

## A Multiorganization Approach to Improving Palliative Care in Honduras

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Since 2011, oncology nurses and physicians in the United States have been volunteering in Honduras with the International Cancer Corps (ICC), organized by the American Society of Clinical Oncology (ASCO), in partnership with Health Volunteers Overseas (HVO). In this article, the authors will summarize the work of the ASCO/HVO ICC teams that developed educational programs with local partners to improve cancer and palliative care in Honduras.

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Cancer is a leading cause of morbidity and mortality worldwide, with an estimated 14.1 million new cases and 8.2 million deaths in 2012 (International Agency for Research on Cancer, 2012). In 2010, the number of cancer cases was projected to double in the next 20–40 years because of population growth in low- and middle-income countries (LMICs) and the aging of populations worldwide (Thun, DeLancey, Center, Jemal, & Ward, 2010). Poverty and stigma in LMICs may limit access to and uptake of screening tests and delay early detection and treatment, leading to diagnoses at later stages and poorer prognoses (Thun et al., 2010). In addition, infectious etiologies such as the human papillomavirus and the development of cervical cancer are increasing the incidence of cancers particularly in resource-challenged settings (De Lima et al., 2013; Thun et al., 2010).

LMICs face a heavier cancer burden because of later stages of diagnosis, scarcity of diagnostic and treatment resources, and lack of trained oncology providers. In 2011, the World Health Organization (WHO), the United Nations, and the Union for International Cancer Control held the first high-level meeting to discuss the growing burden of noncommunicable diseases, including cancer, in LMICs (United Nations General Assembly, 2011). This meeting called for global partnerships between

countries and organizations to enhance cancer care, with a goal of reducing cancer mortality by 25% by 2025.

Regardless of the purpose of global programs, their principles should include collaboration, curiosity, compassion, courage, creativity, and capacity building (Quill & Abernethy, 2013). In general, the greatest impediment to improving health care in LMICs is the inability to train and sustain an adequate workforce (Hongo & McPake, 2004). The global shortage of professionally trained healthcare personnel, including nurses, and the projected increase in cancer diagnoses require developing strategies to train and educate professionals to respond to this crisis, particularly the palliative care needs of the population (Syed et al., 2012). Global partnerships need collaboration and creativity to increase training and build in-country capacities to provide palliative care services in LMICs.

In the United States, the Institute of Medicine (2014) has recommended international partnerships for improving cancer care in LMICs through twinning or other relationships. The American Society of Clinical Oncology (ASCO)/Health Volunteers Overseas (HVO) International Cancer Corps (ICC) is one partnership between oncology clinicians in the United States and in resource-challenged countries that works to improve care for

people with cancer through training and educational programs.

### Palliative Care as a Worldwide Priority

The World Health Assembly (2014) passed a landmark resolution encouraging all member states to develop greater interest in palliative care. The resolution noted that more than 40 million people worldwide need palliative care services, and 80% of them live in LMICs. However, only 20 countries (8.5%) have integrated palliative care into their healthcare systems. Specific initiatives include education and training for all healthcare workers in palliative care. In addition, in 2014, WHO and the Worldwide Palliative Care Alliance (WPCA) published the *Global Atlas of Palliative Care at the End of Life*, which shows the availability of and need for these services around the world (WPCA & WHO, 2014). The report identified that the highest proportion of adults needing palliative care live in LMICs. Because nurses provide a large proportion of palliative care and because formal education is variable, nurses should be included in education and training initiatives.

### Palliative Care in Latin America and Honduras

Lack of policies on palliative care services, such as national standards and guidelines, often impede the development and implementation of palliative care. Honduras has struggled with political unrest for decades. In addition, it has a two-tier health system—private and public—with scarce resources for the majority of the population. According to the World Bank (2016), 59% of the population is below the poverty line, and 60% of the population receives public healthcare services provided by the Secretary of Health (WHO,

2013). Honduras shares similar burdens with many low-resource countries, including few screening programs, later stages of diagnosis, and greater symptom burden. Each year in Honduras, 7,400 new cases of cancer are diagnosed, with the most frequent cases being cervix uteri, stomach, liver, breast, and prostate cancers (International Agency for Research on Cancer, 2012). Cancer of the cervix uteri is the fourth most common cancer worldwide but the most frequently diagnosed cancer in Honduras and the leading cause of cancer deaths among women.

Palliative care has been almost nonexistent until 2001, when the Latin American Association of Palliative Care (ALCP) was formed. Until then, patients usually died in the hospital after receiving cardiopulmonary resuscitation or, even worse, at home without support or effective medications to control end-of-life symptoms such as pain. The ALCP was formed to promote the development of palliative care in Latin America and the Caribbean, and has published the *Atlas of Palliative Care in Latin America* (International Association for Hospice and Palliative Care [IAHPC], 2012), which provides an overview of the development of palliative care services in Latin America. Given the late stage of cancer diagnosis for many people in Honduras, healthcare providers have witnessed the end-of-life suffering of patients and families and have recognized the need for palliative care.

According to the IAHPC (2012), Honduras ranked lowest in palliative care services/units/teams per 1 million inhabitants (0.24) in Latin America, with one team in the country, no hospice facilities, no faculty teaching palliative care in the medical schools, and no information about the numbers of nursing faculty. Only one palliative unit exists in the country, located at Emma Romero de Callejas Cancer Center

in Tegucigalpa (Sheldon, 2015). The majority of patients with advanced cancer spend their last days of life at home without the support of community-based organizations. Often, patients who live remotely have no access to nurses, physicians, or other providers to ease suffering in the last days of life. In addition, cardiopulmonary resuscitation is performed universally in Honduras, even on patients with terminal illness who die in hospitals.

Pastrana, Torres-Vigil, and de Lima (2014) created indicators to track palliative care development, and found that Honduras ranked in the lowest group with Bolivia, the Dominican Republic, and Guatemala. Their work identified the four main barriers to the development of palliative care: policy, education, medication availability, and implementation. In addition, the process for acquiring morphine and other opioids is limited because of paperwork and cost, and many levels of approval are required prior to prescribing an opioid to a patient to relieve suffering.

### Nurses and the International Cancer Corps in Honduras

The nonprofit organization HVO sends volunteers to resource-scarce settings to teach knowledge, skills, and attitudes to improve health. In 2011, ASCO partnered with HVO to create ICC, which addresses the need for more training of clinicians in cancer and palliative care settings in developing countries. The ASCO/HVO ICC supported the first team to provide the first oncology nursing conferences in Honduras. Subsequent teams have included oncology nurses, physicians, and advanced practice nurses from the United States. For each trip, team members spend three to four months preparing and then one week in the capital city, Tegucigalpa, to run the conferences and work with local colleagues. Prior

to the conferences, the ICC teams work with local partners to design the agendas for the visits to meet the needs of a wide audience consisting of oncology nurses, surgical and medical oncologists, medical students and residents, social workers, and psychologists.

Topics requested by Honduran partners for the first oncology nurse conference included cancer pathophysiology, cancer treatment modalities, symptom management, pain control, and psychosocial issues. After collecting feedback from Honduran nurses at the first conference, another team organized a second conference in 2012 to provide advanced content and topics identified as key to improving cancer care and palliative care in the country. Findings from the two conferences were summarized for future program development (Sheldon et al., 2013).

In 2015, Honduran partners asked the ICC to develop a team to plan an interprofessional conference to address the palliative care needs of the people. A team of three oncology providers, including two advanced practice nurses and one oncologist certified in palliative care, created two interprofessional workshops to review the key topics in palliative care and discuss the implementation of palliative care in Honduras. The conferences were held in Tegucigalpa, and the audiences included doctors, nurses, psychologists, dietitians, pharmacists, and community advocates. Healthcare providers from the United States and Honduras spoke about the cancer burden, barriers to implementing palliative care programs, provider burnout, and pediatric palliative care. Other topics included pain assessment and dosing based on their available formulary, palliative care emergencies, addressing goals of care, multidisciplinary palliative care, management of symptom clusters, and models of care. Interactive features

included small group workshops on specific topics identified as key issues related to shortened lifespans because of serious illness.

Continuing partnerships between the ICC and Honduras will develop and help to implement additional programs to improve palliative care delivery and alleviate suffering for patients and families.

### Palliative Care Education in Honduras

Education and training in palliative care are needed for all health-care professionals. One of the macroindicators of the development and implementation of palliative care services proposed by Pastrana et al. (2014) was the number of nursing and medical schools that included palliative care education in undergraduate programs. Unfortunately, no information was available regarding the number of Honduran nurses or nursing faculty members providing palliative care education in 2014 (Pastrana, Wenk, & de Lima, 2016). Given the need for palliative care, including psychosocial care and symptom management, nurses need training in undergraduate education, and practicing nurses and providers need more advanced training. Physicians, who are often responsible for educating nurses, need to provide them with both palliative care education and an understanding of palliative nursing.

### Conclusion

Interprofessional teams provide valuable training opportunities that influence palliative care delivery in developing countries. Ongoing programs such as the ICC provide opportunities to create sustainable changes and to build in-country capacity. Program development allows for customized curricula based on the changing needs of patients in need of palliative care

as well as the available resources and the desires of the host country colleagues. The important values of mutual respect and trust are essential to create global partnerships to improve palliative care of patients with serious and life-limiting illness, and to develop relationships between palliative care providers and patients and their families. Nurses and other care providers (physicians, psychologists, spiritual providers, social workers, and community workers) need primary palliative care education on basic pain assessment and management, education on common symptoms management, conversations about advance directives, and an understanding of community resources to care for patients with serious illness and their families.

Clinicians who want to be palliative specialists need advanced education on pain management and complex symptom management, advanced communication skills to address the goals of care, and the holistic management of patients, as well as community partnerships to address particular needs and psychosocial concerns of patients and families with serious illnesses, including cancer (Dahlin, 2015a, 2015b). Ongoing international partnerships provide opportunities for palliative care program development and training initiatives that improve palliative care and empower clinicians to advocate for these services and resources for their patients. With ongoing relationships, specialized education on palliative nursing, and established policies and procedures regarding essential palliative care services, nurses can promote a world culture in which palliative care is a human right and is accessible to every person.

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