



Hanna Guimaraes, Portugal

**PAIN RELIEF:
EQUITABLE ACCESS FOR CHILDREN**

“Pain is inevitable. Suffering is optional.”

Anonymous

We stood outside Mbour District Hospital, enveloped in a tense yet consoling silence. Having just witnessed an 8-year-old girl have her two-inch-deep postoperative leg wound washed with alcohol, the present acoustic vacuum offered us much respite. Our furtive glances betrayed how hard we were trying to make sense of it all – a frightful exhibition of pain, a nurse stoically carrying out his professional duties and a slightly afflicted yet nonetheless passive mother. Our conclusions rested on the belief that in this corner of the world such disheartening cries were still being interpreted as an indicator of proper disinfection, that those unwanted bacteria were being effectively eliminated. Very unfortunate for our petite fille.

Adventurous travellers sooner or later become aware of the enhanced discomfort of succumbing to a disease, be it as trivial as a cold, in a setting with no adequate medical assistance, water or food. Experiencing such a thing in Senegal somehow propelled my imagination to consider a worse, yet very realistic, scenario – that of fighting against a terminal cancer or HIV/AIDS there, in sub-Saharan Africa. Enough of mortality figures with multiple zeros: I started thinking about pain. In a region which concentrates two thirds of the total number of people living with HIV¹, there was bound to be a lot of it. And even as a novice to the theme, hungrily searching through virtual literature, it became apparent to me that addressing the well-being of an unsaved life usually comes second to our efforts on finding ‘the’ cure.

The advances in our understanding of the basic mechanisms of pain, of its negative long-term consequences and of cost-effective methods of relieving it have slowly changed what we consider to be sufficient pain relief. While in the recent past a certain amount of pain following an operation was perfectly acceptable, total pain relief for all patients is a goal common to many nowadays. The World Health Organization’s three-step analgesic ladder (1986), for instance, when applied correctly, has clinically demonstrated that 70% to 90% of cancer patients can achieve pain control, with likewise successful outcomes in patients with HIV/AIDS.² Beyond such medical achievements are other multidisciplinary efforts, as pain specialists are on a campaign to educate medical staff, patients and parents. By all means, ‘end-user’ barriers to pain control, such as fear of morphine addiction and its side-effects, still exist but without a doubt this is a far more dynamic area than it was 10 or 20 years ago.³

Such progress, however, has not been seen reflected in much of the developing world, where most of the emphasis on health work has been on prevention and,

more recently, on antiretroviral drugs. Scarce resources, lack of national policies and other 'macro-level' factors, such as the unnecessarily strict regulations that prevent adequate access to opioid analgesics, are just a few of the obstacles hindering pain relief. Out of the 27 million grams of morphine used legally in 2002, 78% went to six countries (no need here to mention which) – the rest went to the other 142 countries that reported.² A staggering blow: morphine is largely unavailable in Africa, even from health professionals.

Yet, there is another hard-hitting component of the problem, more cultural rather than logistic, namely that of the low priority given to pain relief and the lack of awareness among health professionals and the public that cancer and AIDS pain can be relieved. For what good will it do to have all the previously mentioned 'physical' requirements in order if the mental initiative and willingness are not present? Could there be an ethnic difference in analgesic requirements? How far can culture influence the perception of pain? Such were the questions flooding my mind when trying to comprehend the lax attitude towards pain. Thankfully, an irrefutable constant placed itself above everything else – that regardless of the role racial, cultural and religious factors might play, the existence of pain is ubiquitous. Everyone is subject to it, including children.

The statement 'a child dies of an AIDS-related illness every minute of every day'⁴ is, quite naturally, distressing. What is worse, however, is to realize that even less pain relief is in place for these children than for adults. One may think how, due to the sheer unnatural and unexpected nature of a child's death, this may in part be accounted for by the reticence on behalf of the parents and providers to administer proper doses of opioids. However, it plainly points a finger at the disparity in the availability of services themselves. For example, despite the fact that a number of adult pain clinics are available in South Africa, equivalent ones for the young child have not been made available, neither there nor elsewhere on the African continent.^{5,6} Incredulously, I ask myself, why? Indeed, working with a population comprised of a variety of ages and developmental stages makes it all the more challenging. Simultaneously, research in pain and symptom management in paediatrics lags behind research on adults, resulting in recommendations for the former being extrapolated from adult studies of best practices.⁷ But these are not acceptable setbacks – much on the contrary, they only further exacerbate the pressing need for paediatric pain clinics to be established.

To my relief, there are encouraging bouts of positive action, such as the ongoing funding for a paediatric pain management programme to be set up in Thailand. Most admirable are Dr Rene Albertyn's important findings on paediatric pain relief emerging from her work at Red Cross Children's Hospital, South Africa. One of her contributions has been the creation of a Touch Visual Pain Scale, a device able to overcome the Babylonian confusion of languages and cultures which inhibit verbal communication. This scale also differs from the ones used in the western world in that, apart from pain, it also measures anxiety and discomfort, two very present elements in an African medical context. Dr Albertyn also highlights the paucity of articles on pain management in AIDS infants (in developed countries, children aren't born HIV-positive anymore) as well as the invisibility of their pain.⁷

It seems wasteful, however, to rely solely on generous financial injections and foreign initiatives for appropriate clinics or units to be set up all over the world. Propagating

the practice of pain relief for children stands little chance of success unless the concept of it ascends in the ranking of priorities of the autochthonous population itself. As such, apart from the necessary training of health-care professionals — applying the valuable lessons derived from Albertyn's studies — I place my strongest bet on the parents as vehicles for deconstructing the existing barriers of attitude. The initial and key impulse for change could lie in them, for when parents are empowered, more pressure is placed on those with medical responsibility to assess and treat pain. A simple start would be to engage parents in exemplary, and appropriately talked-through, demonstrations of pain relief at small-scale yet multiple foci — be it local dispensaries, hospitals or family planning clinics (in the case of future vertically transmitted HIV-positive children). Satisfaction on the parents' behalf could lead to a chain reaction, creating more demand for the provision of similar services at other new focal points.

I am compelled to hope for this group of people who do not yet possess sufficiently developed spiritual baggage to protect themselves psychologically from pain; who do not always possess the instruments with which to voice their suffering; and who, due to an inferior hierarchical positioning, would most probably not be heard even if they did. Pain is inevitable, but for these children, suffering is not optional. If anyone especially deserves pain relief, it is them.

We have a habit of emphasizing the importance of education in a child's life, yet here we find ourselves with the challenging task of educating the adult segment of the population first. With luck, if our little Senegalese girl ever has to see her own daughter going through such pain, as she herself once did, her stare will not be one of acceptance but of defiance.

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- 1 Report on the Global AIDS Epidemic: Q&A Part 1. Geneva, Joint United Nations Programme on HIV/AIDS, 2006:13.
 - 2 Pain Control. Disease Control Priorities Project, 2006.
 - 3 Sepúlveda C, Marlin A, Yoshida T and Ullrich A. Palliative Care: The World Health Organization's Global Perspective. *Journal of Pain and Symptom Management*, 2002, 24(2): 91-96.
 - 4 A Call to Action: Children: The Missing Face of AIDS. New York, UNICEF, 2005:2. www.stephenlewisfoundation.org/documents/HIVandAIDSinsub-SaharanAfricafactsheet.pdf
 - 5 Kumar A. Organization and development of pain clinics and palliative care in developing countries. *European Journal of Anaesthesiology*, 2004, 21: 169–172.
 - 6 Ramsay S. Raising the profile of palliative care for Africa. *Lancet*, 2001, 358:734.
 - 7 Brümmer W. Health 24—Pain in Children. *Die Burger*, 2006. www.health24.com/medical/Condition_centres/777-792-820-3507,36832.asp

Hanna Guimaraes graduated in Medical Biology from Edinburgh University. Then cultural ties to Brazil prompted her to continue her studies with a Master's in International Health and Tropical Medicine at the Autonomous University of Barcelona, where her dissertation research involved a study on how socioeconomic factors interfere with the oral hygiene of selected communities living inside the Parque Nacional do Jaú, AM, Brazil. Shortly afterwards she was awarded a research scholarship from the Institute of Tropical Hygiene and Medicine in Lisbon, through which she now finds herself happily investigating the epidemiology of STDs/HIV in Luanda, Angola.