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Pain Management in Low and Middle Income Countries (LMIC)
Just Put Up With It?

Over the last couple of years we have had the privilege of travelling to and working in a number of resource-poor countries exploring pain attitudes, knowledge and treatment options. In this article, we will present our perspective on pain in these countries and give an overview of a pain management course we have developed, which uses a framework we have called **RAT** (**R**ecognise, **A**ssess, **T**reat).

The physiological processes of acute nociception from the periphery to the brain are the same in all humans, irrespective of where they live. The causes of pain are varied:

- Pain from multi-trauma following a motor vehicle crash (an increasing drain on medical services in many countries).
- Postoperative pain following a laparotomy for a perforated duodenal ulcer.
- Lumbar spine pain from a pathological vertebral fracture in a woman with carcinoma of the cervix.
- The first dressing change in a 3-year-old child following extensive burns from a cooking fire.
- Labour pain in a teenager struggling through her first delivery.

Apart from the humanitarian aspects of treating acute pain and decreasing the stress response, the benefits of early mobilisation, ability to self care and quicker hospital discharge would seem to be of value in resource poor countries.

Cancer is a common cause of chronic or acute on chronic pain in LMIC. According to the WHO, a disproportionately high number of new cases occur in the developing world with 80% being incurable at the time of diagnosis. Extrapolating from Australian data, it is probable that at least 75 percent of these cases will experience moderate to severe pain during the course of their illness. This is a very strong argument for the development of palliative care services, including effective pain management.

On the surface, it appears that many people in LMIC accept pain as an unavoidable part of life. Patients may have little or no knowledge that certain treatments are available. Nursing and medical staff, for a variety of reasons, may not offer treatment, reinforcing patient and societal low expectations about pain relief.

Stoicism appears to reign supreme, and individuals appear never to complain because there seems to be no point. It is often difficult to tease out the role that cultural factors

play in the way patients express their pain - pain and suffering may be seen as a test of faith, while some societies will be fatalistic about pain.

Doctors' and nurses' attitudes and knowledge about pain seem to suggest that pain is a symptom of a disease process that they either can or cannot do something about, rather than a symptom that can be treated. For example, there is still a strong belief that treating acute abdominal pain will obscure the diagnosis; therefore the pain is frequently left untreated (1).

Addressing the problem

There has been significant effort by the WHO to prevent cancer and address cancer pain treatment. There have also been huge international efforts to prevent and treat HIV/AIDS and this has had some spin-off benefits for palliative care and pain management of other terminal diseases.

Morphine was included on the WHO's Essential Medicines List back in 1977. Then, in a major advance for cancer pain management, the WHO introduced the Three Step Analgesic Ladder in 1986. Unfortunately however, there are still many places in the world where oral morphine is not available. This is despite its vital role in the treatment of cancer pain, its low cost and ease of preparation. A number of organisations have campaigned for the global availability of morphine and a good overview of some of the issues relating to the unavailability of morphine was recently published in the BMJ (2).

Improving pain knowledge

Staff knowledge and attitudes are important factors when it comes to recognising pain and treating it effectively. We strongly believe that education plays a vital role in improving pain management and we appear to be lagging in our efforts to provide effective pain management to our global patients.

Consequently we developed a one-day workshop called **Essential Pain Management (EPM)** with initial funding from the Australian and New Zealand College of Anaesthetists (ANZCA). The course emphasises low cost management strategies and how quality of life can often be markedly improved with very simple treatments. Delivery of the course in the Western Pacific Islands, Papua New Guinea, Mongolia and recently Tanzania has been generously supported by the IASP, WFSA and private donations.

The EPM course structure is modelled on the successful Primary Trauma Care (PTC) course. It comprises a one day (8 hour) interactive course and a half-day (4 hours) teach-the-teacher course for "local champions" identified during the initial one-day course. Identification of local enthusiasts to continue the educational programme is an essential component of the model – it encourages local ownership of issues and promotes a culture of continuing education and teamwork.

EPM is principally designed for medical and nursing staff, but can be easily modified for other groups of healthcare workers such as pharmacists and nurse aides. The workshop is highly interactive and comprises a series of short lectures, brainstorming

sessions and case discussions. Morning topics include the classification of pain, basic physiology and pharmacology which includes time on non-drug treatments, reasons to treat pain, and pain management barriers. Most of the afternoon is devoted to a series of case discussions illustrating different pain problems, followed by a brainstorming session looking at ways to overcome local barriers.

ABC (Airway, Breathing, Circulation) has proved very successful as a teaching tool in trauma and resuscitation. In EPM, we have coined our own acronym, **RAT**, standing for **Recognize, Assess, Treat**. This simple framework has proved very popular with course participants and provides a good structure (along with subheadings) for the case discussions.

The four-hour instructor workshop is also highly interactive and covers relevant teaching principles and practical issues relating to the running of an EPM workshop.

Participant feedback about EPM has been very positive. One measure of success of the workshop will be whether the course is taken up by local health workers. Since running two workshops in Papua New Guinea in April 2010, several EPM workshops have since been organised and taught by local instructors and the course has also been incorporated into the undergraduate nursing programme.

EPM is in its infancy but we hope it will prove to be an important tool for improving pain knowledge and practice in developing countries.

Please contact either one of us if you are interested in more information about the course.

References

1. Int J Emerg Med 2009;2:211-215
2. BMJ 2010;341:c3800

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