Palliative Care in Vietnam: Long-Term Partnerships Yield Increasing Access

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Abstract
Palliative care began in Vietnam in 2001, but steady growth in palliative care services and education commenced several years later when partnerships for ongoing training and technical assistance by committed experts were created with the Ministry of Health, major public hospitals, and medical universities. An empirical analysis of palliative care need by the Ministry of Health in 2006 was followed by national palliative care clinical guidelines, initiation of clinical training for physicians and nurses, and revision of opioid prescribing regulations. As advanced and specialist training programs in palliative care became available, graduates of these programs began helping to establish palliative care services in their hospitals. However, community-based palliative care is not covered by government health insurance and thus is almost completely unavailable. Work is underway to test the hypothesis that insurance coverage of palliative home care not only can improve patient outcomes but also provide financial risk protection for patients’ families and reduce costs for the health care system by decreasing hospital admissions near the end of life. A national palliative care policy and strategic plan are needed to maintain progress toward universally accessible cost-effective palliative care services. J Pain Symptom Manage 2018;55:S92–S95. © 2017 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.

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Vietnam, palliative care, pain, global health, cancer

Background
Vietnam, a rapidly developing low-middle income country, has a population of 95 million. In 2012, there were 520,000 deaths including 113,000 from stroke, 92,000 from malignant neoplasms (liver and lung cancer were the most common), 55,000 from injuries, 45,000 from infectious diseases (tuberculosis and HIV/AIDS were the most common), 37,000 from ischemic heart disease, and 26,000 from chronic obstructive pulmonary disease. The first palliative care unit in Vietnam opened in 2001. Further development of palliative care began four years later when Vietnam was chosen to receive support from the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR). In 2005, the Vietnam Ministry of Health (MoH) convened a Palliative Care Working Group (PCWG) that included a foreign palliative medicine specialist from Harvard Medical School with...
Policy

In 2005, Vietnam had no specific palliative care policy and no other health care policy that mentioned palliative care. However, the PCWG decided that advocating for creation of a national policy on palliative care or inclusion of palliative care in other national policies might take years. Although national policies on palliative care are crucial for long-term scale-up, the PCWG decided that national clinical guidelines on palliative care that could be drafted with expert foreign assistance and approved by the MoH within months would demonstrate endorsement of palliative care by the government while also enabling and guiding the implementation of palliative care training and services. Funding for the guidelines was provided by PEPFAR, but PEPFAR and MoH officials agreed with the proposal of the PCWG that the guidelines should address palliative care not only for patients with HIV/AIDS but also with cancer. The MoH Guidelines on Palliative Care for Cancer and HIV/AIDS patients were issued by the MoH in 2006.2,6

Opioid Accessibility

The PCWG was aware that training courses for physicians in palliative care would have limited value unless oral immediate-release morphine, the most essential of essential palliative medicines, was available for medical uses such as pain control. Yet the sociohistorical context of opioids in Vietnam and resultant fear of opioids presented challenges to opioid accessibility. Opium had been forcibly sold to the Vietnamese by the French colonialists as means of revenue generation and social control.7 During the Indochina wars in the 1950s, 1960s, and 1970s, foreign and South Vietnamese officials arranged importation and distribution of opium and heroin either to fund covert military operations or for personal profit, and many foreign and Vietnamese soldiers developed dependence.7 In recent decades, unsafe heroin injection has been the main cause of the HIV/AIDS epidemic in Vietnam.8 As a result, opioids came to be regarded as a social evil. Few physicians had permission to prescribe morphine or other strong opioids, those who had permission feared prescribing it, pharmacists did not stock it, and patients feared taking it. A concerted and sustained effort was needed to counteract this pervasive opiophobia and to make morphine safely accessible by anyone in need.

This effort began in 2006 when two MoH officials participated in the International Pain Policy Fellowship offered by the Pain & Policy Studies Group at the University of Wisconsin, U.S. Working with expert mentors, they identified all passages in Vietnamese laws and regulations that were inconsistent with the WHO concept of balance.9,10 They then drafted an Action Plan for making opioids safely accessible and vetted it with key stakeholders, including officials of the United Nations Office of Drugs and Crime, WHO, and the Vietnam Ministry of Police. The plan called for revision of the MoH opioid prescribing regulations, increased domestic production and importation of morphine, and education in palliative care for physicians, nurses, and health care officials. Within one year, the MoH issued two regulations to improve accessibility of opioids for medical uses: Vietnam’s first ever Guidelines for Methadone Substitution Therapy for treating opioid use disorder,11 and greatly liberalized opioid prescribing regulations for treating pain that approximate international standards.10 Dose limits were eliminated, the maximum prescription period for patients with cancer or HIV/AIDS was extended from seven to 30 days, and oral morphine was to be made accessible in every district. However, the latter goal remains aspirational at present, and physicians must have permission from their hospital, department, or clinic leader to prescribe morphine for outpatients. Morphine for injection and morphine 30 mg immediate-release capsules are manufactured in Vietnam. Clinicians train patients and their family caregivers to dissolve the capsule’s contents in water to enable appropriate dosing.

Education/Training

While working on making opioid pain medicines more accessible, the MoH also collaborated with the Harvard Medical School Center for Palliative Care to develop and implement basic, advanced, and specialist training in palliative care for physicians as well as
training for nurses and health care officials. To date, well more than 1000 physicians from major hospitals and cancer centers throughout the country have been trained with the basic curriculum. This curriculum has been adapted for use in Africa, Latin America, and the former Soviet Union, and translated into Vietnamese, French, and Russian. The Asia Pacific Hospice Palliative Care Network also provided training at two major hospitals, and three Vietnamese physicians participated in the Open Society Foundation International Palliative Care Initiative’s International Leadership Development Program in San Diego, CA, U.S. As much as possible, opioid availability in Vietnam was coordinated with training of clinicians so as to avoid trainee frustration from hearing about medicines that are not available or medicines expiring on the shelves because clinicians have not been taught to use them. Although short-term courses in palliative care are necessary to introduce basic concepts, we have found that physicians are most likely to prescribe opioids according to national and international guidelines when they receive long-term clinical mentoring. Among the 25 graduates of the four-month specialist training program in palliative medicine since 2008, several have established palliative care services at their home institutions.

In recent years, the University of Medicine & Pharmacy at Ho Chi Minh City has taken a leading role in palliative care education with technical assistance from the Harvard Medical School Center for Palliative Care. A 35 hours course in palliative care now is required for all its specialist trainees in internal medicine, family medicine, oncology, hematology, infectious disease, geriatrics, and pediatrics. Longitudinal training in palliative care is included in the newly revised curriculum for medical students. A curriculum in palliative care nursing is currently under development. The university is drafting plans to open an academic department of palliative care that will be one of the first in a low-income or low-middle income country.

**Implementation**

Palliative care services in Vietnam have been implemented mostly at major cancer centers and general hospitals. The first inpatient and outpatient services opened at the National Cancer Hospital in Hanoi in 2001, and an inpatient unit opened shortly thereafter at Cho Ray Hospital in Ho Chi Minh City. Further development of palliative care services was catalyzed by partnerships between the MoH, major public hospitals, and foreign experts. In 2011, the Ho Chi Minh City Oncology Hospital opened a Department of Palliative Care that soon included inpatient, outpatient, and home care services for adults and children. Since then, the department has hosted several palliative care training courses each year, and it provides practical training in palliative care for all medical students during their oncology rotation and for all specialist trainees in oncology. These achievements resulted in the hospital’s accreditation by the European Society for Medical Oncology as an European Society for Medical Oncology Center of Integrated Oncology and Palliative Care.

Graduates of the four-month specialist training program in palliative medicine, first held in 2008 in Hanoi and from 2011 to 2014 at the Ho Chi Minh City Oncology Hospital, have helped establish palliative care services at several major hospitals in Ho Chi Minh City and Hanoi. For example, palliative care services for people living with HIV/AIDS were created at Bach Mai National Hospital in Hanoi, and the University Medical Center at Ho Chi Minh City has opened a Department of Palliative Care and Geriatrics. Some palliative care services also are available at hospitals in Danang, Hue, Haiphong, and other cities.

**Research**

In 2006, a study at the National Cancer Hospital in Hanoi revealed a high prevalence of inadequately treated or untreated pain. The same year, the MoH study of the palliative care situation in Vietnam revealed a high prevalence of unrelieved pain and other physical and psychological symptoms and a great need for training. Since then, several palliative care-related studies have begun, funded by grants to the Harvard Medical School Center for Palliative Care, that are designed to further elucidate and measure care and training needs and to inform strategic planning. These include a validation study of a Vietnamese version of the Palliative Outcomes Scale; a study of the palliative care-related knowledge, attitudes, and practices of Vietnamese physicians before and after the basic course in palliative medicine; and an extended cost-effectiveness study of palliative home care.

**Challenges and Future Directions**

In Vietnam, as in most LMICs, most patients in need of palliative care are at home. Yet almost all palliative care services currently available in Vietnam are hospital-based. Community-based palliative care, including home care, can only be scaled up if government health insurance pays for it. For this reason, research on the costs and benefits of community-based palliative care is crucial. This research should measure not only patient outcomes and cost to the health care
system but also cost savings for the health care system and financial risk protection for patients’ families.\textsuperscript{14–16} To create district and provincial palliative care networks throughout the country that link community-based care with higher level hospitals and that are integrated into the health care system, national palliative care policies are needed. Specifically, a national palliative care policy, based on the 2014 World Health Assembly Resolution asserting that palliative care is an ethical responsibility of health systems, could clarify the government’s commitment to palliative care.\textsuperscript{17} A national palliative care strategy could then provide direction for every provincial health department on how to implement palliative care services and training. For palliative care to become accessible to everyone in need, this strategy should mandate permission for all physicians who care frequently for patients in need of palliative care to prescribe morphine for both inpatients and outpatients. It also must devise plans for oral morphine to be accessible in at least one pharmacy in every district and for the most secure supply chain possible that does not compromise care. In addition, it should require training in basic palliative care for all family medicine specialists and all physicians who staff community health centers and more advanced palliative care training for physicians who routinely care for patients with high symptom burdens such as oncologists and geriatricians. Finally, it should require all cancer centers, major general hospitals, and major pediatric hospitals to initiate specialist palliative care within a specified time. This would necessitate official specialist training in palliative medicine at medical universities around the country.

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**References**


