

Palliative care: what approaches are suitable in developing countries?

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Summary

The enormous burden of life-threatening illnesses, including cancer, human immunodeficiency virus infection, and others, such as sickle cell disease, associated with physical and psychosocial suffering explains the illustrious need for palliative care in developing countries. Despite the demonstrated need, current provision of palliative care in Africa is at best limited, and at worst non-existent. Access to essential pain medicines, particularly oral morphine, for control of pain is extremely limited and far below the global mean. There is a general lack of government policies that recognize palliative care as an essential component of health care and there is inadequate training for both health care professionals and the general public about palliative care. A public health strategy, as recommended by the World Health Organization (WHO), offers the best approach for translating knowledge and skills into evidence-based, cost-effective interventions that can reach everyone in need of palliative care in developing countries.

Keywords: palliative care, policy, cancer, HIV, developing countries.

In 1990, the World Health Organization (WHO) defined palliative care for the first time as the active total care of patients whose disease is *not responsive to curative treatment* and that *control of pain, of other symptoms* and of psychological, social and spiritual problems is paramount (WHO, 1990a). The goal of care is achievement of the best possible quality of life for both the patients and their families (World Health Organization, 1990a). Looking at this definition, it would be seen that palliative care comes in when all other curative therapies have failed and many would see palliative care as synonymous with end-of-life care. However, it is now widely recognized that the principles of palliative care should be applied as early as possible in the course of any chronic, life-threatening illness because problems at the end of life have their origins at an earlier time in the trajectory of disease.

Advances in cancer diagnostics and the discovery of novel medicines including anti-retroviral medicines for human immunodeficiency virus (HIV) infected patients as well as new anti-cancer medicines, has rendered good prognoses for these patients and, to many, it seemed like there was no further need for palliative care especially in the high-income countries.

The WHO approach to palliative care has been extended to include the physical, emotional, and spiritual needs of the patient (and family) in addition to pain relief, as these are considered important concerns. Palliative care extends beyond the period of care for the patient, and includes a consideration of the need to support and counsel those who have been bereaved (Sepúlveda *et al*, 2002).

The WHO re-defined palliative care as an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, 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 (WHO, 1998).

Palliative care also applies to children and WHO defines palliative care for children as the active total care of the child's body, mind and spirit, and also involves giving support to the family. Palliative care in children begins when illness is diagnosed, and continues regardless of whether or not a child receives treatment directed at the disease. It requires a broad multidisciplinary approach that includes the family and makes use of available community resources; it can be successfully implemented even if resources are limited. Palliative care for children can be provided in tertiary care facilities, in community health centres and even in children's homes (Di Sorbo, 2011).

Unlike in developed countries, such as the USA, in Africa a prognosis requirement is not attached to hospice eligibility and here the words 'hospice' and 'palliative care' refer to the exact same type of care – holistic, quality care for those with life-threatening illnesses, as was noted by Di Sorbo (2011).

The need for palliative care in developing countries

The need for palliative care in developing countries is significant owing to the high disease burden. By 2008 an

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estimated 22 million people in the region were living with HIV/acquired immune deficiency syndrome (AIDS), i.e., 67% of the global disease burden, with 1.9 million new infections reported in that year alone (UNAIDS, 2008).

There were over 700 000 new cancer cases and nearly 600 000 cancer-related deaths in Africa in 2007, (Garcia *et al*, 2007) and it is expected that cancer rates will grow by 400% over the next 50 years (Morris, 2003). Early diagnosis is fundamental in the management of cancer as it allows for timely treatment while disease burden is still in its earliest stages hence preventing unnecessary complications. Consequently, prognosis may improve, and a cure can be attained with minimal side or late effects, particularly for childhood haematological malignancies, such as Burkitt Lymphoma and acute leukaemia. Unfortunately, early diagnosis is rarely heard of in developing countries where patients usually present late with advanced cancer. In a combined prospective and retrospective study of 194 children diagnosed with cancer at a single centre in South Africa between 2000 and 2009, investigators found that there was considerable delay in diagnosing childhood cancer due mostly to physician delays, among other factors (Stefan & Siemonsma, 2011).

Lack of resources and basic infrastructure mean that most Africans have no access to cancer screening, early diagnosis, treatment or palliative care – the fundamentals for a cancer control programme. Cancer treatment modalities, such as radiotherapy and effective chemotherapy are available to <20% of the population in Africa, and consequently a cancer diagnosis is almost a sentence to a painful and distressing death.

There are major challenges in the management of common cancers, such as lymphomas, in sub-Saharan Africa and, as noted by researchers in Botswana, such challenges include:

- 1 Lack of epidemiological data due to absence of reliable and accurate cancer registries.
- 2 The high prevalence of HIV infection that has led to a high incidence of opportunistic infections during and after chemotherapy treatment, and reduced haematological tolerance to conventional doses.
- 3 Difficulties in making an early diagnosis because symptoms and signs might coincide with those of HIV or opportunistic infections.
- 4 Lack of adequately equipped public hospitals leading to a poorly resourced service of limited value (Cainelli *et al*, 2010).

The WHO has made cancer in developing countries a priority and has produced important guidelines to assist such countries to establish national cancer control programmes that are relevant to their settings (WHO, 2002) As an example, Sudan has instituted a comprehensive national cancer control programme, which is focused on prevention, early detection, improved treatment and palliative care (Hamad, 2006).

Apart from cancer and HIV infection, Africa is filled with other life-threatening illnesses, among which is Sickle Cell

Disease. The greatest burden of sickle cell anaemia occurs in sub-Saharan Africa, where 75% of the 300 000 global births of affected children live, and where 50–80% of these patients will die before adulthood (WHO, 2006a).

Even with the growing awareness of the magnitude of the growing cancer problem in the developing world, there are substantial challenges (Reeler & Mellstedt, 2006) including insufficient political priority and funding amongst donor agencies and governments that have many competing priorities; fragmented and underfinanced health care systems that have not been set up for chronic disease management; a lack of cancer awareness, knowledge and capacity amongst health workers; and lack of diagnostic and treatment capacity, among others.

The burden of symptoms amongst cancer patients is enormous with very few patients being able to access quality palliative care services. Indeed, in a study carried out in two African countries to determine the symptom prevalence and burden amongst advanced cancer patients (Harding *et al*, 2011), the authors noted that pain and psychological problems were four of the five most common symptoms, found in more than 3 out of 4 patients. The prevalence of symptoms is multidimensional, hence the need for holistic approaches to patient assessment and management.

Following the WHO estimation of need as 1% of a country's total population, (WHO, 2005a) approximately 9.67 million people are in need of palliative care across Africa. However, notwithstanding this great need, current provision of palliative care in Africa is inconsistent and access to culturally appropriate, holistic palliative care is at best limited, and at worst non-existent (Harding & Higginson, 2005). A survey of hospice and palliative care services in Africa found not only that 45% (21/47) of African countries had no identified hospice or palliative care activity, but that only 9% (n = 4) could be classified as having services approaching some measure of integration with mainstream service providers (Clark *et al*, 2007).

What palliative care approaches are suitable in developing countries?

Palliative care is a relatively new concept in many countries in the developing world and it is lacking in most African countries. There are a number of potential approaches that might be suitable in Africa but owing to the paucity of data in this field of care, it is difficult to choose an approach based on evidence. However, the WHO has recommended a *public health strategy (PHS)* as the best approach for establishing and/or integrating palliative care into a country. The public health approach is the science and art of preventing disease, prolonging life, and promoting the health of entire populations through the organized efforts of society (Higginson & Koffman, 2005). In 1990 WHO described the first strategy for the establishment of a palliative care programme – the three pillars of palliative care: (i) government policy, (ii) education and

(iii) availability of medicines (opioids) (World Health Organization, 1990a). Public health strategies must be incorporated by governments into all levels of their health care systems and owned by the community.

Since its operational formation in 2005, the African Palliative Care Association (APCA) has been engaged in advocating for, training in, and conducting research into palliative care on the continent. In this work it has followed the new four-pillar WHO PHS i.e. (i) appropriate policies; (ii) adequate drug availability; (iii) education of policy makers, health care workers, and the public; and (iv) implementation of palliative care services at all levels throughout the society (Stjernswärd *et al*, 2007a). African countries need to ensure that the mechanisms for the four pillars of the WHO PHS are in place as the only way of integrating palliative care in the existing health systems.

Access to pain medicines in low income countries

In its resolution 12/24 on 'Access to medicine in the context of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,' the United Nations Human Rights Council encouraged states to consider including information on the measures taken to promote access to medicines in their national reports to the universal periodic review mechanism (United Nations, 2009). Several of the drugs on the WHO's model list of Essential Medicines, including morphine for pain treatment, are regulated by international drug conventions (WHO, 2007). The importation, manufacture and distribution of these medicines are under exclusive government control. Consequently, if governments do not take steps to ensure access to controlled medications, this can lead to violations of the right to the highest attainable standard of health and potentially amount to cruel, inhuman or degrading treatment.

Morphine is the mainstay medication for treating moderate to severe pain and is inexpensive, safe and effective (Human Rights Watch, 2009). However, access to morphine in low-income countries in Africa still remains painfully inadequate. For example, in 2006, the vast majority of morphine was consumed in industrialized countries, while in Africa the regional mean was only 0.33 mg per capita compared with the global mean of 5.98 mg per capita (International Narcotics Control Board (INCB) (2008).

Pursuant to Economic and Social Council resolution 1989/15, the INCB, in cooperation with the WHO, prepared a special report, entitled 'Demand for and Supply of Opiates for Medical and Scientific Needs' in which the Board stated that there was evidence suggesting that the medical need for opiates, particularly for the treatment of cancer pain, was not being fully met (United Nations, 1989). In this special report, the INCB mentioned a number of factors that, if present in narcotics control laws and health-care systems, could limit availability of narcotic drugs for medical and scientific

purposes and requested every government to conduct an examination to determine if such impediments existed and, if they did, to take corrective action.

In 1995, the INCB conducted a study to evaluate the extent to which the recommendations made in its special report in 1989 had been implemented. In this study the Board found that there were several factors that impede the medical use of opioids including – concerns about addiction to opioids; insufficient training of health-care professionals about opioids; excessively restrictive laws and regulations on manufacture, distribution and prescription of opioids; reluctance to stock opioids because of concerns about theft or robbery, among others, and made recommendations to both governments and the international bodies (INCB, 1996). Since then, some governments have taken steps to improve their annual estimates and to improve access to pain medicines but the improvements may not have led to levels that could be considered adequate, because of low starting levels. Indeed, the 2010 report of the INCB on the availability of internationally controlled drugs concluded that a large number of countries in many regions continue to record inadequate levels of availability of internationally controlled substances, with Africa remaining the region with the largest number of countries recording little or no availability (INCB, 2010).

Actions taken to ensure improved access to opioid analgesics

More than 20 years ago the INCB became aware of inadequate availability of opioids for medical use in the world, being in a singular position to assess consumption in various countries. The INCB together with the WHO, were among the first to issue a warning that availability of narcotic drugs was not ensured in a majority of countries.

The regular analysis of opioid consumption data, and the assessment for medical need in 1989, convinced the INCB and WHO that the level of consumption of opioids particularly for the treatment of pain was very low in a number of countries. Therefore, the INCB published a special report, entitled Availability of Opiates for Medical Needs (International Narcotics Control Board., 1996), with specific recommendations to Governments, the United Nations International Drug Control Programme, the Commission on Narcotic Drugs, WHO, international and regional drug control, health and humanitarian organizations and educational institutions and non-governmental health-care organizations, including the International Association for the Study of Pain, and other health-care representatives. The recommendations of the special report are still valid.

The World Health Assembly, in its resolution WHA58.22 (WHO, 2005b), and the Economic and Social Council, in its resolution 2005/25 (United Nations, 2005), invited WHO and the INCB to examine the feasibility of an assistance mechanism to facilitate the adequate treatment of pain using opioid analgesics.

The WHO Access to Controlled Medications Programme (ACMP), implemented by the WHO in collaboration with its partners and endorsers, supports governments in identifying and overcoming obstacles that hinder the procurement and distribution of controlled medication to help ensure adequate availability of opioid analgesics for pain treatment and opioid dependence. The ACMP addresses all aspects that act as barriers to obtaining controlled medicines for medical treatment including legislative and administrative procedures, as well as knowledge among policy makers, healthcare workers, patients and their families.

The Pain and Policy Studies Group (PPSG), established in 1996 at the University of Wisconsin Comprehensive Cancer Center (now the Paul P. Carbone Comprehensive Cancer Center in the University of Wisconsin School of Medicine and Public Health), has developed methods and resources to assist governments and pain and palliative care groups to examine national policies and make regulatory changes. The PPSG is developing several new resources, including a training programme for Fellows from low- and middle-income countries, enhanced support of collaborators working on opioid availability, an internet course in international pain policy, an improved website with policy resources and country profiles, and new approaches to the study of opioid consumption indicators (Joranson & Ryan, 2007).

The APCA has been engaged in advocating for increased access to pain medicines in Africa since its operational formation in 2005. One of the main activities of APCA in Africa has been advocacy for improved access to pain relieving medicines. Since 2006, APCA and its' partners has organized four regional workshops advocating improved access to pain medication accessibility. These workshops have been held in East and Central Africa, Western Africa, Southern Africa and North Africa. The aims of the workshops were three-fold: (i) improve participants' knowledge of the policies, tools, and infrastructure necessary to make opioids available; (ii) support participants in evaluating their national medicines policies and laws on opioid availability; and (iii) support participants in developing effective pain medication advocacy strategies/action plans. A total of 19 countries have participated in these workshops.

At the end of each workshop, each country team developed an action plan/strategy on how to address the identified challenges impeding access to opioid medications in their country. APCA has been following up on these countries and providing them with technical support as well as small grants to help in the implementation of these strategies. There have been varying degrees of progress in advocacy activities among all the countries that participated; some have moved on fairly well while others have made less progress. There are various factors that have influenced implementation progress in the countries. Kenya, Tanzania, Malawi, Zambia, Ethiopia, Namibia, Swaziland, Cameroon and Ghana have made great progress in ensuring that there is availability of oral morphine in their countries.

APCA advocates for cheap but effective oral liquid morphine that is reconstituted from morphine sulphate powder to an elixir. In describing their experience in pioneering palliative care provision in Africa, Merriman and Harding (2010) examined the steps to achieving wider availability of opioids for pain management for those with far advanced disease. The authors noted that for pain relief to be possible continuously in the home, which is the preferred place to die (Kikule, 2003; Manicom, 2011), morphine needs to be given orally, with the patient and family being in control after they are trained on how to administer the medicine.

APCA has also developed model Guidelines for ensuring patient access to, and safe management of, controlled medicines (APCA, 2010). These guidelines are to be adapted by governments to develop their own guidelines to ensure patients with life-threatening illnesses can access opioid medicines.

Government policy to ensure access to palliative care in developing countries

To effectively integrate palliative care into developing countries there must be appropriate national policies that provide for adequate medicines availability (particularly opioids); education of health care workers and the general public; and culturally appropriate implementation of palliative care services at all levels of society. Governments in developing countries have been encouraged to include palliative care in the National Health Plan, policies, and related regulations as well as to devise a mechanism for funding and/or service delivery models that support palliative care service delivery (Stjernswärd *et al*, 2007b). Unfortunately, most countries in Africa have not yet included palliative care in their national policies or regulations.

Uganda has been a model in ensuring that there is affordable and culturally appropriate palliative care in developing countries. A recent publication (Jagwe & Merriman, 2007) noted that Hospice Africa Uganda introduced palliative medicine to Uganda in 1993 with enough funds to support a team of three clinicians for 3 months. Since then, Uganda has achieved the three essential components of an effective public health strategy – Government policy, availability of palliative care medicines (opioids) and education in palliative care for all. It has also been the first country to have palliative care described as an essential clinical service and included in both the government's Strategic Health Plan and to change the law to allow nurses and clinical officers who complete special training in palliative medicine at Hospice to prescribe oral morphine. Palliative care is spreading throughout the districts of Uganda, as a result of civil society organizations working in collaboration with the Ministry of Health (MOH) in two umbrella organizations: the Palliative Care Association of Uganda and the Uganda Palliative Care Country Team. The country team is chaired by the MOH, and operates with the government to implement an integrated, coordinated,

affordable, and culturally acceptable palliative care service throughout the country.

The Uganda model is an extremely cost effective approach that would enable patients with life threatening illnesses access affordable quality palliative care.

Other countries that have made progress in ensuring that palliative care is integrated into health systems include Rwanda and Swaziland. Rwanda recently (2011) launched their National Palliative Care Policy, and Swaziland will be launching soon. Both countries are advocating for affordable service delivery models and recommend oral morphine, elixir an affordable and effective formulation. Ethiopia is also considering including palliative care in their non-communicable diseases policy and a committee has been set up to spear head an advocacy campaign for inclusion of palliative care in national policies.

Palliative care education

The need for improved educational programmes related to palliative care has never been more evident: there is derisory understanding of palliative medicine for both health care workers and the general public in low-income countries.

In 1990, the WHO report, *Cancer Pain Relief and Palliative Care*, recommended to all its member states that 'Pain relief and palliative care programmes are incorporated into their existing healthcare systems...' One of the recommendations being that 'governments should ensure that healthcare workers are adequately trained in palliative care and the relief of cancer pain' (WHO, 1990b).

For a palliative care education programme to work effectively, it is important to identify national opinion leaders responsible for education, e.g., deans of medical, nursing, pharmacy, and social work schools and to ensure that they are all engaged in the process and willing to change existing educational curricula and courses and develop new ones. The other important aspect is to identify target audiences – the general public, the media, health and allied professionals, spiritual advisors, and patients and their families, who will require education to increase their awareness and change their attitudes, knowledge, and skills related to palliative care. In developing countries, it is particularly important to engage the media and heighten public awareness of the need and benefits of palliative care. To facilitate uptake of palliative care education and highlight its importance, questions on palliative care should be included in undergraduate and postgraduate examinations. Most patients with life-limiting illnesses prefer to be at home and they will primarily receive their care from family members and friends; it is therefore important to develop educational interventions and tools to enhance the knowledge and skills of family caregivers.

Palliative care education in developing countries needs to be concerned with *attitudes, beliefs and values*, which should include topics such as the philosophy and ethics of palliative care; personal attitudes towards cancer, pain, dying, death and

bereavement; illness as a complex state with physical, psychosocial and spiritual dimensions; team-work; and the family as the unit of care. Palliative care education should also emphasize the principles of *effective communication* so as to be able carry out an impeccable holistic patient assessment and development of a management plan. In Africa we have been emphasizing that opportunities should be provided for the application of learned knowledge through practice – role-plays and discussion of real case histories. Palliative medicine needs to be introduced as a formal designated subject within the medical and nursing curriculum. Unfortunately, palliative medicine in Africa has been seen to enter the competition for curriculum space in most medical schools that are already concerned about information overload. However, it is possible to integrate palliative care and this has been seen to work in countries such as Uganda, where education and training were started in two medical schools by delivering palliative care lectures to fourth-year medical students, from 1993 in Makerere University, and from 1998 at Mbarara University of Science and Technology, the second public medical school based in the southwest of the country (Jagwe & Merriman, 2007).

The 2006 *World Health Report* (WHO, 2006b) advocated for increased community participation and the systematic delegation of tasks to less-specialized cadres – task shifting. It has been used in many countries either as a response to emergency needs or as a method to provide adequate care at primary and secondary levels, especially in low resource countries, to enhance quality and reduce costs. The rapidly increasing care needs generated by the HIV/AIDS epidemic, the escalating cancer disease burden and accelerating human resource crises in many African countries have given the concept and practice of task shifting new prominence and urgency. As an example, Uganda passed legislation in 2004 that allows nurses and clinical officers that have undergone a nine months *Clinical Palliative Care Course* (CPCC) to prescribe certain formulations of morphine as a way of shifting the task from doctors who are too few to serve the entire country.

The University of Cape Town School of Public Health and Family Medicine offers Post Graduate Programmes – *Diploma/MPhil*, in Palliative Medicine for experienced doctors who wish to gain expertise in the practical management of patients with non curable and terminal illness as well as some aspects of oncology and HIV care. These programmes are provided on *distance and practice-based learning* techniques which are particularly suitable for palliative care in Africa. The Masters programme is a 2-year coursework-based degree and includes a research component, which may be completed in year 3. This is appropriate to doctors working in palliative care organisations or in family medicine. The Diploma programme is an 18-month course that is designed for general practitioners and hospital medical officers. There are a number of grants available for those applicants who wish to apply for financial assistance.

Makerere University College of Health Sciences, through its affiliated institution Hospice Africa Uganda in partnership with the African Palliative Care Association offers a *Bachelor's Degree in Palliative Care*, which is a 3-year programme. The degree course is specifically designed to be applicable to palliative care in the African setting. Through the use of a distance learning modality, it is open to all those practicing palliative care in Africa, from a range of clinical backgrounds. The overall objective of this course is to produce graduates from across sub-Saharan Africa who possess the skills necessary to develop and manage palliative care services appropriate to their country situations as well as to lead the development and running of appropriate training, evaluation and advocacy programmes. These are some of the examples of training programmes that are possible for adaptation into other countries in Africa to ensure that palliative care education is instituted for all.

Approaches for implementation of palliative care service delivery

Palliative care services in developing countries need to be delivered in a way that meets the cultural, spiritual and economic needs of the people (Merriman, 1999). The WHO public health model recommends that, when considering starting a palliative care service, it is important to start by identifying organizations that have the potential to become centres of excellence in palliative care, the patient population they are caring for, and to engage with community, clinical, and administrative leaders to help them to identify the need for palliative care for their patients and families (Stjernswärd *et al*, 2007a,b). In order to provide palliative care for all, it needs to be integrated in the existing health infrastructure into all levels of society – from community level upwards to the tertiary level and downward to the community. There must be funding and service delivery models in place that provide the financial and manpower resources and the service structure needed to support the delivery of effective palliative care services throughout the country (Stjernswärd *et al*, 2007b).

Various factors would influence the place of care, including patient's choice as well as resources availability. A study to determine the place of death and its predictors among palliative care patients with cancer concluded that the place of death is influenced by the socio-demographic characteristics of patients, the characteristics of their caregivers, and health service factors (Masucci *et al*, 2010).

Home-based care (HBC) has been the most common service model in Africa, because it is cheap and, most of the time, acceptable to the patient and family, as well as respecting their cultural practices (Jagwe & Barnard, 2002; Merriman, 2002). Various models are included within the HBC model; indeed, a review by APCA (*unpublished observations*), which aimed to establish the type and level of services needed in order to make recommendations for palliative care integration and determine the development of palliative care standards suitable for all

levels of service delivery, identified seven models of HBC: Community HBC (CHBC); Integrated community-based home care (ICHC); Hospice care with HBC services; Hospital-supported HBC services; Outreach services that include HBC; Government District Level HBC services; and Home Visiting. CHBC and ICHC were the two models with greatest opportunity for palliative care integration. The best practice model was judged to be ICHC followed by CHBC.

The in-patient model where patients are admitted at a Hospice is available in some countries, including Zambia, but this is not seen as an appropriate model because it is relatively expensive. Other good models of care include outpatient clinics and day care where patients visit a palliative care facility for services. Hospital-based palliative care programmes are another way of extending palliative care services to those in need. This is an affordable model as it takes advantage of sharing the resources within the hospital. The hospital team then liaises with a HBC team to ensure continuity of care for patients.

Another model is the Hospital outreach services; this model has the potential to avert hospital admissions in generally overcrowded services in low-resource settings and may improve the quality of life of patients in their home environments (Hongoro & Dinat, 2011).

Regardless of the model of service delivery, it is important that palliative care is implemented in a standardized way. APCA has developed evidence-based palliative care standards so as to address issues concerning the definition of palliative care, maintenance of quality care, and to define an absolute minimum package for palliative care. These standards are currently available only at APCA (info@africanpalliativecare.org) but APCA encourages providers at all levels of service delivery to adopt them so as to ensure quality care for their patients.

Coverage is a key indicator for all community-based, public-health programmes and, to ensure coverage in palliative care service delivery, there is a need for training across all levels including the community as well as developing simple guidelines that offer protocol-led instructions for both clinical and lay assessment, treatment, prevention, and care (WHO, 2003).

In summary, for successful palliative care service implementation, and as has been previously noted (Harding & Higginson, 2005), it is important to understand the capacity and needs of the community to expand sustainable care. Community and home care services seem to be working well for many projects in Africa, but the successes are poorly described and disseminated. Patients should be able to access the essential palliative care medicines, including oral opioids for pain control, from anywhere, including their homes.

Conclusions and recommendations

Palliative care in developing countries has a special role during the disease trajectory for both cancer and non-cancer patients and their families. There are a number of challenges

including lack of government policies, education, and access to essential medicines (particularly opioids), that still make access to palliative care almost impossible despite the need. However, there are demonstrated approaches that are appropriate in advancing palliative care in developing countries, and in Africa the APCA is taking a strategic lead in ensuring that, through the WHO public health strategy, there is access to palliative care for all. At the country level, however, it is acknowledged that situations including traditions and cultural attitudes may differ widely as well as the frameworks of the existing health care services into which palliative care services must fit. HBC is by and large the best way of achieving good quality care and coverage in low-income countries with strong family support but a poor health infrastructure.

We recommend that irrespective of resources, all countries need to implement comprehensive palliative care programmes with the purpose of improving the quality of life of patients with life-threatening illnesses, and their families through a multi-sector-wide approach. Governments need to ensure that

there are mechanisms for providing pain relief and holistic symptom management, as well as promotion of awareness among the public and health professionals. Governments need to further examine their medicines control policies to make sure that there are provisions that are overly restrictive to impact access to opioids (oral morphine) for pain control. The *APCA palliative care standards* could be adopted in Africa and other low income countries, to ensure that minimum standards for pain relief and palliative care are progressively adopted at all levels of care in targeted areas, and that there is high coverage of patients through services provided mainly by home-based care.

Multi-national pharmaceutical companies could support cancer treatment in Africa by providing new drugs free of charge to poorer countries, as has been seen with the Glivec International Patient Assistance Program for patients with chronic myeloid leukaemia (CanTreat International, 2010).

Access to novel anti cancer drugs would greatly improve the quality of life for patients with cancers such as acute leukaemia and lymphoma in Africa.

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