Integrating Palliative Care into HIV/AIDS & Cancer Care in Developing Countries Using a National Public Health Approach: The Case of Vietnam

Eric L. Krakauer, MD, PhD
Director of International Programs
Harvard Medical School Center for Palliative Care.
Associate Physician, Palliative Care Service, Massachusetts General Hospital.
Consultant, International Palliative Care Initiative, Open Society Institute.

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Objectives

A. To review barriers to palliative care for patients with AIDS, cancer and other serious chronic illnesses in developing countries and to suggest ways to overcome the barriers.

B. To describe the WHO public health strategy for palliative care.

C. To show how the Vietnam palliative care initiative has progressed to date using the WHO public health strategy.
Barriers to Palliative Care in Developing Countries

1) Misunderstandings of palliative care.
2) Lack of awareness of the need for palliative care.
3) Lack of national palliative care policies & guidelines.
4) Lack of availability of opioid analgesics and other essential palliative medications.
5) Lack of clinicians trained in palliative care.
6) Lack of inpatient and community-based palliative care services.
Barrier #1: Misunderstandings of Palliative Care

- Confusing definitions of palliative care
  - PEPFAR definition: extremely broad
    - “everything but antiretroviral (ARV) therapy”
  - WHO definition: written for cancer patients
    - “regards dying as a normal process”
    - “intends neither to hasten or postpone death”

- Confusing statements by palliative care advocates (with the best intentions)
  - “the only feasible and humane response to AIDS in the poorest settings”

- Mistrust of palliative care
  - Advocates for the poor and for social justice
    - “second rate care for the poor”
Barrier #1: Misunderstandings of Palliative Care

• **Solution:**
  – Define palliative care locally or regionally by modifying the WHO definition to emphasize:
    • Pain & symptom relief and psycho-social support for patients and their families are essential aspects of comprehensive HIV/AIDS & cancer care.
    • Palliative care promotes access & adherence to preventive, curative and disease-modifying therapies:
      – Prevention, diagnosis & treatment of TB and other OIs;
      – HIV prevention and ARV therapy;
      – Prevention, diagnosis & treatment of cancer.
Palliative Care is Essential to Comprehensive HIV/AIDS & Cancer Care

– There is no dichotomy between palliative and disease-modifying interventions for HIV/AIDS patients.
  • Palliative care (symptom relief & psycho-social support) can improve adherence and access to ARV therapy and reduce mortality.*
  • OI treatment and ARV therapy often can relieve pain and other symptoms.

– HIV/AIDS or cancer care without palliative care is second rate:
  • Is not as medically effective as it should be;
  • Is not as compassionate as it should be;
  • Does not fulfill our patients’ human right to palliative care.**

Mai Hoa AIDS Center
Cu Chi, Vietnam
WHO Public Health Strategy for Palliative Care

- Stjernswärd developed for WHO a method of overcoming the remaining barriers:
  - Establish a national palliative care steering committee that includes healthcare leaders in both HIV/AIDS and cancer.
  - Carry out a situation analysis of palliative care need.
  - Develop and carry out a plan to build the “4 pillars” of a national palliative care program:
    1. **Policy**: Development of national palliative care policies & guidelines
    2. **Drug Availability**: Assurance of the availability of opioid analgesics and other essential palliative medications
    3. **Education**: For clinicians (physicians, nurses, community health workers) and healthcare officials
    4. **Implementation**: Of palliative care clinical programs
Vietnam

Demographics

Population:
86 million

Life expectancy:
72

Average per capita GNI (2007):
US$ 790
(Official Exchange Rate method)
Vietnam Cancer Situation

- In 2007:
  - Estimated new cancer cases: 200,000
  - Estimated cancer deaths: 70,000 – 90,000
- Estimated number of new cancer cases increasing annually.
- Most patients present with far-advanced disease.
- Cancer registration system is still not completed. A few models have been applied for limited periods in some provinces.
- Facilities for diagnosis and treatment are very inadequate.
- The network of cancer prevention and control is still being developed.
Vietnam HIV/AIDS Situation

- Estimated HIV (+) people: >300,000
- Estimated adult HIV prevalence: ~0.5%
- Estimated AIDS cases: ~71,000
- Patients on ARV therapy (ART): ~21,000
- Estimated patients in need of ART: ~50,000
- AIDS deaths:
  - >25% increase/year 2002-2007
  - ~20,000 AIDS deaths in 2007
  - AIDS death rate may be falling – rising number of people living with AIDS.
- IDU (heroin) is dominant form of transmission.
- Chosen as PEPFAR focus country in 2004.
Crucial First Steps to Overcoming the Barriers in Vietnam

• Sense of Congress in 2003 that 15% of PEPFAR funding should be for palliative care - made MoH aware of the concept.
• Decision by MoH to focus on both HIV/AIDS and cancer.
• International experts to provide consistent technical assistance (little palliative care expertise in the country).
• MoH convened Palliative Care Working Group.
• MoH Palliative Care Working Group adopted the WHO public health strategy.
Barrier #2: Lack of Awareness of the Need for Palliative Care

• Healthcare officials and clinicians often do not recognize the scale of suffering due to pain, other physical symptoms, and psycho-social distress.

• **Solution**: A situation analysis of local palliative care needs.
  – Can begin small: one or more provinces, cities, hospitals, or clinics.
  – Use simple survey instruments available online:
    • African Palliative Care Association Palliative Outcome Scale (POS)
    • Brief Pain Inventory (BPI)
  – Publish or circulate the results.
Vietnam’s Palliative Care Situation Analysis

• 2005: Rapid Situation Analysis of palliative care needs and services in 5 provinces.
• Important results:
  – Severe chronic pain is common among HIV/AIDS & cancer patients.
  – Psychosocial supports for HIV/AIDS and cancer patients and their families are badly needed.
  – Availability of opioid analgesics and other palliative medications is severely limited.
  – Clinicians lack adequate training in palliative care.
  – Most healthcare policy makers recognize the need for more palliative care.
Barrier #3: Lack of National Palliative Care Policies or Guidelines

• Without official palliative care policies or guidelines issued by the MoH, palliative care:
  – May be provided only piecemeal in a few locations, if at all;
  – May be of poor or uneven quality;
  – Cannot be scaled up.

• Solution:
  – Develop national palliative care policies based on the need demonstrated by the situation analysis:
    1) National palliative care guidelines: consult existing guidelines from WHO (IMAI), South Africa, Uganda (now also Vietnam).
    2) National opioid policies.
Vietnam’s National Palliative Care Guidelines

- Based on the Rapid Situation Analysis, National Palliative Care Guidelines were written by the MoH that are relevant to the local needs, clinical situation, and culture.
- Unveiled in 2006 at workshops in major cities.
- Sections:
  - Medical and ethical principles of palliative care
  - Treatment of pain and other physical symptoms
  - Psycho-social support
  - Palliative care for AIDS patients taking ARVs
  - Palliative care for cancer patients receiving radiation therapy, chemotherapy or surgery.
  - Pediatric palliative care
  - Care for the dying patient / Bereavement care
Report on Rapid Situation Analysis (RSA)
National Guidelines on Palliative Care
(English translations)
Barrier #4: Lack of Essential Palliative Medications

• Strong opioid analgesics such as oral morphine and other essential palliative medications often are not available. Typical reasons:
  – Unwarranted fear of opioid side effects, addiction, and diversion;
  – Extremely restrictive opioid prescribing regulations;
  – Lack of financial incentive for importation or local production of opioid analgesics;
  – Self-perpetuating cycle of low use and demand resulting in limited availability resulting in low use.
Barrier #4: Lack of Essential Palliative Medications

• **Solutions:**
  - Review WHO document on “Achieving Balance in National Opioids Control Policy”.*
    • Use the assessment tool to analyse current national opioid policies.*
  - Obtain training and information on improving national opioid control policies - available online from the Pain & Policy Studies Group, University of Wisconsin, USA.
  - Educate healthcare opinion leaders about the safety and importance of opioid analgesics.
  - Include the *Essential Palliative Medication List* of the International Association of Hospice and Palliative Care (IAHPC) in national essential drug lists.**

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Vietnam’s Progress toward Availability of Palliative Drugs

• 2006:
  – Two MoH officials accepted into International Pain Policy Fellowship offered by Pain & Policy Studies Group (PPSG) at the University of Wisconsin, USA.
  – PEPFAR and PPSG supported MoH to assemble and translate all Vietnamese laws and regulations governing opioid availability.
    • All documents were reviewed by technical advisors from PPSG and Harvard Medical School.
  – Action Plan drafted for revising and achieving “balance” in Vietnam’s opioid policy as per WHO recommendations.
Vietnam’s Progress toward Availability of Palliative Drugs

• 2007:
  – MoH held high-level Workshop on Opioid Policy to discuss the Action Plan (with PEPFAR support).
    • Participants included Ministry of Police, national institutes of infectious disease & cancer, WHO, UNODC, international NGOs.
  – Final Action Plan approved by MoH.
  – MoH issues Guidelines for Methadone Substitution Therapy.

• 2008:
  – MoH issues liberalized Opioid Prescribing Regulations that reflect international standards:
    • Maximum prescription length increased from 7 to 30 days.
    • No maximum dose.
    • Requirement that opioid be available by prescription in every district nationwide.
    • Strict regulation of storage and handling.
Barrier #5: Lack of Training in Pain Relief and Palliative Care

• Physicians, nurses, and community health workers lack adequate training in pain relief & palliative care.

• Healthcare officials need training to properly implement new palliative care and opioid policies.

• Solutions:
  – Train healthcare officials in all new palliative care & opioid policies.
  – Require training in palliative care for all clinicians who care for cancer or HIV/AIDS patients. Request that all training-of-trainers in HIV/AIDS care offered by foreigners include palliative care.
  – Use available palliative care training materials to develop locally relevant, standardized training curricula for clinicians:
    • Education in Palliative and End-of-Life Care (EPEC)
    • African Palliative Care Association (APCA)
    • Harvard Medical School Center for Palliative Care (HMS CPC)
    • End-of-Life Nursing Education Consortium (ELNEC)
Vietnam’s Training Programs in Palliative Care

• 2007: Training Begun
  – Intensive, five-day basic training courses for physicians using curriculum based on national Guidelines (MoH / HMS CPC Palliative Care Module 1).
  – Two-day training courses on national Guidelines for provincial healthcare officials (taught by MoH).

• 2008: Additional Training Courses Initiated
  – Three-day advanced and refresher course for previous trainees (MoH / HMS CPC Palliative Care Module 2).
  – MoH piloted Fellowship & Certification Program in Palliative Medicine (curriculum developed for MoH by HMS CPC).
  – Training for provincial healthcare officials in new Opioid Prescribing Regulations.
Palliative Care for HIV/AIDS and Cancer Patients in Vietnam

Basic Training Curriculum

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Editor-in-Chief

Palliative Care for HIV/AIDS and Cancer Patients in Vietnam

Advanced Training Curriculum

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Editor-in-Chief
Barrier #6: Lack of Palliative Care Services

• Inpatient and community-based palliative care services for HIV/AIDS and cancer patients typically are available only in a few locations, if at all.

• **Solutions:**
  – Develop local leaders in palliative care education.
  – Encourage or require development of palliative care programs in major HIV/AIDS and cancer centers.
  – Require integration of palliative care services into community-based cancer, HIV/AIDS, and primary care programs:
    • Train ART adherence supporters to provide basic palliative care services (eg. psycho-social assessment and support).
    • **Partners in Health** model of *accompagnateurs*
    • Make palliative care assessment and intervention a standard task of HIV and cancer outpatient clinics.
    • Assure availability of oral morphine by prescription at the district level.
Vietnam’s Implementation of Sustainable Palliative Care Programs

- Vietnamese trainees are receiving mentoring to gradually take over palliative care teaching responsibilities.
- National curriculum in palliative medicine is nearing completion with assistance from Harvard Medical School.
- Vietnamese colleagues and Fellows are carrying out palliative care projects at their home institutions.
- Nascent palliative care services in some locations:
  - Hospital for homeless people with AIDS in Hanoi.
  - Hospital for homeless people with AIDS in Ho Chi Minh City.
  - A few major regional hospitals and cancer centers.
  - Some home-based HIV/AIDS care programs.
Next Steps

1) Continue TA in palliative care for MoH.
   a) Develop national Guidelines on Home-Based Palliative Care.
2) Continue joint training interventions in palliative medicine for HIV/AIDS and cancer patients:
   a) Fellowship in Palliative Medicine
   b) Training courses for physicians
   c) Mentoring of Vietnamese faculty members
3) Continue training health officials in national Guidelines on Palliative Care & Opioid Prescribing Regulations.
4) Develop standardized palliative care nursing training.
5) Develop standardized palliative care training for community health workers.
6) Intensify integration of palliative care into standard cancer and HIV/AIDS care at all levels:
   a) Intensify TA & clinical mentoring in palliative care at major HIV and cancer centers – develop Centers of Excellence in PC.
   b) Provide technical and financial support for palliative care units in hospitals and palliative care services in the community.
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Thanks

- Major Funder: US PEPFAR / US CDC Global AIDS Program
- Other Funders: Open Society Institute
  US Cancer Pain Relief Committee
- Collaborators:
  - Dr. Luong Ngoc Khue, Ministry of Health of Vietnam
  - Mme. Nguyen Thi Phuong Cham, Ministry of Health of Vietnam
  - Prof. Nguyen Ba Duc, National Cancer Institute of Vietnam
  - Prof. Nguyen Duc Hien, National Institute of Infectious & Tropical Disease of Vietnam
  - Dr. Nguyen Thi Minh Ngoc, USAID
  - Kim Green, Family Health International
  - Dr. Phan Thu Phuong, Family Health International
  - Dr. Chu Phuc Thi, VCHAP
  - David Joranson & Karen Ryan, Pain & Policy Studies Group, University of Wisconsin

This project was supported by Cooperative Agreement Number U62/CCU122408-04 from the United States Centers for Disease Control and Prevention (CDC). The contents are the sole responsibility of the author and do not necessarily represent the official views of the CDC or the US Government.