Pain education as a model for global health impact: Goals and metrics that facilitate change

International Association for the Study of Pain
IASP
Working together for pain relief

Beth B. Murinson[1], Michael Bond, and the Developing Countries Working Group of IASP

[1] Department of Neurology, Johns Hopkins School of Medicine, 600 N. Wolfe Street, Pathology 509, Baltimore, MD 21287, bb@jhmi.edu

ABSTRACT

The scale of pain as a global health challenge is enormous.

Millions of people in developing countries die in pain each year and millions more endure decreased mobility, partial productivity, disrupted relationships, diminished life enjoyment, and fragmented sleep due to undertreated pain.

Even as world organizations come to recognize the right to relief of suffering as a fundamental human right, medical advances have continued to shed increasing light on the importance of addressing pain in it's various manifestations: whether as a symptom of serious disease, or as a harbinger of chronic pain; and have yielded new strategies for the assessment and treatment of pain.

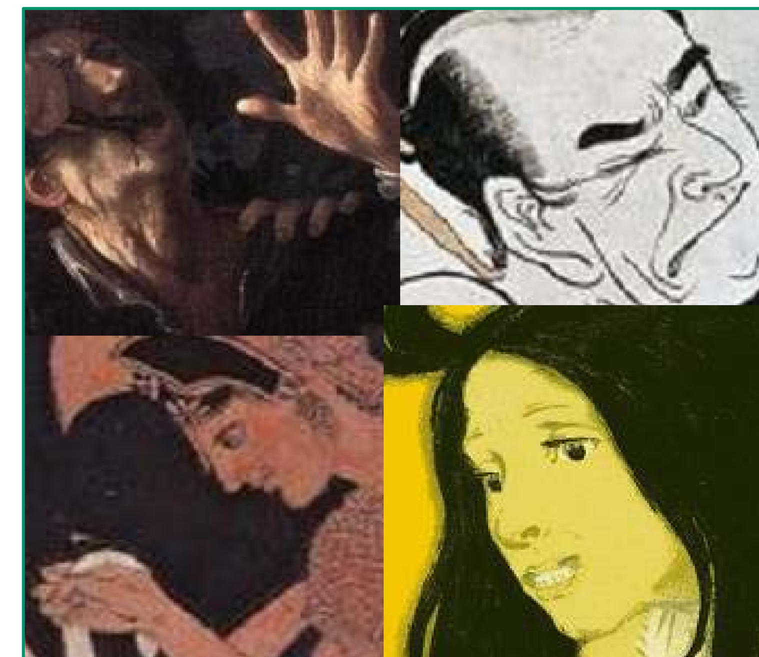
Clinical research shows that certain core knowledge is essential for improved pain care delivery. This core knowledge includes the recognition that pain intensity can and should be measured through the use of validated pain scales, pain assessment must include characterization of the primary features of a pain problem, pain treatment should not be delayed until after assessment is completed, and an array of cost-effective pain therapies can and should be used to improve quality of life and clinical outcomes.

The IASP's Pain Education in Developing Countries Working Group was created with the goal of improving pain care in developing countries by establishing credible model pain education projects in developing countries.

The process of creating this global network of pain courses has followed a 'locally initiated' model process.

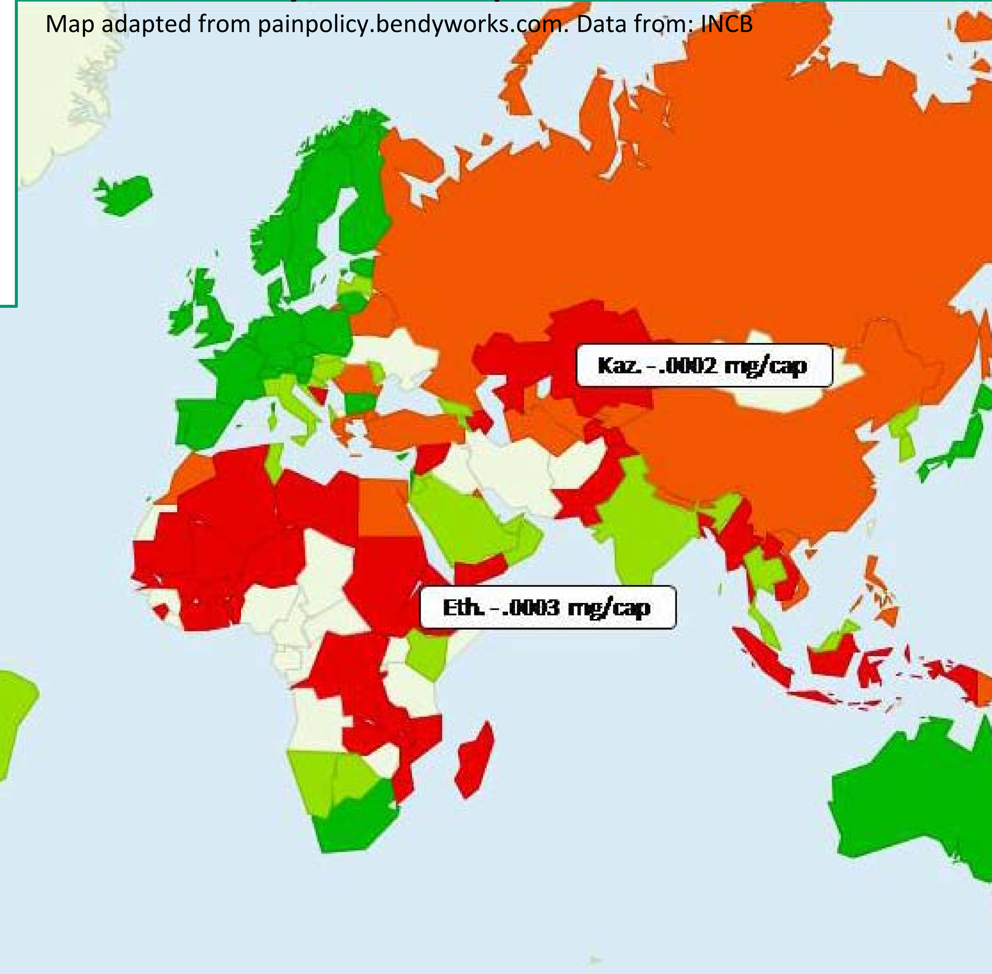
In this it has been possible to create a application process that enables reviewers at a distance to assess the appropriateness of the projects, the strength of the applicants and the likelihood of the project to influence the practice patterns of a wide number of clinical practitioners. The review process for applications involves the review of 3-5 page applications by a large number of reviewers with geographically diverse representation, an important consideration in minimizing bias and ensuring an equitable selection of grant recipients. This process is well supported by the literature. The Working group has also developed a process of evaluating the pain education projects and metrics for success now includes careful follow-up with grant recipients through the submission of quarterly reports during the one-year funding cycle and completion of a detailed final status report. This close monitoring of grant outcomes has allowed the working group to provide feedback to the IASP and has supported the continued funding of this program as well as some expansion of additional programs pain education in developing countries.

Pain has many faces



Access to treatment for severe pain varies greatly

Availability of Morphine, 2007



WHO Essential Medicines: Analgesics, a limited selection

Medication name	Dosage and route	Recommended usage	Comments/limitations
ASA (acetylsalicylic acid, aspirin)	Oral: 100-500 mg Suppository: 50-150 mg	Analgesia	Not especially potent, prevents clotting
Ibuprofen	Oral: 200 mg, 400 mg	Analgesia	
Paracetamol (acetominophen)	Oral: 100-500 mg (tab) 125 mg/5 ml (liquid) Suppository: 100 mg	Analgesia	Not useful as an anti-inflammatory
Codeine	Oral: 30 mg (phosphate)	Analgesia	Drug must be metabolized to provide pain relief, 15% are non-metabolizers
Morphine	Oral: 10 mg (IR tab) 10 mg/5 ml liquid 10, 30 & 60 mg (ER) IV: 10 mg/1 ml amp.	Analgesia	Access is tightly controlled and extremely limited in many countries
Propranolol	Oral: 20 mg, 40 mg (tab)	Migraine prevention (prophylaxis)	Not effective for other pain conditions
Amitriptyline*	Oral: 25 mg (tab)	Depression	Class exemplar is 'pain-active' for neuropathic pain, substitute anti-depressants may not be.

Data from: www.who.int/medicines/publications/08_ENGLISH_indexFINAL_EML15.pdf

Developing Countries Working Group of IASP

GOALS

1. To improve Education and Clinical Training in Developing Countries.
2. To build contacts with other organizations to improve education and clinical training in these countries.
3. To develop a forward strategy that encompasses guidelines, milestones and deliverables

PRINCIPAL STRATEGY

Identifying high-quality local initiatives to improve pain education

METRICS

Criteria (rate 0 to 3)	Details of the Assessment	Ratings
Evidence of organizers ability	Prior experience organizing educational events. Evidence of expertise in education. Sufficient background in basic and clinical aspects.	
Appropriate target group & numbers	Adequate # of learners. Outcome measures provided. Sustainability, e.g., mentoring.	
Project identifies local needs	Evidence of local needs: survey, research, national data.	
Curriculum is compre-hensive, suitable and relevant to audience	e.g. IASP Core Curriculum. Multi-professional instruction where appropriate.	
Budget is detailed and realistic	Including teaching fees, materials, site costs, local travel for speakers.	
Program evaluation is planned	E.g., pre- and post- course surveys. Practicums as appropriate.	
Further comments (no rating assigned)	Is applicant known to reviewer? Has a visit to applicant been made?	

RESULTS

1. Award of 12 grants: Educational Projects in Developing Countries at $10,000 each.
2. Additional programs in Bangkook, Columbia
3. Project award to KYBELE and negotiations with Hospice Africa.

CONCLUSIONS

1. Clear, relevant rating criteria are needed.
2. Many raters from diverse environments are essential to ensure impartiality.
3. Specific application instructions are important for applicants.
4. A dispersed network of knowledgeable special-ists is important for validation of remote ratings.