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Report

Report of an Online Seminar Titled “People-Centered Palliative Care for Poor in the Developing Countries: Activities in the Philippines”

Yasuko NAGAMATSU[1)]　Nanette Ramilo CRUZ[2)]

教育プログラム実施報告 : 途上国における貧困層むけ People-Centered 緩和ケア —フィリピンの活動—

長松　康子[1)]　ナネット ラミロ クルース[2)]

〔Abstract〕

While palliative care improves the quality of life of patients and their families and relieves suffering, it is not universally available. Access to palliative care is typically poor in low-income countries. Therefore, the World Health Organization emphasizes a Primary Health Care approach to improve equitable access to palliative care services. The World Health Organization guidelines for palliative care in developing countries recommends a community-based integrated care using inexpensive medicines and equipment by trained medical staff and health volunteers for primary health care. An online seminar about “People-centered palliative care for poor in the developing countries: Activities in the Philippines" was conducted and experience was shared with students and faculty. The Catholic charity organization, Canossa Health and Social Center, provides people-centered palliative care especially for poor people. The program staff includes the Canossian Sisters, community health volunteers, volunteer doctors, medical students, patients’ families, Chaplains and lay ministers of the local Catholic Church. The volunteer doctor carefully assesses the symptoms and prescribes the medications needed such as short-acting morphine, available in selected drug stores. If a patient is unable to afford the medication, payment is exempt. The community health volunteers visit patients at home regularly to assess the symptoms and report the uncontrolled symptoms to the doctor. Spiritual care by the parish church chaplain is available on request. The community health volunteers play a key role in finding the patients, assessing the symptoms, as well as providing psychological and emotional support for patients and families.

〔Key words〕 Palliative Care, Primary health care, People-Centered care

〔要 旨〕

緩和ケアは患者の苦痛を和らげ，患者と家族の QOL を向上させが，十分に提供されている国は一部で，特に低所得国では緩和ケアへのアクセスが悪い。世界保健機関は，緩和ケアへのアクセス向上のためのライマリヘルスケアアプローチ，即ち，訓練を受けた医療従事者やヘルスボランティアによる廉価な薬剤や医療器具を用いたコミュニティを基盤としたケアを推奨している。

「途上国の貧しい人を対象とした People-centered 緩和ケア：フィリピンの活動」と題したオンラインセ

1）St. Luke’s International University, Graduate School of Nursing Science・聖路加国際大学大学院看護学研究科
2）San Beda University, College of Medicine, Family and Community Medicine・サンベダ大学医学部家庭地域医療

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ミナーを開催し，学生や教員が参加した。カトリック慈善団体が運営するカノッサヘルスセンターは，特に貧しい住民向けに緩和ケアを提供している。ボランティア医師による診察後，モルヒネをなどの処方を行う。ヘルスボランティアは，緩和ケアの必要な患者発見，症状アセスメン，患者と家族への心理的支援などを行う。希望者には司祭らがスピリチュアルケアも行っている。

〔キーワーズ〕 緩和ケア，プライマリヘルスケア，People-Centered ケア

Ⅰ. Introduction

The opportunity to die without suffering is one of the most fundamental of all human rights. Palliative care is an approach that improves the quality of life of patients and their families who are facing problems associated with life-threatening illness and that prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual[1). However, about 5.5 billion people still have limited or no access to medicines containing narcotic drugs, such as codeine or morphine, leaving 75 percent of the world population without access to proper pain relief treatment at the end of life[2).

Access to palliative care is typically poor in low-income countries. In 2014, the United States of America, Canada, Europe, Australia, New Zealand, and Japan consumed 91 % of total global morphine consumption, whereas other countries representing 81% of the world's population consumed a mere 9% of the total global morphine[2). Promotion of palliative care in developing countries is an urgent goal to be achieved. Various barriers such as misunderstanding of palliative care, lack of policy, lack of training program, lack of staff position for practicing palliative care, lack of insurance coverage of palliative home care, fear of opioid side effects and lack of incentive to import or produce morphine impeded access to palliative care[3). The guidelines of palliative care for developing countries by the World Health Organization (WHO) recommend community-based integrated care using inexpensive medicines and equipment by trained medical staff and health volunteers for primary health care[3). The authors collaborated to promote palliative care in poor urban settings in the Philippines. To share the current activities including needs of palliative care in the community and the challenges, the authors conducted an online seminar about, "People-centered Palliative Care for Poor in the Developing Countries: Activities in the Philippines".

Ⅱ. An Online Seminar titled "People-Centered Palliative Care for Poor in the Developing countries: Activities in the Philippines"

The seminar was conducted on July 28, 2021 using Zoom. The lecture was provided in English. To make sure that Japanese participants fully understood the contents of the seminar, partial translation and explanation was provided in Japanese using the chat function. The Powerpoint slides were shown with minimal translation of the key words.

Ⅲ. Contents of the seminar

1. Needs for Palliative care

As the population grew and continued to age, medical technology continued to improve and advance. The result of which gave all the opportunity for longer and healthier lives. But along with it, is an increase in diseases that comes with age. The world's biggest killer is ischemic heart disease. Stroke and chronic obstructive pulmonary disease are the 2nd and 3rd leading causes of death. People with this disease do not die suddenly but suffer from lingering diseases.

2. Approach and Principles of Palliative care

Palliative care 1) treats the person rather than the disease, 2) focuses on quality rather than length of life, 3) provides family-centered care and involves the patient and the family in making decisions, 4) promotes understanding and accepting that the journey of life eventually leads to death, and encourages people to view this experience as an opportunity for growth.

Palliative care includes interdisciplinary care, medical appliances and supplies, drugs for symptom and pain relief, short-term inpatient and respite care, counseling, spiritual care, volunteer service and bereavement service.

The standard palliative and hospice care programs do not support euthanasia and place an equally heavy taboo on it as does the rest of the medical community.

3. Barriers to palliative care

Failure to acknowledge the limits of medicine leads to futile care, lack of training for health care providers, hospice/palliative care services that are poorly understood, few rules and regulations, lack of access to opioids and denial of death.

4. Current situation of palliative care in the Philippines

In the Philippines, 54% of medical expenditures were paid out of pocket and the majority of expenditures are spent for curative care. A 2015 quality of death study index has listed the Philippines as one of the worst places to die, next to Iraq and Bangladesh[5]. The low ranking of the Philippines in the overall scores of qualities of death index was attributed to the following: severe shortage of specialized palliative care professionals, lack of government-led strategy for the development and promotion of national palliative care, limited number of government subsidies or programs for individuals accessing palliative care services, and limited public understanding and awareness of palliative care services

As a result of the Philippines' low ranking in the quality of death index, it inspired our health policy makers to develop policies that will address such problems. The government was quick to respond and, along with the private sector in health care, started establishing training programs and providing palliative care services. However, having a devolved health care system (decentralization: the national government vests power and authority upon local government units to perform specific functions and responsibilities on health care delivery), those at the grassroots level have yet to experience the growth of palliative care.

5. People-Centered Palliative care at Canossa, Bulihan Cavite

A palliative care service for poor is available in a barangay in the municipality of Bulihan, Silang, in the province of Cavite, south of Manila. Its population as determined by the 2015 Census was 23,275. The palliative care service was started in 2011 and was run by the religious charity organization named Canossa Health & Social Center. Along with this program, the health services provided by the center are as follows: out-patient medical consultation for adults and children, directly observed short-course treatment for tuberculosis, rehabilitation medicine for stroke patients, dental clinic, psychiatric consults for mentally ill, and feeding program for undernourished children. The most common health problem requiring palliative care was stroke, followed by cancer. The program staff included the Canossian Sisters, health workers, volunteer doctors, medical students, patients' families, chaplain and lay ministers of the local Catholic Church. It is common that patients are cared for by family and die at home.

The volunteer doctor assesses the symptoms carefully and prescribes the medications needed. If a patient cannot afford the medication, payment is exempt. Short acting morphine tablets are available in selected drug stores. The health volunteers visit patients at home regularly to assess the symptoms and report the uncontrolled symptom to the doctor. (Picture 1) Spiritual care by the parish church chaplain is available on request. The health volunteers play a key role in finding the patients, assessing the symptom, as well as providing psychological and emotional support for patient and family. (Picture 2)

Picture 1. Home visiting by volunteer doctor and medical student

Picture 2. Spiritual care by parish church

6. Activities under pandemic of COVID-19

Since the site was under moderate risk for transmission of COVID-19, face-to face contacts and community exposures were limited. Online consultation through Facebook messenger was available. A Facebook page to disseminate information and a public health campaign about COVID-19 was established. Coordination with the community officials and block leaders was ongoing to help promote the services to their residents. Canossa Health and Social Center distributed the food and life supplies to the patients who lost their income. (Picture 3)

Picture 3. Facebook messenger for online consultation

Ⅳ. Result

1. Participants

Fifty-one participants including students and nursing faculty from Japan, Hong Kong, Myanmar, Bangladesh, China, and Indonesia attended the seminar.

2. Questions from the participants

1) The barriers to palliative care

Majority of Filipinos are Catholic (Christians). Teachings include death is accepted as part of life. However, they still hesitate to speak about their own death. Another barrier is that people who belong to the lower economic level are not aware of what palliative care is and how it helps suffering patients. In the beginning, the project certainly experienced resistance, not only from lay people, but also from medical specialists who are not yet aware of this approach.

2) Use of morphine

Prescription of morphine for medical purposes is legal. Because prescription of opioids requires a special license and the use of yellow prescription pads (required for prescribing dangerous drugs) for the physician, plus the fear of inducing harm for the patient, many physicians do not prescribe morphine in the Philippines.

3) Use of marijuana

Using marijuana for any purpose remains illegal in the Philippines.

3. Feedback from the participants

The authors received positive feedback from the participants. Many were impressed by the innovative palliative care provision using a multi-disciplinary team including non-medical specialists such as health volunteers and parish church chaplain and lay ministers.

Ⅴ. Discussion

The people-centered palliative care for the poor in Bulihan, Cavite contributes to the achievement of good death of the local poor residents. However, for the provision of sustainable palliative care, the project needs some support.

As WHO recommended, continuous training for health workers is fundamental[3]. The evaluation of the activity is also necessary for the next step to improve the quality of care.

Now, the COVID-19 pandemic is affecting palliative care activities. Canossa Health and Social Center spends more on food and fundamental supplies to distribute to the people who lost their income from the pandemic. To maintain the stock of necessary drugs for palliative care, financial support is needed. Authors will collaborate to support the people-centered palliative care for the poor in Bulihan, Cavite.

Ⅵ. Conclusion

An online seminar about “People-centered Palliative Care for Poor in the Developing Countries: Activities in the Philippines” was conducted and the experience was successfully shared with students and faculty.

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