Special Article

Vietnam: Integrating Palliative Care Into HIV/AIDS and Cancer Care

Eric L. Krakauer, MD, PhD, Nguyen Thi Minh Ngoc, MD, Kimberly Green, MA, Le Van Kham, MD, MA, and Luong Ngoc Khue, MD, MPH, PhD
Harvard Medical School Center for Palliative Care and Vietnam-CDC-Harvard Medical School AIDS Partnership (E.L.K.), Boston, Massachusetts, USA; and U.S. Agency for International Development (N.T.M.N.), Hanoi; Family Health International (K.G.), Hanoi; and Department of Therapy (L.V.K., L.N.K.), Ministry of Health, Hanoi, Vietnam

Abstract
Vietnam is struggling to meet the growing need for both disease-modifying and palliative care for people with life-threatening chronic diseases such as HIV/AIDS and cancer. Recently, Vietnam initiated rapid development of a national palliative care program for HIV/AIDS and cancer patients that builds on existing palliative care programs and experience and integrates palliative care into standard HIV/AIDS and cancer care. National palliative care guidelines have been issued by the Ministry of Health based on a rapid situation analysis. Plans now call for review and revision of opioid laws and regulations to increase availability of opioids for medical use, training in palliative care for clinicians throughout the country, and development of palliative care programs both in the community and in inpatient referral centers.

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Palliative care, AIDS, cancer, Vietnam, developing country, opioids

Background
Vietnam, a developing country of over 84 million people, has for decades had health indices that are much better than that predicted by its economic status.1 This is due in large measure to Vietnam’s vast health care system, which reaches from the national to the communal level, and to national health programs that have provided free childhood immunizations and free treatment for diseases such as tuberculosis and malaria.2 Yet new health care challenges have arisen since the nation embarked on a process of political and economic liberalization (Doi Moi) in 1986.3 With the increasing privatization of the health care sector and the existence since 1989 of user fees, many cannot afford health care.4,5 In addition, an HIV/AIDS epidemic developed in the mid-1990s, driven largely by an epidemic of intravenous heroin

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Address reprint requests to: Eric L. Krakauer, MD, PhD, Center for Palliative Care, Harvard Medical School, 641 Huntington Avenue, Boston, MA 02115, USA. E-mail: ekrakauer@partners.org

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dependence. An estimated 263,000 Vietnamese had been infected with HIV as of December 31, 2005, resulting in an adult prevalence of 0.5%. An estimated 25,000 people were in need of antiretroviral (ARV) medication by the end of 2005, but only about 3,000 were receiving it. AIDS deaths are increasing rapidly as those infected years ago develop advanced AIDS. An estimated 14,000 Vietnamese died of AIDS in 2005, an increase of 55% from 2003.6 AIDS is now Vietnam’s second most common cause of hospital death.1

Cancer appears to be a growing problem as well. In 2006, cancer diagnoses numbered approximately 200,000 and cancer deaths 70,000, as of September 30.7 As is the case with HIV disease, cancer usually is diagnosed at a late stage. Vietnam lacks adequate cancer treatment facilities, and a National Cancer Control Program is still in preparation.8

Early Palliative Care Programs

Vietnam’s first and largest palliative care program was founded at the National Cancer Institute in Hanoi in 2001. It has 35 inpatient beds and an outpatient clinic. More recently, smaller inpatient palliative care wards for cancer patients were established at Cho Ray Hospital in Ho Chi Minh City and Hue Central Hospital. Vietnam’s first AIDS hospice was established near Ho Chi Minh City in 2001 by the Daughters of Charity of St. Vincent de Paul, with support from the Catholic Archdiocese and the People’s AIDS Committee of Ho Chi Minh City and from international donors. In some locations, communal health centers, self-help groups, faith-based organizations, and other nongovernmental organizations (NGOs) have developed limited community- and home-based support services for advanced cancer and AIDS patients. The nation’s only pain clinic was founded at Trung Vuong Hospital in Ho Chi Minh City in 1997, with support from a foreign drug company. Since foreign support was withdrawn in 2000, the clinic has continued operating with minimal resources.

National Palliative Care Strategy

Efforts to promote palliative care in Vietnam were greatly strengthened in 2004 when it became the 15th country to receive support from the $15 billion United States Leadership against Global HIV/AIDS, Tuberculosis, and Malaria Act of 2003 (commonly known as the “President’s Emergency Plan for AIDS Relief” or PEPFAR), which earmarked funds specifically for palliative care.9 At the request of the Ministry of Health, a palliative care working group was convened in 2005, chaired by the Director of the Ministry’s Therapy Department and consisting of Ministry and PEPFAR officials, physicians from Vietnam’s national cancer and infectious disease hospitals, and experts in palliative care, community-based care, and health care policy from PEPFAR-funded NGOs. Initial plans called for a palliative care rapid situation analysis (RSA) to assess the availability of and need for palliative care in Vietnam and development of national palliative care guidelines based on the findings of the RSA.

Palliative Care RSA

The objectives of the RSA were:

- To describe the range of palliative care services available in Vietnam.
- To identify unmet palliative care needs among people with HIV/AIDS and cancer and their family/household caregivers.
- To evaluate palliative care knowledge, attitudes, and training needs of health care workers at national, provincial, district, and communal levels.
- To evaluate the need for palliative medications and supplies at all levels.
- To learn opinions of national and provincial leaders about palliative care and availability of opioid analgesics.
- To assemble and review existing laws and regulations governing palliative care.
- To assemble and review existing laws and regulations governing opioid availability and use for medical purposes and to evaluate current patterns of opioid analgesic use.
- To provide a knowledge base for development of national palliative care guidelines.10

Surveys were developed to interview each of the following categories of informant: people living with HIV/AIDS or cancer, family
Caregivers of people living with advanced AIDS or cancer, bereaved family caregivers of deceased AIDS or cancer patients, health care workers who care for people with HIV/AIDS or cancer, managers of programs that provide some type of palliative care service for people with HIV/AIDS or cancer, national and provincial health care leaders, and national and provincial health care policy makers. Tools also were developed for the review of laws and regulations. Palliative care surveys from other countries and international organizations were consulted to develop the Vietnam surveys. Caregivers of people living with advanced AIDS or cancer, bereaved family caregivers of deceased AIDS or cancer patients, health care workers who care for people with HIV/AIDS or cancer, managers of programs that provide some type of palliative care service for people with HIV/AIDS or cancer, national and provincial health care leaders, and national and provincial health care policy makers. Tools also were developed for the review of laws and regulations. Palliative care surveys from other countries and international organizations were consulted to develop the Vietnam surveys.11–13

Five provinces were chosen for the RSA. Provinces were selected to achieve a balance of northern and southern provinces and of urban and rural areas and to include areas with the highest prevalence of HIV infection. Inclusion of Vietnam’s three largest cities permitted interviews with health care leaders from Vietnam’s major HIV and cancer centers, and with key national and provincial policy makers. Interviews were performed by two study teams, one for northern and one for southern provinces. Each survey team consisted of physician and nurse investigators, as well as members of HIV/AIDS peer support groups. Each team was led by an official from the Ministry of Health Therapy Department and received technical assistance from international advisors from Family Health International and Harvard Medical School. Funding for the RSA was provided by PEPFAR.

The principal results of the RSA were as follows:10

1) Severe chronic pain is common among cancer and HIV/AIDS patients.
2) Availability of opioid analgesics and other essential palliative medications is severely limited. Only 5% of health care workers reported availability of oral morphine in their institutions, and parenteral morphine, though more available, is rarely used.
3) Only a few health care centers, most of them major cancer centers, provide palliative care to more than 60 patients per year. At these centers, the cost of palliative care services makes them largely inaccessible to the poor. Thus, palliative care is not readily available to the vast majority of Vietnamese.
4) Clinicians lack adequate training in palliative care.
5) Psychosocial supports for HIV/AIDS and cancer patients and their family caregivers are badly needed.
6) The majority of health care workers surveyed supported prescription of oral morphine for use at home.
7) The overwhelming majority of health care policy makers recognize the need for greater availability of pain control and palliative care for HIV/AIDS and cancer patients.

Based on these findings, and following World Health Organization (WHO) suggestions for development of national palliative care programs,14 key recommendations were:

1) Develop and disseminate national palliative care guidelines.
2) Develop and disseminate a national opioid control policy that achieves a balance between maximizing availability of opioids for medical use and minimizing risk of diversion of opioids for illicit purposes.12
3) Improve and expand palliative care training for physicians, nurses, pharmacists, social workers, and psychologists. Establish certification programs in palliative care.
4) Improve the availability and quality of palliative care services at national, provincial, district, and community levels.10

National Palliative Care Guidelines

In August 2005, the Minister of Health appointed a Project Committee on Development of National Palliative Care Guidelines. Funding for development of the guidelines was provided by PEPFAR and included compensation for three of the authors (ELK, NTMN, KG) to provide technical assistance to the writing committee. Existing palliative care guidelines were consulted.15,16 Care was taken to ensure that the guidelines were relevant to local needs and culture and consistent with current or expected medication availability. The Guidelines on Palliative Care for Cancer and AIDS Patients were issued by the Minister of Health in September 2006.
The guidelines begin with an introductory chapter on basic medical and ethical principles of palliative care and on approach to the palliative care patient. The largest chapter covers pain and other symptoms and psychosocial support. The first section addresses pain classification, assessment, and treatment in cancer and HIV/AIDS patients, including those with a history of opioid dependence. The WHO three-step pain ladder is presented, and proper dosing and possible side effects of nonopioid, opioid, and adjuvant analgesics are presented in table format. The section on other symptoms emphasizes differential diagnosis and recommends treatment based on the most likely cause of the symptom. Guidance is provided for treatment both in medical facilities and in the home following the format of the WHO guidelines on palliative care in the integrated management of adolescent and adult illness. The psychosocial support section provides guidance in assessing and responding to psychosocial needs and preventing caregiver burnout. A chapter devoted to palliative care for patients receiving ARV therapy focuses on adherence support and control of adverse effects of ARV therapy. Another chapter focuses on palliative care for cancer patients receiving radiation therapy, chemotherapy, or cancer surgery. The chapter on pediatric palliative care outlines the developmental stages of childhood and the special needs of ill and grieving children at each stage. It also provides pediatric dosing for palliative medications. The final chapter reviews care of the actively dying patient and bereavement care. An annex provides guidance on safe handling and storage of opioid medications and includes a sample opioid contract for use with patients with a history of opioid dependence or misuse. Other annexes address HIV prevention and infection control and traditional medicines in palliative care.

National Opioid Policy

According to the International Narcotics Control Board (INCB), Vietnam’s per capita morphine consumption in 2004 was 0.1 mg (compared with 115.7 mg in Austria), and Vietnam ranked 122nd in morphine consumption out of 155 countries reporting to the INCB. Opioid analgesics are not readily available in Vietnam. Yet Vietnam is estimated to have over 150,000 injecting drug users dependent on illicit heroin. In light of both problems, Vietnam’s Ministry of Health recognized the need to carefully review its laws and regulations governing opioid availability for medical use and to seek ways to greatly increase opioid availability for medical use while minimizing the risk of diversion. It recognized in particular the need to increase the availability of oral and parenteral morphine to treat pain and of methadone for substitution therapy for patients with a history of opioid dependence or misuse.

In summer 2006, work began to assemble all laws and regulations relevant to opioid availability. Supported in part by a two-year International Pain Policy Fellowship for a senior pharmaceutical expert from the Ministry of Health’s Therapy Department, awarded by the Open Society Institute and the University of Wisconsin Cancer Center’s Pain and Policy Studies Group, and with technical assistance from members of the Fellowship’s International Expert Collaboration, the Therapy Department will analyze these documents and propose revisions aimed at achieving a coherent national opioid policy that safely and responsibly improves opioid availability. Workshops have been proposed for all ministries and government agencies with a stake in opioid policy to discuss possible revisions.

Palliative Care Clinical Training and Certification

Extensive nationwide training in palliative care is being planned. In spring 2007, the Ministry of Health and National Institute for Infectious and Tropical Disease will hold palliative care train-the-trainers conferences for physician-leaders in HIV/AIDS and cancer in partnership with the National Cancer Institute and with palliative care experts from the Vietnam-CDC-Harvard Medical School AIDS Partnership and the Harvard Medical School Center for Palliative Care. All participants will be trained not only to provide palliative care following the new national Guidelines but also to use the Vietnamese-language curricular materials to train others in their home institutions and provinces. The syllabus
is being designed in the format of a concise clinical manual.

Plans also are being formulated for fellowship programs in palliative care for both nurses and physicians that will provide intensive training in palliative care for one to three months and lead to nationally recognized certification in palliative care.

Establishment and Scale-Up of Clinical Palliative Care Programs

Participants in palliative care training programs will be chosen from institutions and provinces deemed by the Ministry of Health to be most in need of palliative care. Participants from each institution or province will be asked to formulate a plan for implementation of palliative care. Later meetings have been proposed where previous trainees could meet to share successes as well as barriers to implementing palliative care programs. Particular foci for integration or scale-up of palliative care programs are cancer centers, existing HIV outpatient and home-based services, and AIDS palliative care centers under development in major cities. Plans call for the latter to provide comprehensive HIV/AIDS care including ARV therapy, prevention and treatment of opportunistic infections, and palliative care and thereby to overcome the “false dichotomy between ARV therapy and palliative care.”

Conclusions

Since 2005, Vietnam has moved quickly to develop and implement a national palliative care strategy for patients with HIV/AIDS, cancer, or pain of any cause. These developments were possible because of strong leadership by the Ministry of Health and its leaders in clinical HIV/AIDS and cancer care, as well as international financial and technical support. A rapid situation analysis of palliative care services and needs and national palliative care guidelines based on the situation analysis were completed within two years. Work is under way to safely and responsibly improve availability of opioid analgesics, to develop a cadre of certified palliative care providers nationwide, and to integrate palliative care into standard HIV/AIDS and cancer care.

References


