

Profile of Maryann Muckaden

Radiation Oncologist/Palliative Care Consultant

Interview conducted at the Palliative Care Australi Conference, 2009, Perth

Muckaden is a village in the state of Kerala, India. This tells us something of how family names are derived in this part of the world. However, Maryann's maiden name tells us more of her ancestry and origins. She is a tenth generation 'Gonsalves' - a well known Portuguese family name. Additionally, she speaks of being a descendent of St. Thomas who came to Kerala from the Holy Land.

Born in the USA in New York she knew little of life in India until she was a young adult. Her father was an Indian career diplomat, rising to the rank of a Charge d'Affair. Maryann was raised in a number of countries. Her early memories of life in Myanmar are of a happy freedom unlike the repressed state that exists there now. At age 10 they moved to the UK, so her formative years were varied and exciting.

Talking to Maryann I was 'struck' by her openness and desire to talk about her life.

It is hard to ignore Maryann's pronounced limp due to post-polio syndrome. Unfortunately, on a trip home to India at age 4 she was exposed to the virus, as at this time the USA did not include immunisation against polio.

She has been left with profound weakness of her right leg, but is adamant that living with this has resulted in "more good than bad in her life"!

She believes she is a more compassionate doctor as a result, and identifies closely with patients with disability. "I couldn't take part in sports, I felt unattractive as a woman"

These difficulties from an early age inspired her to pursue a medical career. Her mother strongly encouraged her. She was determined that Maryann is a doctor and Maryann recounted how her mother later lived vicariously through her.

Her first marriage was arranged. Six months later they had separated. She described a traumatic period in her life. She was only 26. Fortunately she found happiness later in her second marriage. Her husband of 20 years has been a very positive influence in her life.

After graduating from St. John Medical College in Bangalore in 1976, she decided on a career path in Radiation Oncology. She spent several years in New Delhi at AIIMS then moved to the Tatum Memorial Hospital in Mumbai in 1983.

It wasn't until 1994 that she started in Palliative Care. She 'crossed paths' with Gilly Burn and spoke of her "belief in the hand of God" for this change of direction.

Maryann successfully convinced her hospital administration that they needed to have a Palliative Care unit. This was opened in 1996.

When I asked how she gained her knowledge to care for patients she spoke of reading anything she could 'get her hands on'. Later she completed the Diploma of Palliative Medicine through University of Wales and this year will complete a Master of Science in Palliative Care.

Her service rapidly developed with the commencement of a weekly symptom clinic supported by herself, a nurse and an anaesthetist. They continue to this day to manage pain with low dose Morphine and anaesthetic blocks.

In 1999 she was able to appoint at Medical Registrar and start a Home Care Service in the area. The community service now employs two nurses. Overtime she has expanded this service to include 16 trained volunteers, and has counselling and social work support as needed. As a testament to her abilities the Out-patient service now employs five doctors full-time.

Financial support has come from NGO's. A group of local industrialists have put up substantial funds through a Trust paying \$5000 rupees per patient.

Returning to more personal aspects of her life and her work in Palliative Care I asked what continued to motivate and 'nourish' Maryann.

Her reply was unhesitating-"making a difference for both the patient and family- the patients and families get something more".

When asked to say how she would describe herself, she speaks of being 'shy and reserved, yet passionate and dominating'!

I noted she is a woman who smiles a lot.

Her pastimes include reading detective stories, watching English movies and TV comedies. She loves to sing and engages very actively in her local Catholic church. She is a proud devoted mother of two sons who have gone on to study Engineering.

Finally this inspirational Indian leader in Palliative Care 'dreams' that one day the Specialty of Palliative Medicine will be formally recognised in India, and all patients will have access to appropriate services and be able to die in the place of their choice.

Carol Douglas

*Palliative Care Physician
Royal Brisbane Hospital, Brisbane QLD*



Mentoring the Mentors

WORKSHOP JANUARY 2010

As a result of discussions which took place at the national palliative care conference in Perth in September 2009, Pallium and APLI have agreed to develop a mentoring program between Australian and Indian palliative care services.

Palliative care providers from Australia will be linked to fledgling palliative care services in cancer centres in India to provide mentorship aimed at improving the quality of patient care and sustaining the practitioners in India.

The first stage of the collaboration will be to conduct a workshop for volunteer mentors. The workshop will be held in January 2010, at Peter MacCallum Cancer Centre, Melbourne. The aims of this workshop will be to introduce the two organisations, APLI and Pallium India, and provide background on both, to orient the volunteers to India and more specifically, to palliative care development in India, to discuss the cultural sensitivities to be considered when providing education and mentorship across cultures and to

discuss the aims of the mentorship program and how it will be evaluated.

DETAILS OF THE WORKSHOP

Date: 8 January 2010

Time: 9am - 4pm (Lunch will be provided)

*Venue: Seminar room, Education Centre,
Peter MacCallum Cancer Centre*

There will be no fee for attending this inaugural workshop

People will need to register their interest in attending the workshop by 4 January, 2010. Numbers will be limited to 10. For further information please contact Dr Odette Spruyt at odette.spruyt@petermac.org or Dr Judith Lacey at judith-lacey@optusnet.com.au

Returning to India

Returning to India for the 16th international conference of the Indian Association of Palliative Care on the 13-15th Feb 2009 was, as always, a stimulating and enjoyable experience. The conference was held in New Delhi with Dr Sushma Bhatnagar, the organising secretary, assisted by her dedicated team at the All India Institute of Medical Sciences (AIIMS). Sushma was a tireless force throughout the conference ever present with mobile phone tucked in the palm of her hand, quietly coordinating and smoothing out program hitches, guiding and encouraging the many volunteers and staff and no doubt, continuing to manage her department duties at the same time. Her enthusiastic team were an inspiration and clearly enjoyed working together and responding to the challenge of delivering their high tech expertise to the management of cancer pain at AIIMS.

The conference dinner entertainment was homegrown and exuberant with the dancing by the AIIMS team a highlight! Sharp contrast to the dignified professional performance of last year's conference at Bhaghaty palace, Kochi. Great fun and inspired many dinner guests to strut their stuff also.

The stated objective of the conference was to "Update Knowledge in Palliative Care" and the theme of the conference was "Freedom from Pain". On the day preceding the conference, there was an Interventional Pain Management Techniques cadaveric workshop.

The conference was well attended by Indian palliative care professionals of all disciplines. As India develops economically, so health services and expectations are also growing. However, access to palliative care continues to be very patchy. Regional differences in service delivery and development of palliative care are marked but to some extent, to be expected given the cultural and social diversity that characterises India. It is increasingly clear that one model of palliative care delivery will not work in every part of India and there is now open discussion of the need for development of different models suited to regional circumstances. Factors such as the availability of volunteers and family as carers, with some parts of India having the more nuclear family as in the West, poverty, religious attitudes and expectations, literacy or its absence, availability of health professionals and centres of excellence have an impact on the face of palliative care across the subcontinent.

Remembering that many states of India house many more times the number of people than in the whole of Australia, it then seems naive to expect that there would be one model of palliative care across the whole country. The core principles however permeate all regional expressions-dignity of the person, person-centred care, care for the family, continuity of care, expert



Sushma and team

symptom management and end of life care. As always, the pioneers of Indian palliative care persevere against great odds to plant the seeds of palliative care in the soil of their region. Future generations will be the ones who will benefit from their labours.

**Liliana de Lima, Gayatri Palat
and David Joranson**



'Returning to India'; continued

There was also a large international group attending the conference and participating as faculty at the meeting, including Cecilia Sepulveda, WHO Head of Cancer and Palliative Care, Liliana de Lima, EO of IAHP, Dr Suresh Reddy of MDAnderson, Dr Mhoira Leng, now Professor of Palliative Medicine, Uganda and Prof. Geoff Hanks. Australians present included Dr Meera Agar and Meg Hegarty.

Next year, the seventeenth conference, will be held in Tiruchirappalli, Tamilnadu, India, also known as Trichy. The conference dates

are 12th, 13th & 14th February 2010. Information about the conference can be found at www.palcontrichy.com/main/index.php

The objective of this conference is to "Update the Palliative Care today and to have a Vision for tomorrow" and the theme is to "Light up the Twilight years" 'Bringing Excellence for the Elderly'.

Tiruchirappalli is situated in the Banks of the river Cauvery. It has a rich heritage historically, and surrounded by the Great Temples of South Indian Culture including

the Srirangam which is the 'Gate way Heaven'. It promises to be a true South Indian cultural experience with entertainment including 'Bharatha Natiyam' and the folk Dances of Tamilnadu. Please support our Indian colleagues who are working against enormous odds to alleviate the suffering of millions. Their experience can teach so much to us and our colleagues in the developing world.

Odette Spruyt

Palliative Care Physician

Peter MacCallum Centre Melbourne, VIC

odette.spruyt@petermac.org.au

Trichy Palcon 2010 Important Dates

Last date for Abstract submission:

30th September, 2009

Last date for submission of manuscript:

30th November, 2009

Important Dates

Last date of Registration: 10th January 2010

Pre Congress Workshop - 11th February 2010

Conference 12th, 13th & 14th February 2010

Venue: Hotel Sangam, Tiruchirappalli

News Bites

http://www.sdhospice.org/The_Institute_for_Palliative_Medicine.htm

The Institute for Palliative Medicine, San Diego Hospice - new initiative 2009

THE INTERNATIONAL PROGRAM

The IPM International Program helps countries and healthcare systems build palliative care programs that fit with their expressed needs, available resources, and cultural values. Working in partnership with leaders in these countries, the International Program: (1) provides consultation on needed changes in health policies; (2) facilitates increased medication importation and improved distribution and prescribing practices to increase access to opioids and other essential palliative medicines; (3) presents workshops and bedside training courses for health professionals; and (4) provides technical assistance with the development of strategic and business plans, quality standards, and program evaluation strategies. Most activities are conducted within the host countries to maximize participation and minimize costs.

IPM also offers International Fellowship Training Programs that enable clinicians from other countries to receive specialist-level bedside training in San Diego based on US Palliative Medicine Fellowship training standards, while they develop palliative care services in their home institution. In keeping with the vision of "bringing the experience back home," new insights on the provision of

culturally appropriate and integrated palliative care are shared with health professionals throughout the United States.

Indian Palliative Care

Taskforce Recommendations

Strategy for palliative care: National Cancer Control Program, 11th five year plan 2007-2012

Highlights the need for Palliative Care to be integrated into Cancer Care in all Regional Cancer Centres and 100 other cancer treatment facilities in the country.

The Mentoring collaboration between Pallium and APLI will support this strategy.

Excerpt from article from Pallium

India newsletter, 1 November 2009

<http://www.palliumindia.org/>

From Nicola Connelly, a medical student from UK:

Nicola underwent a month's palliative care course with Pallium India in Trivandrum and at the time of leaving, shared her thoughts. "I have learnt a lot of palliative care theory and especially enjoyed the communication skills sessions. - I liked the home visits a lot, and it was especially exciting when there was a snake on the path! However, on a couple of occasions I found the experience challenging - seeing the poor living conditions and seeing that patients had become so ill because they had not been able to afford cancer treatment. I had to step out of the house on one occasion and then I realised that I was walking away from the situation

because it was too painful to see. I realised that the patient was not able to do that and what is so amazing about the work of Pallium India is that the patient is not left by himself, no matter how emotionally difficult it can be and I think I have learnt not to be afraid of properly empathising with patients."

Care of the Elderly and Palliative Study Tour in South India

24 January - 8 February 2010

Visiting Cochin, Trichur, Calicut, Mysore, Bangalore, Vellore, Chennai

Led by Gilly Burn

At end of tour, there is the option to extend onto the Indian Association of Palliative Care conference in Trichy in Tamil Nadu

Contact Jon Baines

Tours on:

info@jonbainestours.co.uk
www.jonbainestours.co.uk/indiapal

Palliative Care as an International human right

There are major disparities in the provision of palliative care around the world. Over recent years a statement of advocacy and objective has been repeatedly articulated : that the provision of Palliative Care is a human right. This article examines the foundation for this assertion in the context of international human rights law. The nature of both the right and, correlatively, the obligation on individual governments are discussed. Recent developments in this area are also examined. The content of this overview synthesises material from two articles previously written or co-written by the author: Brennan FP. Palliative Care as an International Human Right. *Journal of Pain and Symptom Management* (2007) 33: 494-499 and Gwyther L, Brennan FP and Harding R. Advancing Palliative Care as a Human Right. *Journal of Pain and Symptom Management* (2009) 38 (5): 767-774. Readers are invited to refer to those articles, which cover this area more broadly, and which contain full references for all material cited.

Throughout the world there are wide disparities in the capacity, resources and infrastructure devoted to the care of people with life-limiting illnesses. The majority of countries have neither formal palliative care policies nor integrated palliative care services, do not meet basic international guidelines in the provision of palliative care and have legislation or policies whose effect restricts the availability of opioids for medical purposes.

In 1992 Margaret Somerville, a pre-eminent scholar of medical law, wrote a seminal paper arguing that the relief of suffering is a common goal of both medicine and human rights and that the relief of the pain and suffering of terminally ill patients is a human right. In recent years that term has entered the discourse : a Standing Committee of the Canadian Senate , The Cape Town Declaration, the European Committee of Ministers, the International Working Group (European School of Oncology), Pope Benedict XVI, The Korea Declaration and The Joint Declaration and Statement of Commitment on Palliative Care and Pain Treatment as Human Rights have all asserted that palliative care is a fundamental human right.

What, if any, are the foundations for articulating such a right ? This paper will address one answer to that question: palliative care as an international human right.

The international human right to health care

The International Covenant on Economic, Social and Cultural Rights (ICESCR) states :

Article 12 1. The State Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

2. The steps to be taken... to achieve the full realisation of this right shall include those necessary for :

... d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

In addition, the right to health is articulated in several other international covenants.

It is important to emphasise several aspects of this right to health. Firstly, the right is not absolute, to be fulfilled immediately. At its inception there was a clear recognition that resources varied significantly throughout the world. Rights articulated in this Covenant were seen as aspirational – rights to be achieved progressively over time to the maximum capacity of each signatory nation state. Secondly the Covenant imposes obligations solely on governments that are signatories. It does not obligate private citizens, including health professionals. Finally there is no appeal process or mechanism for complaint. Nevertheless, signatory nations are expected to regularly report to a Committee overseeing the Covenant.

There is no express right to palliative care in these United Nations documents. Nevertheless, the World Health Organization defines both health and palliative care broadly. Health includes the health of people with life-limiting illnesses. The provision of palliative care, where appropriate, is one part of a continuum of health care for all persons. Therefore, an argument can be made that a right to palliative care can be implied from the overall international human right to health. Assuming that a right to palliative care can be implied from the overall international human right to health what, correlatively, is the content of the obligation ?

The content of the obligation

The ICESCR Committee

In 2000, the Committee overseeing the ICESCR issued a General Comment on the right to health, stating what it saw as the “core obligations” of all signatory nations, irrespective of resources. They include obligations to

ensure access to health facilities, good and services on a non-discriminatory basis, to provide essential drugs, as defined by the WHO, and to adopt and implement a national public health strategy. Interpreting this Comment in the context of palliative care, this would oblige nations to ensure a universal access to services, the provision of basic medications for symptom control and terminal care and the adoption and implementation of national palliative care policies.

The World Health Organization

For palliative care, a further guide to minimum standards expected by the international community emerges from WHO recommendations. These include that all countries should adopt a national palliative care policy, ensure the training and education of health professionals and promote public awareness, ensure the availability of morphine in all health care settings and that all countries should ensure that minimum standards for pain relief and palliative care are progressively adopted at all levels of care. The symmetry is clear: the obligations of governments, as interpreted by the Committee that oversees the international right to health, accords exactly with the recommendations of the pre-eminent world health body.

Recognising the widely divergent capacities of countries, the WHO set out general recommendations for different resource settings. For countries with low resource settings, home-based care is probably the best way of achieving good quality care. In countries with medium level resources, services should be provided by primary health care clinics and home-based care. In high resource settings, there is a variety of options including home-based care.

International statements

Several international statements have been made, over recent years, asserting that the provision of palliative care is a universal right. Collectively they represent statements of advocacy and objective. In addition they provide a sense of the architecture and content of this purported right.

Conscious of the appalling unfolding tragedy of HIV/AIDS, the poorly-met needs of cancer patients and the inadequacy of governmental response throughout the African continent, the Cape Town Declaration (2002) asserted four main propositions :

1. Palliative Care is a right of every adult and child with a life-limiting disease.
2. Appropriate drugs, including strong opioids, should be made accessible to every patient requiring them in every sub-Saharan country and at all levels of care.
3. The establishment of education programmes at all levels of the learning continuum.
4. Palliative care should be provided at all levels of care...While primary care is emphasised, secondary and tertiary level teams are needed to lead and foster primary level care.

In 2004, the International Working Group (European School of Oncology) released a position paper "A new international framework for palliative care". It stated that "there should be free access to palliative care ... for all cancer patients, as a fundamental human right." The Korea Declaration emerged from the 2nd Global Summit of National Hospice and Palliative Care Associations in 2005. It stated that governments must "make access to hospice and palliative care a human right." Specifically it called on governments to include palliative care as part of health policy, integrate palliative care training into the curricula of health professionals, ensure the availability and affordability of all necessary drugs, especially opioids and strive to make hospice and palliative care available to all citizens in the setting of their choice.

In 2008 there were three major international statements of advocacy by representative bodies in Palliative Care and pain management. The first was the World Hospice and Palliative Care Day (2008). Its theme was "Palliative Care as Human Right". Historically that echoes the theme of the inaugural Global Day Against Pain in 2004 - "Pain Relief as a Human Right". Concurrent with the World Hospice Day the International Association for Hospice and Palliative Care (IAHPC) and the Worldwide Palliative Care Alliance (WPCA) promulgated the Joint Declaration and Statement of Commitment on Palliative Care and Pain Treatment as Human Rights (2008). This was the first international Declaration joining palliative care, pain, cancer, AIDS and other related organizations for this same purpose. In addition to its declaratory status it was also designed to be a tool of advocacy to be used by civil society/Non-governmental Organizations (NGOs) and professional organisations when approaching various levels of organizations and governments to support the advancement of palliative care and pain treatment around the globe. Finally the International Association for the Study of Pain (IASP) designated

the year commencing October 2008 as the Global Year Against Cancer Pain.

Another significant international statement that has clear implications for the provision of palliative care was the Montreal Statement on the Human Right to Essential Medicines (2005). The Statement expressly linked the international right to health with a universal access to these essential medications.

Synthesising these sources (the Committee that oversees the international right to health, the WHO and the international palliative care community) a consensus on the content of the obligation on individual governments in relation to palliative care appears to be emerging.

From theory to practice – recent practical developments in marshalling human rights to advance pain management and Palliative Care

The last year has seen significant activity in employing an approach based on human rights to advance both pain management and Palliative Care. Singly each development is important. Taken together they represent a discernible shift in the level and focus of activity in this area. Advocacy by global bodies is leading to an explicit acknowledgment within the United Nations. In summary these developments include :

Statements by UN Special Rapporteurs on human rights

Following sustained advocacy by the International Association for Hospice and Palliative Care (IAHPC) and the Worldwide Palliative Care Alliance (WWPCA) two United Nations Special Rapporteurs on human rights issues have made clear and explicit statements to the international community linking pain management and Palliative Care to human rights. In a statement made to the UN Human Rights Council in 2008 the Special Rapporteur on the Right to Health placed palliative care firmly within the obligations that derive from the international right to health :

Many other right-to-health issues need urgent attention, such as palliative care...Every year millions suffer horrific, avoidable pain... Palliative care needs greater attention.

Similarly the UN Special Rapporteur on Torture in his report to the Human Rights Council in January 2009 stated "the de facto denial of access to pain relief, if it causes pain and suffering, constitutes cruel, inhuman or degrading treatment or punishment" and "all measures should be taken to ensure full access [to pain treatment and opioid analgesics] and to overcome current regulatory, educational

and attitudinal obstacles to ensure full access to palliative care."

The two Rapporteurs also made a joint statement to the Chairperson of the Commission on Narcotic Drugs in late 2008. After reviewing the inadequacies of pain management and Palliative Care around the world, stated that :

The failure to ensure access to controlled medicines for the relief of pain and suffering threatens fundamental rights to health and to protection against cruel inhuman and degrading treatment. International human rights law requires that governments must provide essential medicines – which include, among others, opioid analgesics – as part of their minimum core obligations under the right to health. ...Lack of access to essential medicines, including for pain relief, is a global human rights issue and must be addressed forcefully...

That statement proceeded to make clear, practical recommendations for all Member nations including that they :

- (a) Ensure that national drug control laws recognize the indispensable nature of narcotic and psychotropic drugs for the relief of pain and suffering...
- (b) Review...national legislation and administrative procedures...that unnecessarily impede their accessibility and availability for medical use...
- (c) Ensure that national competent authorities and health ministries, in consultation with healthcare providers, work to establish healthcare systems that are capable of ensuring wide availability of controlled medicines...
- (d) Ensure appropriate instruction to health professionals on the medical use of all controlled medicines listed on the WHO Model List of Essential Medicines...and on the legal requirements for prescribing and dispensing controlled medicines.
- (e) Allocate sufficient funds and personnel to implement all the above stated objectives.

These Statements are a major breakthrough. They not only represent the most explicit linkage of human rights with pain management and Palliative Care made to date by representatives of the United Nations, but they also provide clinicians and advocates a clear statement of recommendations to present to the health ministries of individual countries. It is one thing for clinicians and advocates to argue on the basis of evidence and a medical and moral imperative. It is altogether another to argue armed with clear statements of national obligations articulated by senior members of the United Nations system.

Submissions by the Pain and Palliative Care communities to the United Nations

In late 2008 a joint submission was made by the International Association for Hospice and Palliative Care (IAHPC), the Worldwide Palliative Care Alliance (WWPCA) and the International Association for the Study of Pain (IASP) to the UN Human Rights Council. In summary it outlined the human rights implications of pain management and Palliative Care for patients with HIV/AIDS and their families. It stated that Palliative care, generally, and pain management, in particular, for patients with HIV/AIDS, is undertreated, poorly resourced and subject to multiple barriers. It outlined the obligations of individual countries in the provision of health care for patients with HIV/AIDS, including all aspects of pain management and palliative care.

At the same time, the Committee overseeing the ICESCR, preparing a General Comment on the issue of discrimination, called for submissions. A submission has been made to the Committee by the IAHPC, WPCA and IASP describing discrimination in the provision of, and access to, both pain management and palliative care. The submission argued that draconian domestic opioid laws, policies and practices that restrict opioid availability, accessibility and affordability constitute a significant discrimination against patients in pain and the dying. Other examples of de facto discrimination in the provision of pain management and palliative care are laws, policies and practices that fail to provide adequate health care services in rural and remote areas or fail to provide adequate health care services for children, patients with HIV/AIDS, indigenous persons, persons with disabilities, prisoners, women, refugees and stateless persons.

Shadow reports on individual countries

All nations that are signatory to the International Covenants that contain the right to health care are expected to report to Committees overseeing those Covenants on the progress of their compliance with that obligation. Non-government organizations may submit shadow reports on that country's performance. It is planned that the coalition of the International Association for Hospice and Palliative Care (IAHPC), the Worldwide Palliative Care Alliance (WPCA) and the International Association for the Study of Pain (IASP) will commence submitting shadow reports on the status of Palliative Care and pain management of individual nations.

Conclusion

Given the enormous unmet needs of patients with life-limiting illnesses in the world, it is not surprising that advocates have promoted the provision of palliative care as a human right. Indeed, those statements have emerged in an era where links are being generally made between health and human rights. A human right to palliative care may be implied from the international right to health care.

However, that right should not be seen in isolation. If the goal is freedom from unnecessary suffering then the provision of all possible measures to ensure that relief is met must be present – including adequate housing, nutrition, water and sanitation. For the progressive fulfilment of a human right to palliative care much will be required: flexible and creative public policy, greater access to opioids for medical purposes, tireless advocacy, comprehensive education, professional leadership, and continued calls upon individual compassion for this most vulnerable group of people. Following statements that emerged from the pain management and Palliative Care communities the United Nations itself has begun to respond. Those statements clearly recognise the specific obligations that lie with individual nations in this vital area of health care. It remains to be seen what practical dividends flow from these developments.

Frank Brennan

*Palliative Care Physician
Calvary Hospital Sydney, NSW*

fpbrennan@ozemail.com.au

Expression of Interest

Call for consultants or organizations to provide clinical palliative care training, curriculum development and mentoring in Vietnam

Background

Family Health International (FHI) Viet Nam was recently awarded a five-year cooperative agreement by the CDC-HHS/PEPFAR to build the palliative care clinical capacity of health care workers in Vietnam.

FHI is seeking expressions of interest (EOI) from consultants and organizations experienced in clinical palliative care in developing country contexts. Expression of interests should be emailed to Dr Pham Le Huy in the format described below at huy@fhi.org.vn - no later than 5pm, Vietnam time, on January 15, 2010. The expressions of interest will be reviewed by FHI who will then develop a detailed scope of work and contract with the successful consultants and/or organizations.

Queries:

Clarification questions may be sent to huy@fhi.org.vn until December 15, 2009.