

CANCER IN THE DEVELOPING WORLD

Palliative Care Gains Ground in Developing Countries

By Kristine Crane

As cancer rates climb in the developing world, an urgent need for palliative care services has emerged, outpacing even the need for cancer treatments, since most cancer is diagnosed at a late stage.

Palliative care is care intended to improve the quality of life for patients and their families facing problems associated with life-threatening illnesses, according to the World Health Organization (WHO), “through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial, and spiritual.” The WHO defines the palliative care public health model as having three basic components: policy, education, and drug availability. In developing countries, attention to palliative care has been minimal, since public health programs have focused largely on preventing and treating infectious diseases and malnutrition. Studies have shown that only about 6% of all palliative care services are located in Asia and Africa.

Palliative care has gained ground in developed countries over the last few decades, with the loosening of laws on morphine use and the introduction of palliative care programs in many large hospitals. In the U.S., recent attention has focused on how it saves on expensive life-sustaining treatments of questionable benefit; improves the quality of life for patients and their families; and, according to a recent study, may even prolong survival.

But also in the past two decades, nonprofit groups and international organizations have begun introducing palliative care to the

developing world. At this year’s annual American Society of Clinical Oncology meeting, an expert panel discussed palliative care in the developing world, with speakers from some of the U.S.-based groups that have been crucial to launching palliative care programs in developing countries. Among other actions, they have helped revise regulations on access to pain medications and trained thousands of health professionals in palliative care.

Common Foe, New Problem

Cancer has only recently emerged as a public health problem in the developing world, even though those areas have half the world’s roughly 10 million cancer diagnoses each year. Other diseases, namely, infectious diseases, have been the main priority. Because access to health care can be minimal and diagnostic services poor, most cancer is diagnosed at late stages of the disease, making palliative care an immediate need.

For that reason, international and other nonprofit groups often see palliative care as an entry point to setting up comprehensive cancer treatment programs in the developing world.

“It’s a great way to start managing cancer,” said Frank Ferris, M.D., the director of international programs at San Diego Hospice and the Institute for Palliative Medicine. “As resources become available, we can do early detection, but [with palliative care] at least you are doing something for your people.”

Through the institute, Ferris runs palliative care training programs in Lebanon and Jordan, as well as a fellowship program

for physicians to learn about palliative care. He has worked in Georgia and the Ukraine and hopes to develop programs in Turkey, Cyprus, Palestine, Israel, Egypt, and Latin American countries over the next 5 years.

Like others in the field, Ferris has focused many of his efforts on improving access to pain medication. One of his programs set up a pharmaceutical company in Jordan that manufactured morphine tablets. In little less than a decade, opiate usage increased 20-fold in Jordan, from 2.5 kg imported in 2001 to 39 kg in 2010, Ferris said.

Fighting Opiophobia

That increase was a huge breakthrough, given the overall resistance to opioids throughout the developing world. The fear of addiction, combined with the influence of U.S. efforts to curb illegal drug importation, has made distinguishing the need for drugs from their abuse hard, according to Ferris.

Furthermore, in countries where opiate dependency was part of colonial control, such as China and Vietnam, resistance to opiates is even stronger, said Eric Krakauer, M.D., Ph.D., director of international programs at the Harvard Medical School Center for Palliative Care. “On top of that, there was opiate abuse among American and South Vietnamese soldiers during the Vietnam War; and now, injection drug use is driving the HIV–AIDS epidemic,” said Krakauer, explaining that people are overly concerned about a connection between medical use of opioids and illicit drug usage.

Meanwhile, cancer-related pain in the developing world is pervasive. In a study

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of patient-reported pain at a large cancer treatment center in Hanoi, Vietnam, which was published in the *Journal of Pain and Symptom Management* in 2006, half of the 178 cancer patients surveyed reported having pain; 31% reported it to be of moderate to severe intensity. Many patients said the pain interfered with their daily living. Other studies in Hong Kong and Israel found most cancer patients reporting that cancer pain impaired their daily activities.

Developing countries consume only about 9% of the world's morphine, even though they account for 83% of the world's population. Meanwhile, only 10 countries consume 91% of the world's morphine, according to the Pain Policy Studies Group at the University of Wisconsin.

That group works on making morphine available in developing countries, which often means helping governments to reform laws or make sure existing laws are applied. For example, in Jamaica, where the group is now working, morphine is legal, but in practice it is kept under a "dual lock" system in hospitals, which makes it nearly impossible to get morphine to patients in need in a timely manner. A paranoia surrounds consumption of the drug; its regulation, in fact, falls under the domain of the director of dangerous drugs, said Jim Cleary, M.D., director of the group.

In other countries, authorities such as the "director of poisons" oversee morphine availability. So overcoming opiophobia—the fear of addiction associated with opioids—is one of the biggest challenges, said Cleary.

The group has helped make morphine available in Vietnam, Romania, and Serbia and aims to make it available in 140 countries by 2020. In 2003, the Ministry of Health in Romania invited the group to review the country's policy on pain, working together with a specially appointed commission on palliative care. On the basis of that review, and the group's 16 recommendations, legislators drafted a new law widening access to pain medications the next year.

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International organizations have also made access to pain medications a priority in their overall aim to improve palliative care around the world. The WHO in 2005 established the Access to Controlled Medications Programme, with the aim of improving access to opioids, as part of its *Public Health Strategy* for integrating palliative care into a health care system.

The nongovernmental organization Human Rights Watch has also made opioid availability one of its causes. In 2008, the *World Cancer Declaration*, from the Union for International Cancer Control, made pain management a goal by 2020, when 15 million cancer diagnoses could occur each year.

The Boston-based Partners in Health, founded by Paul Farmer, M.D., focuses on the suffering of the poor and has cancer-control projects. According to Harvard's Krakauer, "In some ways they do avant-garde palliative care. Their psychosocial and adherence support programs for patients receiving burdensome treatments are second to none," he said. "They carefully look at what the problems are, at what's causing the suffering. If people are getting [tuberculosis] because there are no decent places to live, they start building decent housing."

Training in Vietnam

For some leaders in this area, palliative care is a personal crusade. When Krakauer first visited hospitals in Vietnam in the 1990s on personal travels, "a pandemic of unnecessary pain and suffering" repeatedly confronted him.

"Take a walk through the wards of Vietnam's major cancer centers; you'll see patient after patient diagnosed at stage IV, often far away from home, in the big city, dying of cancer," he said. "The family is spending all of its meager resources and going into debt to pay for treatments that may have little benefit. Then the patient dies, usually without access to pain relief."

For HIV–AIDS patients, no antiretroviral medications were available, and palliative care wasn't even on the radar screen, said Krakauer, who decided then to dedicate his career to palliative care. "It's a path that makes sense by taking the Hippocratic Oath seriously. To keep the sick from harm and injustice: When one finds that injustice causes enormous suffering around the world, that's a call to action."



Eric Krakauer, M.D., Ph.D.

Krakauer began to collaborate with the director general of the Vietnam Administration of Medical Services, Luong Ngoc Khue, M.D., Ph.D., and with Nguyen Phi Phuong Cham, Pharm.D., senior pharmacist at the Ministry of Health, in whom he found a "kindred spirit," he said. "She just understood palliative care, partly because her sister had died of cancer."

He got funding from the U.S. Centers for Disease Control and Prevention in 2002 to teach HIV–AIDS treatment and palliative care to Vietnam's nurses and doctors.

Krakauer's efforts were helped when Vietnam became the 15th country to receive PEPFAR (President's Emergency Plan for AIDS Relief) funding in 2004. At the time, Joseph O'Neill, M.D., was the White House AIDS adviser, and he moved palliative care up on the agenda by suggesting that 15% of PEPFAR funding be for palliative care.

"That gave palliative care a boost," said Krakauer, who the next year conducted a survey of palliative care services in hospitals throughout Vietnam. Only one hospital had oral morphine, and few clinicians had specific training in palliative care.

As a result of those findings, the Health Ministry issued palliative care guidelines for cancer and AIDS patients in 2006. Krakauer's program at Harvard has helped train hundreds of physicians in palliative care, and palliative care training recently became a required part of training at the Ho Chi Minh Hospital. Just 2 years ago, the hospital had no palliative care services, whereas today it has a 12-bed inpatient unit and is starting home care and palliative care consultation, Krakauer said.

Home care is especially important, since most patients prefer to die at home. That means ensuring access to morphine in all 525 districts in the country.

Palliative cancer care in Vietnam and other developing countries emphasizes pain relief because that often is the most urgent problem, Krakauer said. “A comparative study revealed that Scottish cancer patients’ physical pain usually was relieved—but not their emotional pain,” he said. “In Kenya, it was the opposite. Patients felt emotionally supported by their families and communities, but pain relief often was inaccessible.”

But psychiatric issues such as anxiety and depression, delirium, and dementia also plague the dying in the developing world, which has a dearth of antidepressants.

Krakauer says at least one selective serotonin reuptake inhibitor should be available in all countries. “We’re not doing our job if we’re not diagnosing and treating depression in dying patients,” he said, adding that doing so can be difficult in a place such as Vietnam, where “mental illness is highly stigmatized.”

Shifting Perspectives

To some extent, the urgent need for palliative care in the developing world has meant less resistance than in developed countries to the very concept of palliative care, which

has traditionally been synonymous with end-of-life care.

Kathleen Foley, M.D., the longtime champion of palliative care at Memorial Sloan–Kettering Cancer Center in New York, notes a “basic unwillingness to talk about the care of the dying in developed countries. What’s happened in most developed countries is that there is so much focus on treatments and prevention that they forget to take care of the patient.”

A study published in the *New England Journal of Medicine* in August suggested that palliative care can lead not only to better quality of life at the end of life but also to longer survival. The study, led by Jennifer S. Temel, M.D., of Massachusetts General Hospital in Boston, and colleagues, compared metastatic non–small-cell lung cancer patients who received palliative care integrated with standard oncologic care to those receiving standard oncologic care. Those receiving palliative care lived a median of 2 months longer and had an overall better quality of life than those receiving standard care. Furthermore, introducing palliative care at diagnosis led to less aggressive—and less costly—life-sustaining treatments.

Krakauer said that the NEJM article wasn’t the first to confirm that palliative care reduces end-of-life care costs in the U.S. but that the renewed insight could

have particular importance for the developing world.

“[Palliative care] usually does not need to be expensive. It can be labor intensive, but family caregivers expect to provide most of the care in many developing countries. And the basic medications are quite cheap.”

Krakauer expects palliative care to get even more attention from scientists and the general public in the developing and the developed world.

“I think [the Temel study] should be the beginning of a paradigm shift,” he said. “There is scientific evidence that we need to attend not just to the disease but to the suffering of human beings. And when we do that, good things happen: People live longer.”

This perspective could help make palliative care more acceptable in both developed and developing countries, said Ferris of the San Diego Hospice. Regardless of cultural differences, whether people embrace palliative care depends universally on how it’s introduced.

“There’s not a place in the world where I’ve found people eager to die,” Ferris said. “If [palliative care] is marketed as end-of-life care, there is the same reluctance; if it’s marketed as a way to have a much better life and help you live longer, then it’s much more acceptable.”

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