



# Palliative care in the Middle East

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# Where is the Middle East (ME)?



**Bahrein**  
**Cyprus**  
**Egypt**  
**Iran**  
**Iraq**  
**Israel**  
**Jordan**  
**Lebanon**

**Oman**  
**Palestine**  
**Qatar**  
**Saudi Arabia**  
**Syria**  
**Turkey**  
**UA Emirates**  
**Yemen**

# AIM

- **Current status of palliative care (PC) in the ME**
  - ME compared with western countries
  - What is there?
  - What is missing?
  - The diversity
- **Barriers regarding PC services in ME countries**
- **Future directions to take**

# We are not Europe or America

Middle East is mostly “developing”

## Medically:

- Less benefited medical sciences than “West”
- Life expectancy lags far behind
- Young populations – different causes of death (and end-of-life trajectories)
- Cancer incidence rates are **half** those of developed world, BUT cancer mortalities are **similar** (so, relatively **greater mortality**...)

(Hajjar et al. 2015)

# We are not Europe or America

## **Socially:**

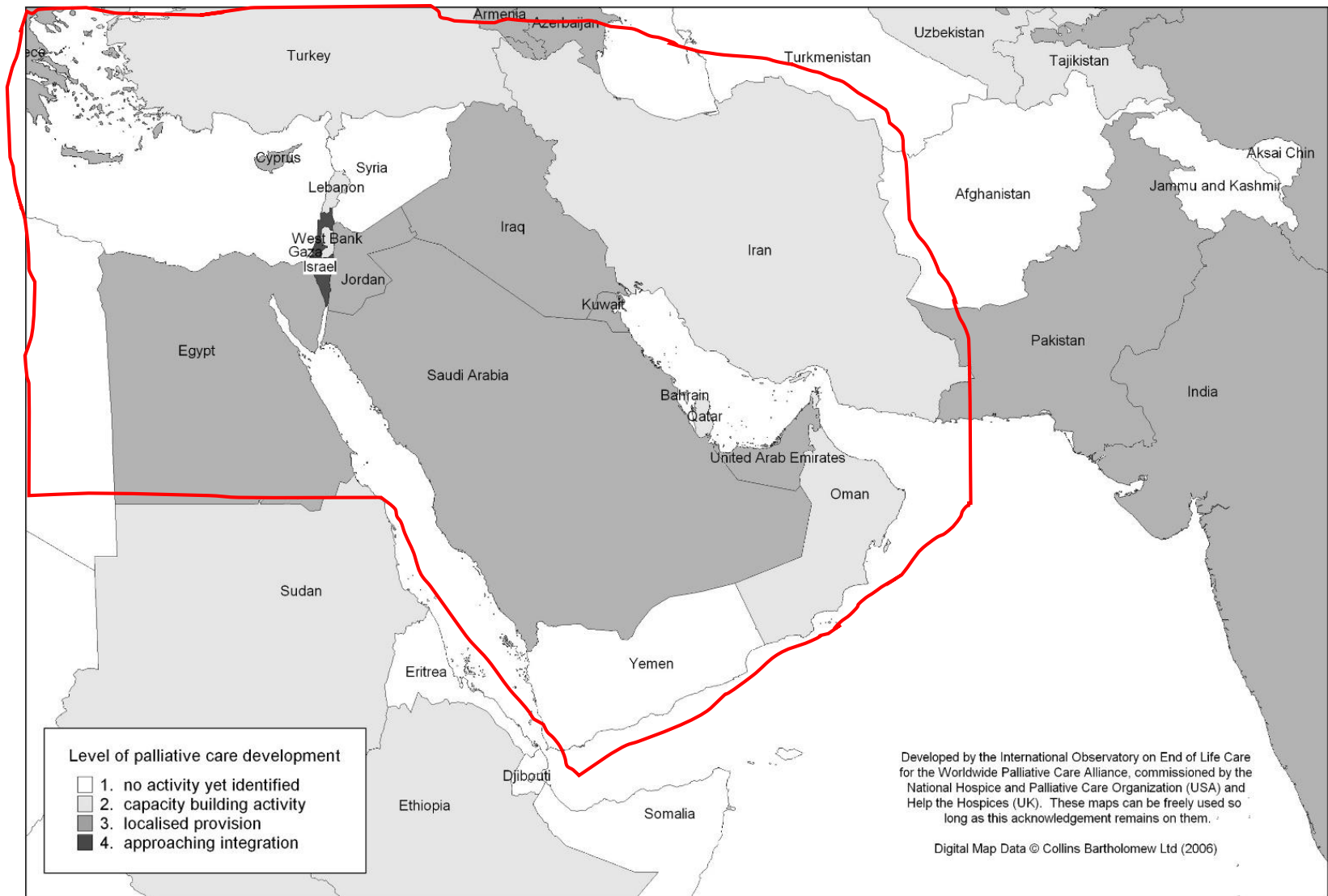
- The value of autonomy is less important
- Extended family is vital in decision-making

## Socially (cont.)

The **cultural code** for the position of the elder within the family, puts **boundaries** that regulate:

- ✓ proximity vs. separateness
- ✓ hierarchy
- ✓ values associated with individuation vs. family
- ✓ communication styles with health care providers

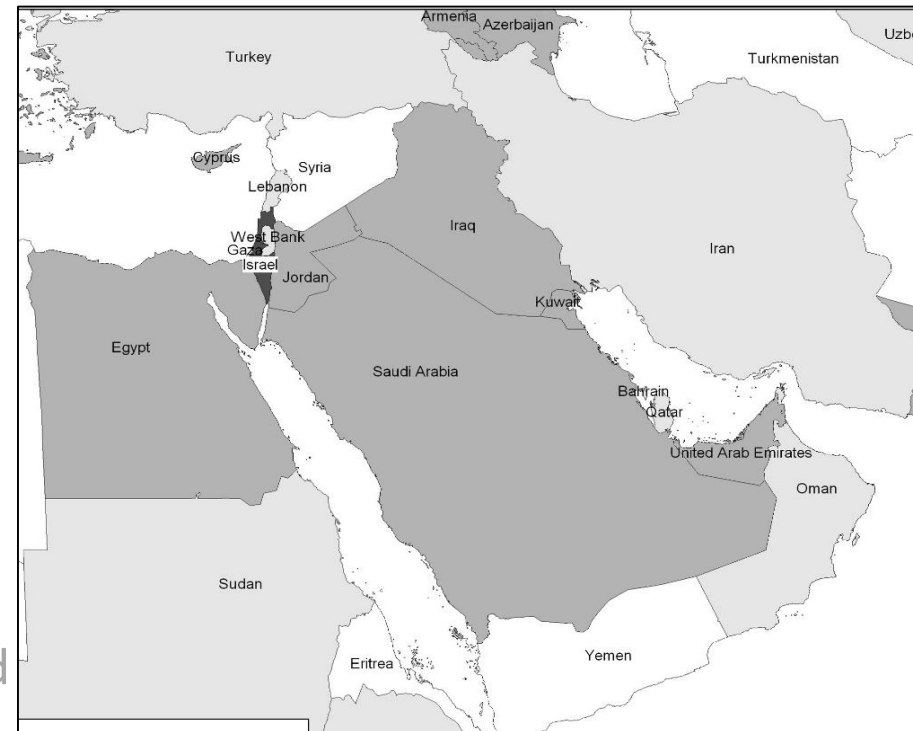
# What PC is there?



(Wright et al. 2008)

# Palliative care (PC) development 2011

- Group 1: No known Hospice/PC activity  
(Yemen, Syria).
- Group 2: Capacity-building activity  
(Oman, Palestinian Authority).
- Group 3a: Isolated PC provision  
(Egypt, Iraq, Iran, Lebanon, Morocco, Pakistan, Saudi Arabia, United Arab Emirates).
- Group 3b: Generalized PC provision  
(Cyprus, Jordan, Turkey).
- Group 4a: Hospice/PC services near integration (Israel).
- Group 4b: Hospice/PC services at advanced integration (no ME countries).





# Barriers to better PC

- Lack of health policies/legislation to support PC development
- Some hindering policies (for example opioids)
- Lack of relevant training to healthcare workers
- Poor accessibility of essential PC drugs
- Fear of causing addiction from opioids/others

# Is it about money...?

The more wealthy Muslim Majority countries with GDP per capita in excess of \$20,000

(Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and UAEmirates) achieved category 2, or 3a.

Jordan has reached category 3b

Aljawi and Harford (2012)

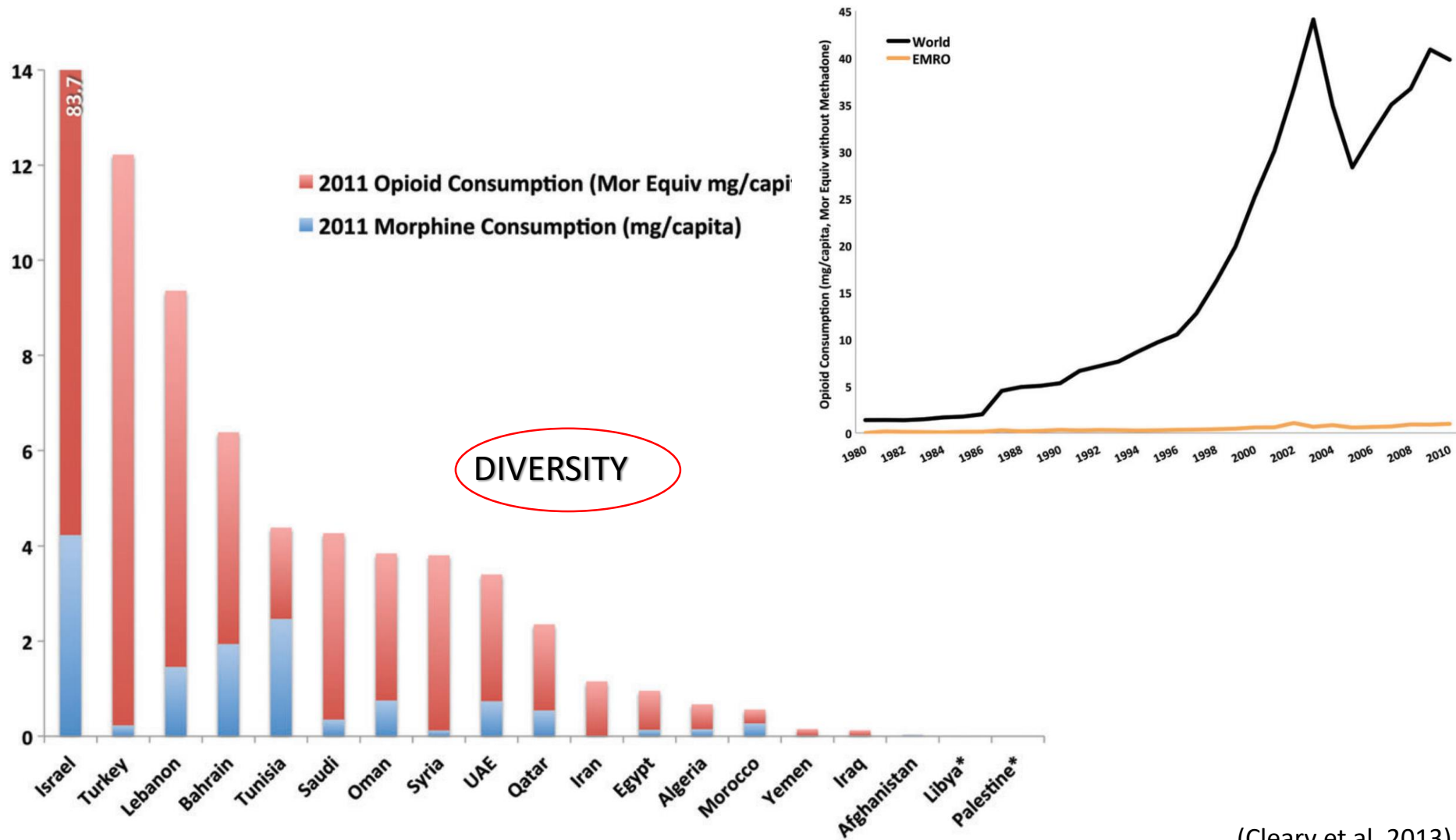
**PC is cheaper than most medical care!**

(example: The model in Kerala, India)

# Opioid availability

- Mostly limited access to essential opioids
- TD fentanyl was usually available.
- Investment in highly-profitable med<sub>s</sub>.
- Reluctance to invest in low-profitable products (IR morphine or oxycodone).
- **Jordan**, initiated their own manufacturing process for **IR oral-morphine**

# opioid consumption



**Table 2**

**Availability of opioids in the ME according to International Association of Hospice and Palliative Care (IAHPC) lists**

	Cyprus	Egypt	Israel	Jordan	Lebanon	Oman	Palestine	Syria	Turkey
Codeine, oral	✓	X	✓		✓	✓	✓	✓	✓
Morphine, oral immediate release	✓	✓	✓	✓	X	✓	X	✓	X
Morphine, oral controlled release	✓	✓	✓	✓	✓	✓	✓	✓	✓
Injectable morphine	✓	✓	✓	✓	✓	✓	✓	✓	✓/X <sup>a</sup>
Oxycodone, oral immediate release	✓	X	✓		X	X	X	✓	X
Methadone, oral immediate release	✓	X	✓		X	X	X	X	X
Fentanyl, transdermal patch	✓	✓	✓		✓	✓	✓	✓	✓

**It is also a matter of doses!**

# Diversity...

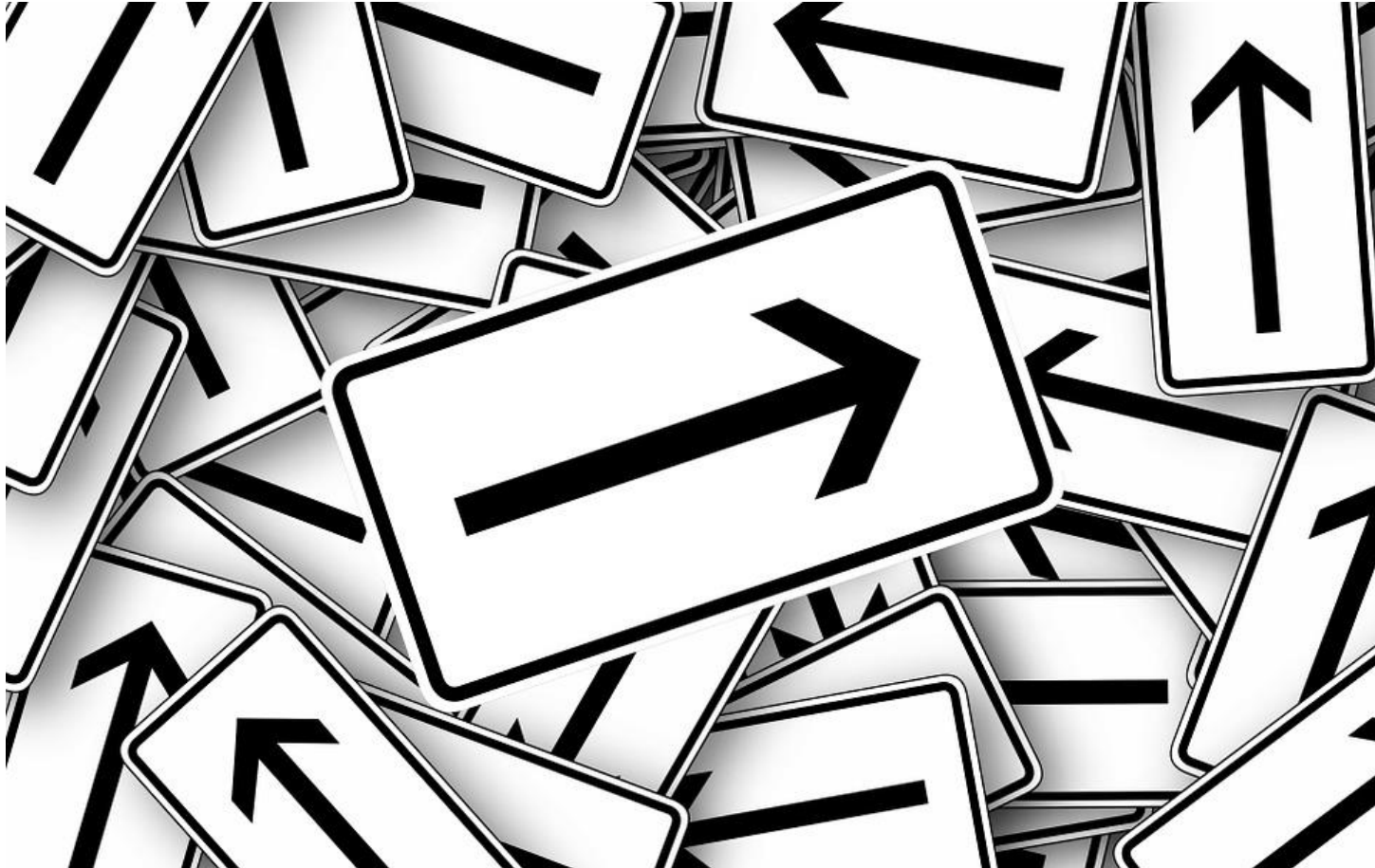
**Table 4**

**Opiate use for select Mediterranean and ME countries in 2001 and 2011 and comparison with the United States and global consumption**

Country	2001 Morphine Equivalence (mg/person)	2011 Morphine Equivalence (mg/person)	Increase in Morphine Equivalence (mg/person)	Increase in Morphine Equivalence (%)
Cyprus	12.2	35.1	22.9	187.7
Egypt	0.7	1.0	0.3	42.8
Israel	150.2	154.8	4.6	3.1
Jordan	9.2	24.3	15.1	164.1
Lebanon	5.4	4.9	-0.5	-9.2
Oman	1.8	3.9	2.1	116.7
Syria	1.1	3.8	2.7	245.5
Turkey	3.8	12.2	8.4	221.1
Italy	75.9	169.4	93.5	123.2
Greece	48.6	115.0	66.4	136.6
United States	542.8	749.8	207.0	38.1
Global	39.3	61.7	22.4	57.0

Data from Pain and Policy Studies Group, University of Wisconsin, Madison WI. Available at: <http://www.painpolicy.wisc.edu>. Accessed October 26, 2014.

Where do we want to go?



Where do we want to go?

## **INTEGRATING PC** into mainstream care

We need:

- A critical mass of **activists**
- Multiple providers and **service types**
- An **awareness** of PC (HCPs/public)
- The availability of strong, **pain-relieving drugs** (opioids, in all doses)
- An impact of PC upon **policy /legislation**
- The development of recognized **education centers**
- **Academic links** with universities
- The existence of a **national association/**initiative?

(wright et al., 2008)



Cont.

- Increase considerably the number and capacity of PC services

Example: Egypt had 3 services whereas the UK had nearly 1400 services, with similar population

(Aljawi & Hardford, 2012)

- Palliative care services can take many forms:
  - ✓ Hospital consulting services/ dedicated palliative beds
  - ✓ Inpatient hospice facility
  - ✓ homecare palliative/hospice services

What works...?

# Palliative care for cancer AND more...

- Cancer incidence will grow and ageing will increase
- We need to improve PC for patients with advanced cancer
- Other long term conditions need PC too
- Children need PC too...
- The community is pivotal for developing PC services
- Promoting PC education and certification for physicians and nurses is crucial

# WHO

Any governmental cancer program, should address 4 key components of care:

- Prevention
- early detection
- Treatment
- Palliative care

# WHO

Any governmental cancer program, should address 4 key components of care:

- **Palliative care**
  - **Prevention**
  - early detection
  - Treatment
- } FIRST

# The example of **Jordan** 2001-2006

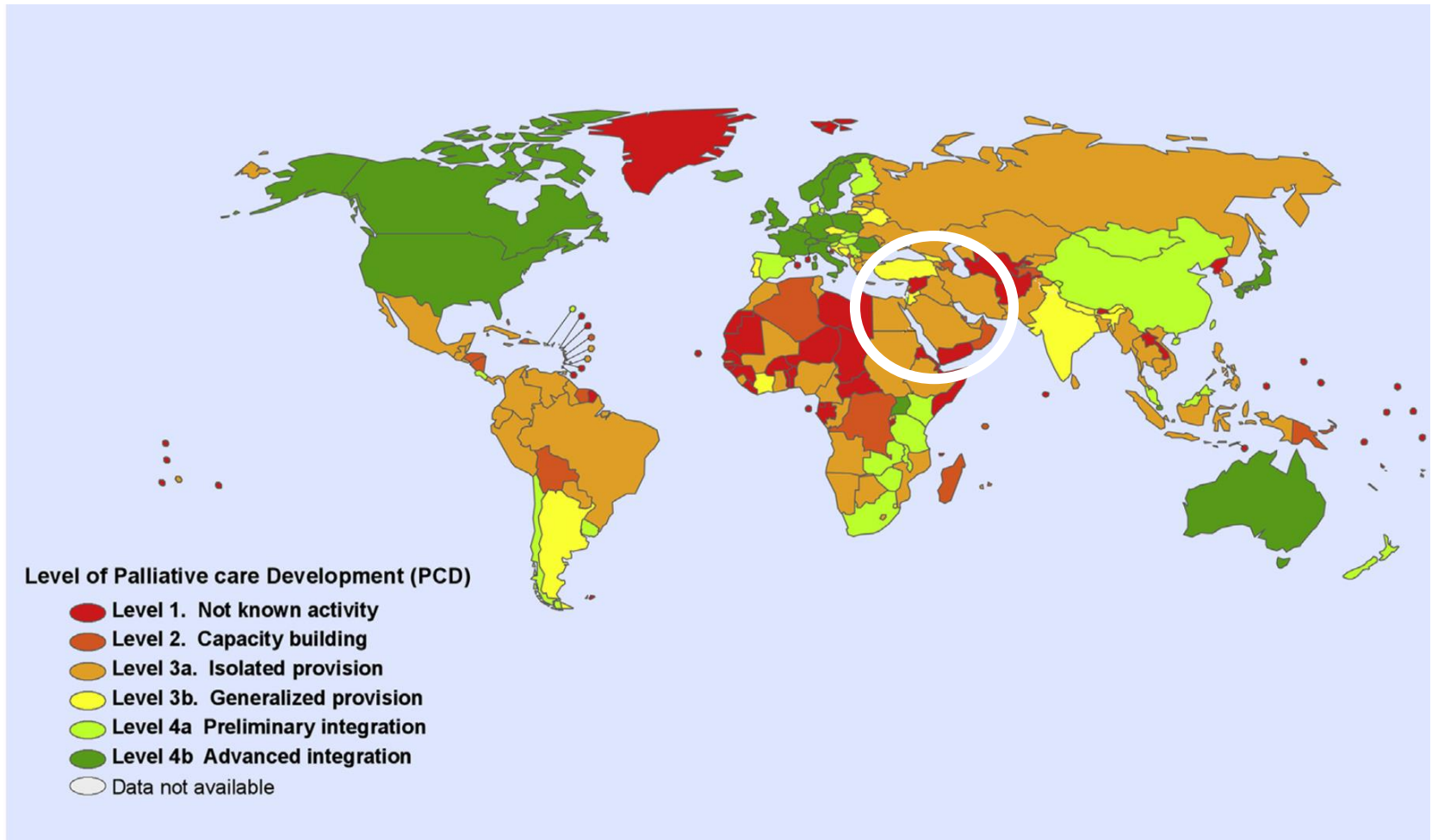
- King Hussein Cancer Centre (KHCC) in Amman provides PC for **inpatients, outpatients**, and patients at **home**.
- Change in **regulations** governing opioid prescribing
- The national opioid **quota** has been increased.
- Cost-effective, generic, immediate-release **morphine** tablets produced **locally**

# Jordan (cont.)

- Bedside training courses health care professionals to overcome “opio-phobia”
- professionals take up PC as a profession.
- “Champions” for PC leading the development of PC in Jordan’s health care systems
- Increase within 3-4 years, from 250 to 800 patients per year receiving PC
- support neighboring countries to develop pain relief and PC.

(Stjernswärd et al., 2007)

# We want to be GREEN

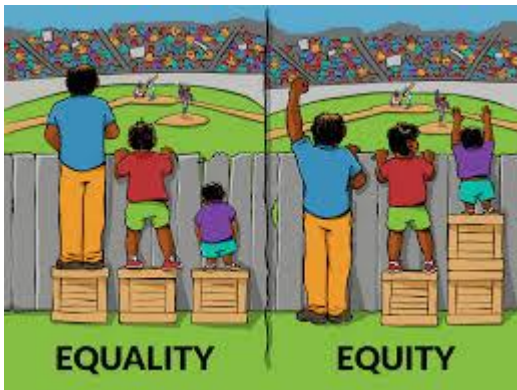


(WPCA, 2011, in Lynch et al., 2013)

# Conclusion

In order to make this happen we should aim:

- To work hand in hand
- To create equity to countries that need greater support
- And to become one community





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