# 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.*

***Key Words***

*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.[1] 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

Publication of this article was supported by Public Health Program of Open Society Foundations. The authors declare no conflicts of interest.

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*Accepted for publication: March 21, 2017.*



0885-3924/$ - see front matter
http://dx.doi.org/10.1016/j.jpainsymman.2017.03.038

experience working as a clinician-educator in developing countries who was prepared and funded to provide training and technical assistance to the MoH and Vietnamese colleagues long term.[2,3] The working group adopted the World Health Organization (WHO) public health strategy for national palliative care programs.[4] This entails a rapid situation analysis of palliative care services and needs (supply and demand) followed by attention to palliative care policy, essential drug availability (especially oral immediate-release morphine), education, and implementation. The situation analysis, completed in 2005, revealed that severe chronic pain is common among people with cancer and HIV/AIDS in Vietnam, that oral morphine was virtually unavailable, that injectable opioids including morphine were available in major hospitals but were seldom used, and that clinicians lacked adequate training in pain relief and palliative care.[5]

## 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