
African Palliative Care Association
APCA
Relieving Pain and Suffering

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Hitting Global Targets: Building National Capacity for cancer and NCD control

Creating Regional Guidelines for Pain Control

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The presentation

- Why regional guidelines for Pain control?
- The reality
- The gaps for integration and advocacy for Palliative care & pain control in management of NCDs
- The UN NCD High Level Meeting and Advocacy for Pain Relief at National level
- Best practices in Pain Control Advocacy
- Suggestions

Why guidelines for Pain control?

- Ensure alignment and consistence with WHO guidelines
- Quality' equity - standard practices while retaining local context
- Protection of the patients and care providers
- Informing training and clinical modeling of service providers
- Inform advocacy & awareness for policy makers and other key stakeholders – political commitment
- The burden of disease & pain in Africa
- Limited capacity for prevention, early diagnosis & treatment of cancer & other NCDs

The burden of cancer & other NCDs in Africa: Implication for Pain control

- Pain highly prevalent in Ca affecting 9m people each year
- 75% of people with advanced & terminal disease will suffer pain (Goudas, Carr, 2001)
- Made worse by increasing HIV and aging population;
- Improved life expectancy draws Africa towards more cancer burden, yet cancer care is very poor in all Sub-Saharan Africa.
- Inadequate capacity of health care systems, traditional beliefs & myths either delay or prevent early disease diagnosis

The burden of HIV

- HIV contributes to a large number of people needing palliative care currently in Africa
- The highest HIV prevalence countries are in Africa (Uganda 7%, SADC >10%, etc
- A very big paediatric HIV population- over10% in most SSA countries

The burden of pain in HIV

- With CD4 >500 this is about 30% but goes up to over 75% in those with CD4 < 200 (WHO 2006)

- Prevalence of pain Pre-HAART (Highly Active Antiretroviral Therapy)
  - Estimates vary between 53%-97% (Schofferman, 1998; Singh, Fermie & Peters, 1992; Breitbart *et al*, 1996)

- Prevalence Post-HAART
  - Estimate of 30% (Newshan, Bennett, Holman, 2000)

The interplay between HIV, cancer, other NCDs & aging

- HIV increases the risk for some cancers
- Aging increases the risk of some types of cancer
- ARVs have increased survival but not the need for palliative care in the long run
- Survival and longevity increases risks of many cancers, NCDs and need for PC that includes pain control

The reality

- NCDs currently a leading global cause of death worldwide
- Of 57m death in 2008 globally, 36m (2/3) were due to NCDs
- Combined burden of cardiovascular diseases, cancers, diabetes & chronic lung diseases rapidly increasing in lower income areas

(WHO, 2012)

- Unpublished study in Uganda (Mulago PC Unit) showing 311 patients per month with end-stage 4 heart failure

Concerns for Palliative care

- Who are the 36m people who die of NCDs annually?
- Do they have Palliative care needs? Are these met?
- How many PC patients have a multiplity of NCDs
- How do they navigate the health systems to access care along the continuum of care?
- What happens to their pain and symptoms?
- How do they die?
- What happens to their families?

The gaps

"In 2007, six developed countries reported the highest level of morphine consumption and 132 of 160 signatory countries that reported consumption were below the global mean. This implies that millions of patients with moderate to severe pain caused by different diseases and conditions are not getting treatment to alleviate their suffering"

WHO (2011)

The gaps

- PC & pain control not included in NCD strategies/ plans & management
- Access to pain medications:

  - Non-availabiltiy, stock-outs, costs
  - lack of awareness at all levels - ignorance
  - Health care providers focusing on side effects rather than the benefits of opioids – myths and fears, penalties etc
  - limited prescriber base
  - small quotas compared to need
  - Availability of opioids at community level
  - No manufacturer in Africa, limited suppliers

The gaps

- Lack of policy/guidelines on use of opioids and national PC policy
- Scattered disease specific legislation, policies, guidelines etc
- Limited intentional integration & linkages between NCD management and other health interventions such as PC
- Lack of quality data on cancer and other NCDs
- Other medications not widely available – chemotherapy, radiation etc
- Medications such as ARVs & chemotherapy causing pain which is not addressed

General statistics for Rwanda

	HIV/AIDS	MDR/XDR TB	CANCER	NCDS
Total population affected by:	220980	since 2005 up to now, **532** MDR-TB patients initiated second line anti TB drug	Unknown	Unknown
National prevalence	3% DHS	TB drug resistance survey done in 2005, MDR-TB is prevalent at **3.9%** of new sputum smear positives and at **9.4%** of retreatment cases	Unknown	Unknown

Dr Rosette Nahimana, Head of Non Communicable Division/RBC, Aug 2012

General statistics for Rwanda

	HIV/AIDS	MDR/XDR TB	CANCER	NCDS
Percentage of men affected	43% (90,399)	in year 2011, 55 cases were male: **64.7%**	Unknown	Unknown
Percentage of women affected	57% (119,795)	in year 2011, 30 cases were female: **35.3%**	Unknown	Unknown
Percentage of children affected	4.9% (10786)	**2.4%.**	Unknown	Unknown

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General Statistics for Swaziland

	HIV/AIDS	MDR/XDR TB	NCDS (including cancers)
Total population affected by:	90223	1287/100 000	36686
National prevalence	19% (DHS)	84%	39%
Percentage of men affected	31%(DHS)		
Percentage of women affected	20%(DHS)		
Percentage of children affected			

The UN NCD High Level Meeting and Advocacy for Pain Relief at National level

- Pain control considered a priority in more national health strategies & development plans
- Countries adopting morphine –equivalent of consumption of strong opioid analgesics as a core indicator for access to PC
- Leadership from Directorates of NCDs on PC e.g. Rwanda, TZ
- Development of position papers, national strategies, more integration of NCDs in PC work
- PC leaders engaging in advocacy for integration in NCDs – side event at the World Health Assembly, Africa Regional Advocacy meeting etc
- Involvement of PC players within NCD planning

Progress/some best practices

- Use of WHO guidelines on Pain control
- Regional guidelines - Africa:

  - Guidelines for Ensuring Patient Access to, and Safe Management of, Controlled Medicine
  - Using Opioids to Manage Pain: A Pocket Guide for Health Professionals in Africa
  - Beating Pain: A Pocket Guide for Pain Management in Africa
- National Palliative care policies, guidelines & standards (i.e. Rwanda, Swaziland, Uganda, Malawi, Kenya, Tanzania, Ethiopia, Mozambique)
- National guidelines on the use of Class A drugs - Uganda
- National Cancer strategies (i.e. Kenya, Rwanda etc)
- National NCD strategies (i.e. Rwanda, Kenya, Swaziland, TZ


African Palliative Care Association
Guidelines for Ensuring Patient Access to, and Safe Management of, Controlled Medicines
A Pocket Guide
USAID
AIDSTAR-One

Progress/some best practices

- Public/private partnerships in making pain control medications available – Uganda, Kenya etc
- Governments taking responsibility for availability and access to pain medications - Uganda
- Revising prescription laws to increase prescriber base – task shift ing – nurses prescribing opioids in Uganda
- NCDs included in Health Sector strategic & investment plan with QOL for terminally ill and families as critical intervention – (*Uganda Health Sector Strategic &Investment Plan 2010/11-2014/15)*
- Pain control as a human rights issue

Progress/some best practices

- Inclusion of pain medications on national essential medicines list – Uganda, Malawi, Rwanda, Swaziland etc
- PC and pain control a component of essential clinical services/ minimum health care package - Uganda
- More intentional integration of PC and pain control in national health systems to lowest level
- Development & use of hospital protocols on pain and symptom control – Uganda
- Hospital PC & pain control teams
- Country PC & Pain control advocacy teams/task forces
- More voices on Pain control APCA, ICPCN, NAs, partners from the North

Policy framework for Rwanda

Document	Yes	No
National Palliative Care ***Guidelines****?*	X	
Stand-alone palliative care ***Policy?***	X	
National Palliative Care ***Strategy****?*	X	
National HIV/AIDS Strategy containing *explicit* reference to palliative care provision?	X	
National Cancer strategy containing *explicit* reference to palliative care provision ?	X(under developpment)	
National opioids guidelines?	X	
Any other relevant policy that explicitly includes or supports opioid use in palliative care palliative care?	X	

Policy Frameworks for Swaziland

Document	Yes	No
National Palliative Care ***Guidelines***?	x	
Stand-alone palliative care ***Policy?***	x	
National Palliative Care ***Strategy***?	x	
National HIV/AIDS Strategy containing *explicit* reference to palliative care provision?	x	
National Cancer strategy containing *explicit* reference to palliative care provision ?		x
National opioids guidelines?		x
Any other relevant policy that explicitly includes or supports opioid use in palliative care palliative care?	x	

Some suggestions

- National population based policies on PC & Pain control & inclusion of NCDs in relevant policies, strategies, plans
- PC and pain control an integral part of NCD planning and management, multisectral approach
- Integration & linkages of NCD management & other responses e.g. HIV and AIDS
- More research and evidence to support prevalence & priotisation of PC, pain control & NCDs and models of service delivery
- Continued advocacy at all levels of health system
- Potential for quality data on NCDs through Palliative care e.g. mortality at facility & community level
- Collaboration & partnerships e.g. traditional healers
- Forming regional coalitions on Pain control

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