source of drug can attract from which target group including NSSF group.

Recommendation 2: Empower community support

Based on the discussion, a participant asked for clarification on the level of sharing the decision-making as part of strategy # 3. This point should be clearer.
Moreover, one participant clarified the term peer educator and the Community health workers. He shared that peer educators are likely to be more effective than Community health workers since they had personal past experience and all went through the same things as patients and were able to manage it successfully.

Recommendation 3: Expand the use of digital technologies to support self-management and coordination for the continuum of care

Most participants agreed that it is good to have a digital platform, but needed more clarification about the its purpose and the target population.

In the meantime, one participant mentioned that the educational material is also beneficial for the patients, especially the digital material.

Currently, there is an app called CarnetDia app used for raising the awareness of diabetes education on patient, recording patient's glucose level, and update accordingly to calculate the danger level of Diabetes patients. However, one participant argued that not many people access this app actually, and we should know clearly about the purpose of the application and the target population who use it before making an assumption for that.

Recommendation 4: Strengthen ownership of local health governance

He also suggested the team to look more in detail on the decentralization in recommendation 4 (strategy 1). According to the decentralization, all working and requesting process need to go through the provincial governance first before going to the MOH which is different from the previous system that start from the OD to the PHD and directly to the MOH. One participant was concerned that MOH only provided distance support currently so how we could solve and support at facility level to achieve "coverage, access and quality".

Next Steps

Next Steps

After thorough discussion of the problem and recommendations, participants agreed on the following next steps:

- Revise the recommendations according to each level following stakeholders' recommendation where is relevant (system/national and facility level)
  - Recommendation 4 is our window of opportunity but it should be dealt with the evolving system such as decentralization due to not clear direction yet.
  - If we could not address at system/national level, but somehow, we can start from implementation/facility level first. One organization is interested in trying some implementations; therefore we at least can test at some Health Centre in Battambang province as implementation research. Thus, we can have more evidence and learn from this process.
- This briefing note will be able to use to support MoH for updating national health strategy 2021-2030 since some strategies mentioned in the briefing note are similar to what was planned.

It was agreed that the NIPH dialogue summary report along with the revised briefing note will be shared with each stakeholder organization as guiding report and that they can use it where applicable and they would communicate internally and externally with relevant stakeholders to advocate for improvements in current organizations and systems. Also, they can discuss the need to operationalize key recommendations that came out from the dialogue meeting and put them into action as a model for other chronic care.