Pain Management in the Middle East: Building Capacity With Global Partners

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The Middle East (ME) is an economically diverse region that includes countries in Central Asia and Northern Africa. Regardless, cancer is a major health concern in the ME, and pain management is an essential component of cancer care across the disease trajectory. This column will provide background on opioid use for pain management in the ME and highlight the collaborative work of the Middle Eastern Cancer Consortium, Omani Cancer Association, and the Oncology Nursing Society to increase pain assessment and management capacity in the ME.

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The Single Convention on Narcotic Drugs requires governments around the world to report opioid consumption statistics annually to the International Narcotics Control Board (INCB) (Berterame et al., 2016; INCB, 2017). The policy was developed in 1961 and amended in 1972, and, today, most countries in the world have signed onto it. The Pain and Policy Studies Group (PPSG), a global research group at the University of Wisconsin, annually receives consumption data for six principal opioids used to treat moderate to severe pain: fentanyl, hydromorphone, methadone, morphine, oxycodone, and pethidine. These data represent the annual amount of medication distributed at the retail level (e.g., hospital, community pharmacy, hospice) for medicinal or scientific purposes and provide a marker to evaluate a country's access to pain relief. A notable limitation is that opioid consumption data reflect distribution at the retail level and, therefore, do not capture the amount of medication actually consumed by patients. To allow for comparisons among countries, the PPSG calculates a milligram per person population-based statistic by first converting the raw consumption data it receives in kilograms to milligrams and then dividing it by the population of a country in a particular year. Examining the 2014 INCB data, PPSG found a large disparity in global morphine consumption between high-income countries (representing 21% of the world's population), which consumed 92% of total morphine worldwide, and low- to middle-income countries (LMICs) (representing 79% of the world's population), which consumed 8% of total morphine worldwide (Berterame et al., 2016; INCB, 2017). These results are particularly concerning considering that 70% of cancer deaths occur in LMICs, countries that use the least amount of opioids (Berterame et al., 2016; INCB, 2017). Significant changes are needed to ensure that patients with pain can safely access opioid medications.

Middle East Pain Management

The use of opioids in the ME is complex and influenced by the culture and government. Opioids are regulated by each country's Ministry of Health (MOH). Each MOH carefully weighs its country's opioid needs and tries to prevent addiction and diversion. Opioid access varies widely in regions related to additional factors, such as economic stability. For example, four countries that reported the lowest consumption of morphine in the world were also the poorest countries in the ME: Iraq, Pakistan, Sudan, and Yemen (Human Rights Watch [HRW], 2011). Poorer countries are not the only ones that have limited use of opioids. Oil-rich nations, such as Bahrain, Kuwait, Saudi Arabia, the United Arab Emirates, and Qatar, also consume less opioids. Iran stands out for its high consumption of opioids,

TABLE 1. Educational Strategies Used in the Middle East for Pain Assessment and Management

Strategy	Description	Outcome
Didactic lecture	• Pain definitions and terminology • Pain syndromes • Physical, psychological, social, and spiritual pain assessment • Pain management – Opioids, focusing on available agents – Coanalgesics, focusing on available agents – Procedures • Nonpharmacologic • Ethical implications of pain management	Discussions of cultural implications and country perspectives included throughout, leading to increased knowledge
Pain jeopardy	Six categories with five questions per category exist. Nurses use an audience-response device to respond to questions.	Areas with the greatest knowledge gap are discussed and recognized, leading to clarification of perceptions and reinforcement of knowledge.
Improvs	Nurses act out scenarios. One person is the patient, and the other person is the nurse. Other actors can be added.	This can include pain assessment and management; pain behaviors can be discussed and better understood, and pain assessment skills can be refined.
Case studies	Nurses break into small groups to reflect on cases by themselves, then with a neighbor, and then with a small group. Each group strategizes pain management options, and each group can report out to the larger group.	Reinforces various factors that influence pain, such as family fear of addiction and other cultural perceptions; nurses can synthesize what they have learned through the case example.
Local expert exemplars	"Positive deviant" RNs (successful in their communities at managing pain) can share their experiences.	Allows group leaders to emerge; others in the audience can be inspired by the success of others.

in particular, methadone; however, a significant portion of that is used to treat drug dependence syndrome instead of pain. Turkey has recently opened a morphine production plant, hoping to increase the availability of opioids in the region. In 2014, Israel had the highest consumption of opioids in the ME, including fentanyl, hydromorphone, methadone, morphine, oxycodone, and pethidine, with over 300 mg per capita. Iran came in second with about 40 mg per capita, and Turkey and Saudi Arabia had about 15 mg per capita (Pain and Policy Studies Group, n.d.).

Opioid availability is only part of the problem, as barriers related to accessing opioids, such as prescription limitations, also complicate the situation in the ME. For example, some countries limit morphine prescriptions to no more than seven days, and one country limits the supply to five days (Cleary et al., 2013). Others allow only 10-day prescriptions for patients with cancer and 3-day prescriptions for other patients (HRW, 2011). Most countries in the region require duplicate or triplicate prescription forms, with a few of them requiring prescribers to pay for the forms (Cleary et al., 2013). It is also more common for patients to receive opioids in urban hospitals; patients in rural areas and those cared for at home often go without opioids. The fear of addiction is prevalent in ME countries, contributing to the hesitancy of physicians to prescribe opioids. In addition, patients and families may be reluctant to take opioids to manage pain. The fear of opioid abuse and misuse can also influence MOH decisions and policies and lead to opioid shortages (HRW, 2011).

Oncology Nursing Society Collaboration

In 2010, the Middle Eastern Cancer Consortium (MECC), a regional initiative for cancer research and treatment, invited the Oncology Nursing Society (ONS) to participate in a course on the influence of spirituality on pain and suffering. Cultural and spiritual influences of pain and its management were openly discussed in a nonjudgmental manner. Spirituality is an integral component of Islamic culture and religion. Pain and suffering can be perceived as a challenge from God but should not be confused with God not loving a person who is in pain. Some Muslims also fear that opioids will interfere with cognition and cause a type of drunkenness, which is prohibited in Islam. The MECC led to the development of action plans among the attendees and the publication of the proceedings, including "Opioids in Middle Eastern Populations" (Silbermann, 2010), "The Global Experience of Cancer Pain" (Brant, 2010), and "Using Leadership and Advocacy to Improve Cancer Pain Management" (Nevidjon, 2010). Additional collaborations began in 2012, when ONS was asked to provide nurses who could conduct a three-day basic palliative care

course in Muscat, Oman, a high-income country bordering the Arabian Sea. About 80 Omani nurses attended. Four hours of content on pain assessment and management was included in the curriculum. At that time, pain of hospitalized patients was not routinely assessed by nurses, and they did not use a standardized pain assessment tool. Nurses feared that addiction was a common problem, believed that a patient who did not look like he or she was in pain was actually experiencing pain, and felt that nurses did not play a significant role in pain management aside from nonpharmacologic issues. Education was provided regarding how to adequately and safely prescribe and administer opioids and how to minimize side effects.

Since the initial course in 2012, a core group of nurses from ONS has conducted two basic and two advanced courses in palliative care and one combined leadership/research course to nurses from 14 ME countries and 3 Northeast African countries. Pain assessment and management were a focus of the courses, and during the past several years, pain assessment and management have become focuses of both cancer and palliative care in the ME.

Educational Strategies in Pain Management

A variety of educational strategies have been used to equip nurses with pain assessment and management skills. Although didactic education has its limitations, it is foundational in communicating how to assess and manage pain. Educators should understand that other strategies are needed to reinforce learning and that increasing knowledge does not always lead to positive change; therefore, allowing nurses to discuss personal perceptions and experiences related to pain management is imperative to increasing knowledge and facilitating change. Case studies can be used to synthesize didactic information into real-life, culturally relevant scenarios. Improvs (role playing) can be used to exhibit existing behavior and improve communication and pain assessment skills. Small group activities can be used to actively engage all nurses, even those who may be reluctant to share their perceptions and experiences in large groups. A variety of educational strategies with desired outcomes used in the ME are included in Table 1.

Building leadership capacity is another objective of the collaborative work in the ME, which will improve pain management and cancer care in the region. Trust-building during the workshops, discussion of important topics and issues related to pain, and the leadership course all have contributed to the development of leaders in the region. Most impressive are the advocacy, assertiveness, and leadership skills that the nurses now possess. They have advanced from "I wouldn't question the doctor's orders for pain medication" to "I will ask you one more time to consider this request."

During the courses, each nurse or group of nurses was instructed to develop an implementation change project. Many of the projects included strategies for nurses to advance the management of pain in their individual settings, such as standardizing a pain assessment tool in their practice or teaching coworkers about available medications to manage pain. Some nurse leaders are working with the MOH in their countries to increase opioid availability.

The ONS team is currently working with ME and now Northeast African nurse leaders to disseminate pain and palliative care knowledge, evidence-based practice initiatives, and research within their respective countries. These nurses are responsible for carrying forward the mission of progressing pain and symptom management and palliative care throughout the region. Strong partnerships and relationships have fostered ongoing growth.

Conclusion

Pain management is expanding in the ME. Nurses are stepping forward in their respective countries to disseminate knowledge about the assessment and management of pain, promote evidence-based practices in pain management, and advocate for expanded opioid availability. Ongoing collaboration with nurses in the ME and supporting their efforts are essential to continue the momentum and expand building capacity in the region.

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