Atlas

of Palliative Care in Latin America

ALCP

INTERNATIONAL ASSOCIATION FOR HOSPICE & PALLIATIVE CARE

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ATLAS OF PALLIATIVE CARE IN LATIN AMERICA

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PARTICIPATING INSTITUTIONS

The Atlas of Latin America is headed by the Latin American Association for Palliative Care (ALCP) in cooperation with the *International Association for Hospice and Palliative Care* (IAHPC). Furthermore, this project has the technical and scientific support of the *European Association for Palliative Care* (EAPC), the Spanish Society of Palliative Care (SECPAL) and the University of Navarra (Spain).

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INTRODUCTION

This Atlas provides an overview of the status of Palliative Care[1] in Latin America.[2] This is the first systematic study attempting to gather information on Latin American countries and highlighting the current status of Palliative Care. For the purposes of this study, the World Health Organization's definition of Palliative Care applies, understood as:

"Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual."[3]

The study on the status of Palliative Care will serve as a stimulus for developing this specialty in the region, and for fostering a network allowing the interchange of experiences.

OBJECTIVES

The primary objective of the Atlas is to assess the degree of development of Palliative Care in Latin America.

Secondary objectives are:

- Ascertain and disseminate the current status of Palliative Care in the region, taking social and health policies into consideration.
- Provide specific data to help policy makers, planners and professional associations make decisions and set policies pertaining to Palliative Care.
- Facilitate access to data and communication between institutions and associations devoted to Palliative Care in the region.
- Identify key individuals involved in developing Palliative Care in each country.
- Promote the development of Palliative Care.

1 In this study, the term *Palliative Care* includes *Palliative Medicine*.

2 With the term *Latin America* we are referring to the 19 countries with Spanish or Portuguese as official languages and which were included in the study.

3 World Health Organization (WHO). National cancer control programs: Management policies and guidelines. World Health Organization/WHO, 2nd ed., WHO: Geneva; 2004.

METHODOLOGY

The Atlas of Palliative Care in Latin America is a descriptive, comparative analysis study of data and/or estimates on the development of in Palliative Care services and initiatives in Latin America.[4]

The creation of and the model for the Atlas of Palliative Care in Latin America were based on the Atlas of Palliative Care of the European Association for Palliative Care (EAPC).[5]

Our information was obtained through a semi-structured survey of Palliative Care professionals in each country. This instrument was developed by Tania Pastrana, Carlos Centeno and Liliana De Lima, and included advice from Isabel Torres.

The instrument was tested in a 6-person pilot study, and necessary changes were made based on the results.

The steps followed for this study were as follows (see Illustration 1):

1. Identify informants (screening):

A list was made of individuals linked to Palliative Care by country, based on the following criteria:

- Individuals with previously published studies on the status of Palliative Care in their own country, and/or
- People whom the ALCP Steering Committee or working group members have made reference to as palliative care professionals.

2. Invite Participation

Three individuals were chosen in each country, one of them being the national association president, if any. These individuals were e-mailed invitations to participate and the questionnaire was sent in PDF and Word.

3. Survey

Over a period of four months (January to April 2012), a 103% (59 participants) response rate was obtained, since in two countries one individual participated on his or her own initiative. Four individuals chosen dropped out of the project and were replaced by other experts in their country, according to the same criteria or by a *snowball effect*.

4. Consensus

The data obtained through the survey were scanned and tabulated in a database (Microsoft Excel Version 14.0). We drafted a preliminary report for every country, highlighting inconsistencies, and unclear or incomplete information.

This preliminary report was sent in August of 2012 to contributors for review, additional information and clarification of discrepancies.

4 Clark D, Centeno C. Palliative care in Europe: an emerging approach to comparative analysis. *Clinical Medicine*. 2006;6(2):197-201

5 Centeno C, Clark D, Lynch T, Rocafort J, Greenwood A, Flores L, De Lima L, Giordano A, Brasch S, Praill D. *EAPC Atlas of Palliative Care in Europe*. Houston: IAHPC Press; 2007.

5. Final Report

Additional discussions by e-mail, phone and Skype were carried out for drafting the final report, in order to answer questions and make necessary corrections. Through an open review process (November 2012), critiques, suggestions and data were collected that were confirmed by the main contributors.

In this first version of the Atlas of Palliative Care, 19 Latin American countries with Spanish or Portuguese as official languages were included.

Each country report is divided into 5 sections:

- Palliative Care Services
- Palliative Care Training
- Professional Activity
- Health Policy
- Palliative Care Development

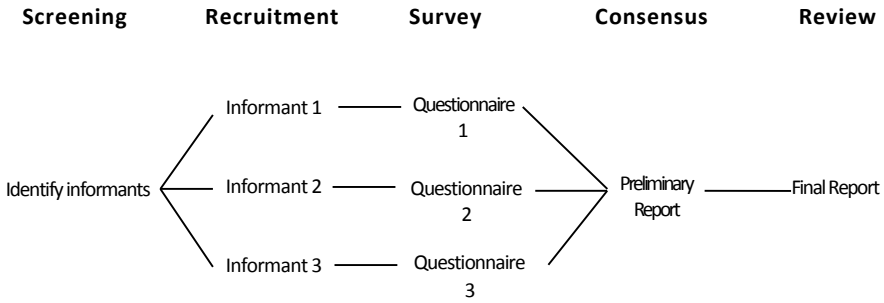

Figure 1: Diagram of steps in the research process

LIMITATIONS OF THE ATLAS

The Atlas of Palliative Care has some limitations:

- Many countries don't have reliable information and the data is the result of personal estimates not always matching that of other informants from the same country.
- The situation in Latin America changes rapidly. From data collection to review (4 months), laws were approved, courses began, new services were opened, and others were closed.
- Health services, and consequently, Palliative Care services, are not the same in the various countries, which creates challenges when trying to use a blueprint for all countries.
- Reports on some countries include Palliative Care services information mixed with pain clinic and cancer and chronic illness programs, which complicates specifying information.

These challenges were handled through an intense communication process with the informants.

PALLIATIVE CARE REGIONAL ANALYSIS

This chapter describes the overall status of Palliative Care in Latin America. It is not intended to be a detailed analysis or to propose development strategies for the region.

Latin America is characterized by its great heterogeneous nature (see Table 1). Among the 19 Spanish and Portuguese speaking countries, there are countries the size of Brazil with an area of 8,514,876.6 km^2 (41% of the area of Latin American), which is 405 times larger than that of El Salvador (21,040 km^2, 0.1% of Latin America). Population varies in the same way: Brazil has 192,376,496 inhabitants (34%), while 3,286,314 people live in Uruguay (0.6% of the total Latin American population). El Salvador has a population density of 295 inhabitants/km^2, while in contrast, Bolivia has 9 inhabitants/km^2.

The number of doctors per inhabitant ranges from 67.3/10,000 inhabitants in Cuba to 1.5/10,000 in Colombia.

According to the World Bank, Latin American countries are middle to high income (13 countries) and low to middle income (6 countries), and have a Human Development Index (HDI) between medium (7 countries), high (10 countries) and very high (Chile and Argentina).

The percentage of people living on less than 1.25 PPP/day varies from 0% (Uruguay) to 23.3% (Honduras). Health expenditures account for between 10.9% (Costa Rica) and 4.8% (Bolivia) of the Gross Domestic Product in PPP.

PALLIATIVE CARE SERVICES

In Latin America, there are a total of 922 services throughout the region, that is, 1.63 Palliative Care services/units/teams per one million inhabitants (million inhab.). The range goes from 16.06 (Costa Rica) to 0.24 services/MM inhab. (Honduras). Chile has the highest number of services in absolute numbers (277 services) and by percentage (30%) of services in the region, although not all services reported have Palliative Care specialists. 46% (Argentina and Chile) of existing Palliative Care services in the region serve 10% of the population (see Table 2).

The types of services most frequently identified are home care teams (0.4/MM inhab.). Chile, Mexico and Cuba have the highest number of these services. Following that in terms of frequency are hospital support services/teams (0.34/MM inhab.) - located especially in Argentina (1.99/MM inhab.) and Chile (4.29/MM inhab.) - and multilevel teams (0.33/MM inhab.), more common in Costa Rica (10/MM inhab.) and Chile (3.30/MM inhab.).

Five hundred twenty-three (523) services/teams (0.93/MM inhab.) provide care in the first level of public healthcare. 586 public healthcare teams were identified in the second and third levels (1.04 services/teams/MM inhab.). These services/teams are most often found in third level public healthcare hospitals.

There are 44 day centers (0.08/MM inhab.) and 115 volunteer teams (0.20/MM inhab.) in Latin America. Costa Rica reported the highest number of day centers (1.63 day centers/MM inhab.) and the largest number of volunteer teams (10.23 volunteer teams/MM inhab.).

Palliative Care Training

Four Latin American countries have official Palliative Care accreditation as a medical specialty and/or sub-specialty, and in 6 countries, it is a course or diploma. The first accreditation was obtained in Colombia in 1998. With the exception of Chile, all countries with accreditation have an active post-graduate course. Paraguay offers post-graduate courses, but no accreditation.

In total, it is estimated that nearly 600 palliative doctors are accredited in the region (average: 31.5, median: 2). Most (70%) are in Mexico, Argentina and Chile.

In Cuba and Uruguay, all medical schools offer Palliative Care, either as a separate course program or as part of other course programs. In contrast, curriculum in medical schools in Bolivia, El Salvador, Honduras and Nicaragua do not mention Palliative Care. There is an average of 14 teachers per country, but this number varies from zero (Bolivia and Honduras) to 45 in Mexico. The number of non-medical faculty professors is much lower (1.5 on average) (see Table 3).

Professional Activity

Eleven (11) Latin American countries have (at least) one Palliative Care association. Brazil and Costa Rica have two associations and Mexico has three, although one is inactive.

Active research groups are located in Chile (10), Argentina (5), Mexico (5), Cuba (4), Colombia (4), Peru (3), Panama (2), Brazil (1) and the Dominican Republic (1).

64 international collaborative initiatives in the region were mentioned. Argentina and Mexico reported the largest number of international partnerships, with 11, and 10 formal partnerships. These partnerships are made with institutions/organizations in the United States, Spain, Britain and Canada and are generally geared toward training and research.

There are regional partnerships with the Latin American Association for Palliative Care (ALCP), Central American and Caribbean Federation for Pain and Palliative Care (FEDOPACC), and Latin American Federation for Pain and Palliative Care (FEDELAT), and between Latin American countries such as Cuba-Mexico, Cuba-Brazil, Costa Rica-Honduras and Bolivia-El Salvador-Venezuela-Honduras.

Ten (10) countries have at least one published Palliative Care guide or standards and five countries have a service directory. Only Brazil publishes a Palliative Care journal, which is currently being indexed.

Brazil and Argentina are the countries with the most active members in the Latin American Association for Palliative Care. At the last two ALCP conferences, they were the most represented both with regard to number of attendees and in terms of scientific participation (these conference were held in those countries) (see Table 4).

HEALTH POLICY

Three (3) countries have a national Palliative Care law. There are national Palliative Care plans/programs in 7 countries, 5 of which are integrated with cancer/pain. Five (5) countries have a monitoring and evaluation system. Most existing programs are linked to cancer/pain programs. In Uruguay and Ecuador, the program is under development/implementation.

Sixteen (16) countries have a national cancer program, 13 of which include Palliative Care. Primary Care Programs exist in all countries and 8 of them include Palliative Care. All countries have a national HIV/AIDS program, 7 of which include Palliative Care.

Five countries have government resources for developing Palliative Care and four have resources available for research.

Cooperation between opiate prescribers and regulators is a normal average (3 on a scale of 1-5). It varies from very poor in Bolivia to very good in Costa Rica (see Table 5).

PALLIATIVE CARE DEVELOPMENT

Palliative care began in the early eighties with the creation of the Pain and Palliative Care Clinic by Dr. Tiberio Álvarez in Medellin, Colombia, and the provision of home care by Dr. Roberto Wenk in San Nicolas, Argentina. In the nineties, other services emerged, and the 21st century started with Palliative Care in 84% of the countries. In the early 2000s, Honduras, Bolivia and Nicaragua began Palliative Care operations (see Illustration 1).

The development of Palliative Care in Latin America has been erratic and with no clear pattern. In these countries, Palliative Care is at varying stages of development. Eleven (11) countries are classified according to the Wright et al. classification[1] as being in Stage 3 (isolated delivery of services), 6 in the preliminary stage of integration with standard health services (4a), and Colombia and Costa Rica are considered to be in the advanced stage of integration with standard health services (4b). Each country faces many challenges, and despite the best efforts of the palliative care professionals and, at times, governments, most of the population remains uninsured for Palliative Care.

1 Wright M, Wood J, Lynch T & Clark D. (2008). Mapping levels of palliative care development: a global view. *Journal of pain and symptom management, 35*(5), 469-485.

Tabla 1: General Characteristics

Country	Population	(%)	Area	(%)	Density (inhab./km²)	Physicians /10,000 inhab.	World Bank Classification	GDP (2011)	HDI		Poverty	Health expenditures (% of GDP)	Per capita total expenditure on health (2010)	Per capita government expenditure on health (%)	
Argentina	40117096	(7.1)	3745997	(17.9)	10.7	31.5	middle to high	15559.35	0.797	very high	0.9%	8.1	1287	703	(54.6)
Bolivia	10426154	(1.8)	1098581	(5.2)	9.5	12.2	lower middle	4736.82	0.663	middle	14.0%	4.8	233	147	(63.1)
Brazil	192376496	(34.1)	8514877	(40.7)	22.6	17.6	middle to high	11585.41	0.718	high	3.8%	9.0	1028	483	(47.0)
Chile	17248450	(3.1)	756626	(3.6)	22.8	10.3	middle to high	15874.10	0.805	very high	0.8%	8.0	1199	578	(48.2)
Colombia	46044601	(8.2)	1141748	(5.5)	40.3	1.5	middle to high	9479.61	0.710	high	16.0%	7.6	713	518	(72.7)
Costa Rica	4301712	(0.8)	51100	(0.2)	84.2	13.2	middle to high	11134.49	0.774	high	0.7%	10.9	1242	845	(68.0)
Cuba	11241161	(2.0)	109884	(0.5)	102.3	67.3	middle to high	9900.00	0.776	high	no data	10.6	431	394	(91.4)
Dominican Republic	10010590	(1.8)	48442	(0.2)	206.6	18.8	middle to high	9688.45	0.689	middle	4.3%	6.2	578	250	(43.3)
Ecuador	14483499	(2.6)	272045	(1.3)	53.2	16.9	middle to high	8206.43	0.720	high	5.1%	8.1	653	243	(37.2)
El Salvador	6216143	(1.1)	21040	(0.1)	295.4	15.9	lower middle	7683.01	0.679	middle	5.1%	6.9	450	278	(61.8)
Guatemala	14713763	(2.6)	108899	(0.5)	135.1	9.0	lower middle	4998.46	0.574	middle	13.1%	6.9	325	116	(35.7)
Honduras	8215313	(1.5)	112492	(0.5)	73.0	5.7	lower middle	4231.71	0.625	middle	23.3%	6.8	263	171	(65.0)
Mexico	112322757	(19.9)	1964375	(9.4)	57.0	19.6	middle to high	14849.46	0.770	high	3.4%	6.3	959	469	(48.9)
Nicaragua	6071045	(1.1)	130000	(0.6)	46.7	3.7	lower middle	2685.32	0.589	middle	15.8%	9.1	253	135	(53.4)
Panama	3405813	(0.6)	75517	(0.4)	45.1	15.0	middle to high	12965.19	0.768	high	9.5%	8.1	1123	844	(75.2)
Paraguay	6561785	(1.2)	406752	(1.9)	16.1	11.1	lower middle	4919.55	0.665	middle	5.1%	5.9	302	110	(36.4)
Peru	28664989	(5.1)	1285216	(6.1)	22.3	9.2	middle to high	9641.92	0.725	high	5.9%	5.1	481	260	(54.1)
Uruguay	3286314	(0.6)	176215	(0.8)	18.6	37.4	middle to high	14667.18	0.741	high	0.0%	8.4	1188	797	(67.1)
Venezuela	28946101	(5.1)	916445	(4.4)	31.6	19.4	middle to high	11705.84	0.735	high	3.5%	4.9	589	206	(35.0)
Total	**564653782**	**100%**	**20936250**	**100%**	**70.5***	**17.6***		**9711.17***	**0.711***	**high**					

* Arithmetic mean

Table 2: Palliative Care Services

Country	Hospice in-patient (per million inhab.)		Home Care (per million inhab.)		Community Center (per million inhab.)		Services/ Units in 2nd level hospitals (per million inhab.)		Services/Units in 3rd level hospitals (per million inhab.)		Multilevel Services/ Teams (per million inhab.)		Hospital Services/ Support Teams (per million inhab.)		Full Services (per million inhab.)		Day Centers (per million inhab.)		Hospice Volunteers (per million inhab.)
Argentina	11	(0.27)	21	(0.52)	0	(0.00)	2	(0.05)	21	(0.52)	16	(0.40)	80	(1.99)	151	(3.76)	9	(0.22)	2
Bolivia	1	(0.10)	1	(0.10)	0	(0.00)	0	(0.00)	0	(0.00)	3	(0.29)	1	(0.10)	6	(0.58)	1	(0.10)	10
Brazil	6	(0.03)	24	(0.12)	0	(0.00)	0	(0.00)	16	(0.08)	26	(0.14)	21	(0.11)	93	(0.48)	13	(0.07)	12
Chile	3	(0.17)	83	(4.81)	0	(0.00)	32	(1.86)	28	(1.62)	57	(3.31)	74	(4.29)	277	(16.06)	0	(0.00)	30
Colombia	4	(0.09)	2	(0.04)	0	(0.00)	1	(0.02)	13	(0.28)	3	(0.07)	0	(0.00)	23	(0.50)	0	(0.00)	1
Costa Rica	2	(0.46)	0	(0.00)	17	(3.95)	0	(0.00)	0	(0.00)	43	(10.0)	1	(0.23)	63	(14.65)	7	(1.63)	44
Cuba	0	(0.00)	40	(3.56)	7	(0.62)	0	(0.00)	3	(0.27)	0	(0.00)	1	(0.09)	51	(4.54)	0	(0.00)	0
Dominican Republic	1	(0.10)	0	(0.00)	0	(0.00)	0	(0.00)	3	(0.30)	2	(0.20)	2	(0.20)	8	(0.80)	0	(0.00)	2
Ecuador	3	(0.21)	2	(0.14)	0	(0.00)	0	(0.00)	2	(0.14)	3	(0.21)	2	(0.14)	12	(0.83)	1	(0.07)	1
El Salvador	0	(0.00)	0	(0.00)	0	(0.00)	0	(0.00)	1	(0.16)	3	(0.48)	0	(0.00)	4	(0.64)	2	(0.32)	0
Guatemala	3	(0.20)	1	(0.07)	0	(0.00)	0	(0.00)	3	(0.20)	0	(0.00)	0	(0.00)	7	(0.48)	0	(0.00)	1
Honduras	0	(0.00)	0	(0.00)	0	(0.00)	0	(0.00)	0	(0.00)	1	(0.12)	1	(0.12)	2	(0.24)	1	(0.12)	1
Mexico	7	(0.06)	47	(0.42)	17	(0.15)	34	(0.30)	10	(0.09)	4	(0.04)	0	(0.00)	119	(1.06)	1	(0.01)	14
Nicaragua	0	(0.00)	1	(0.16)	0	(0.00)	0	(0.00)	0	(0.00)	5	(0.82)	7	(1.15)	13	(2.14)	8	(1.32)	1
Panama	0	(0.00)	2	(0.59)	3	(0.88)	2	(0.59)	1	(0.29)	0	(0.00)	1	(0.29)	9	(2.64)	0	(0.00)	2
Paraguay	1	(0.15)	0	(0.00)	0	(0.00)	0	(0.00)	1	(0.15)	0	(0.00)	2	(0.30)	4	(0.61)	0	(0.00)	1
Peru	0	(0.00)	0	(0.00)	0	(0.00)	1	(0.03)	7	(0.24)	4	(0.14)	0	(0.00)	12	(0.42)	0	(0.00)	1
Uruguay	1	(0.30)	0	(0.00)	1	(0.30)	1	(0.30)	6	(1.83)	14	(4.26)	0	(0.00)	23	(7.00)	1	(0.30)	0
Venezuela	1	(0.04)	0	(0.00)	23	(0.79)	8	(0.28)	10	(0.35)	3	(0.10)	0	(0.00)	45	(1.56)	0	(0.00)	2
Total	**44**	**(0.08)**	**224**	**(0.40)**	**68**	**(0.12)**	**81**	**(0.14)**	**125**	**(0.22)**	**187**	**(0.33)**	**193**	**(0.34)**	**922**	**(1.63)**	**44**	**(0.08)**	**125**

Table 3: Palliative Care Training

Country	Accreditation	(year)	Accreditation Type	Physicians Accredited	Postgraduate Diploma in Palliative Care	Medical Schools	Medical Schools with Palliative Care (%)		Teachers	
									Medical	Other Schools
Argentina	Yes	(2004)	Certification	**100**	Yes	27*	6	(22.2)	15	5
Bolivia	No			--	No	25	0	(---)	0	0
Brazil	Yes	(2011)	Sub-/Specialty	--	Yes	180*	3	(1.7)	5	1
Chile	Yes	(2006)	Certified	70	inactive	21	12	(57.1)	30	40
Colombia	Yes	(1998)	Sub-/Specialty	43	Yes	57	3	(5.3)	20	10
Costa Rica	Yes	(2008)	Specialty	49	Yes	7	2	(28.6)	20	20
Cuba	Yes	(2010)	Diploma	37	Yes	22	22	(100)	43	43
Dominican Republic	No			--	No	10	1	(10.0)	8	0
Ecuador	No			--	No	12	3	(25.0)	3	1
El Salvador	No			--	No	6	1	(16.7)	7	0
Guatemala	No			--	Yes	9	1	(11.1)	2	1
Honduras	No			--	No	2	0	(---)	0	0
Mexico	Yes	(2010)	Certification	250	Yes	54	5	(9.3)	45	25
Nicaragua	No			--	No	6	0	(---)	0	0
Panama	Yes	(2011)	Course	2	inactive	4	2	(50.0)	15	15
Paraguay	No			--	Yes	14*	2	(21.4)	7	4
Peru	No			--	No	21	0	(---)	23	1
Uruguay	Yes	(2009)	Diploma	20	Yes	2	2	(100)	15	5
Venezuela	Yes	(2009)	Specialty	4	Yes	8	1	(12.5)	6	4
Total				**575 (30.3⁺,0§)**					**264 (14⁺,8§)**	**29 (9⁺,4§)**

* The lowest amount given was used; ⁺ Arithmetic mean; § Median

Table 4: Professional Activity

Country	Association for Palliative Care	Research Groups	International Cooperation	Standards, norms or guidelines	National Summit	Directory	National Journal	ALCP Members	Participants to the V ALCP Congress (total scientific participation*)		Participants to the VI ALCP Congress (total scientific participation*)	
Argentina	1	5	10	Yes	Yes	1	0	36	268	(89)	50	(52)
Bolivia	0	0	1	No	No	0	0	1	2	(4)	1	(0)
Brazil	2	1	1	Yes	Yes	2	1	43	91	(70)	483	(269)
Chile	0	27	3	Yes	Yes	2	0	24	50	(13)	34	(10)
Colombia	1	4	3	No	Yes	0	0	20	56	(21)	20	(9)
Costa Rica	2	0	4	Yes	Yes	1	0	8	26	(3)	3	(2)
Cuba	0	4	5	Yes	Yes	0	0	4	1	(2)	3	(3)
Dominican Republic	0	1	3	No	No	0	0	3	7	(2)	6	(0)
Ecuador	1	0	4	No	Yes	0	0	10	13	(2)	12	(5)
El Salvador	1	0	5	No	Yes	0	0	9	3	(0)	5	(1)
Guatemala	0	0	3	No	No	0	0	7	2	(2)	6	(1)
Honduras	0	0	1	No	No	0	0	3	0	(0)	2	(0)
Mexico	3	4	10	Yes	Yes	0	0	27	20	(15)	9	(6)
Nicaragua	0	0	1	Yes	No	0	0	1	0	(0)	2	(0)
Panama	0	2	2	Yes	Yes	0	0	15	15	(1)	18	(4)
Paraguay	1	0	0	Yes	Yes	0	0	4	13	(0)	38	(0)
Peru	1	3	3	No	Yes	0	0	15	31	(2)	9	(5)
Uruguay	1	0	2	Yes	Yes	0	0	16	42	(8)	38	(18)
Venezuela	1	0	4	No	No	1	0	12	12	(9)	23	(16)

* Sum of all scientific activities at the conference (includes: posters, oral presentations, concurrent sessions, workshops).

Table 5: Health Policy

Country	National Law	National Program/Plan	Auditing, monitoring, evaluation	National Cancer Program (including PC)		National HIV/AIDS Program (includes PC)		National Primary Care Program (includes PC)		Development Resources	Research Resources	Opioids: Collaboration between prescribers and regulators
Argentina	No*	No	No	Yes	(Yes)	Yes	(Yes)	YES	(No)	No	Yes[§]	4.0
Bolivia	No	No	No	No	--	Yes	(No)	YES	(No)	No	No	1.0
Brazil	No	Yes[+]	No	Yes	(Yes)	Yes	(Yes)	YES	(Yes)	No	No	3.5
Chile	Yes	Yes[+]	Yes	Yes	(Yes)	Yes	(Yes)	YES	(Yes)	Yes	No	4.0
Colombia	Yes[+]	No	No	Yes	(Yes)	Yes	(No)	YES	(No)	No	Yes	3.5
Costa Rica	No	No	Yes	Yes	(Yes)	Yes	(Yes)	YES	(Yes)	Yes	No	5.0
Cuba	No	Yes[+]	Yes	Yes	(Yes)	Yes	(Yes)	YES	(Yes)	Yes	Yes	4.0
Dominican Republic	No	No	No	Yes	(No)	Yes	(No)	YES	(No)	No	No	3.0
Ecuador	No	No	No	Yes	(Yes)	Yes	(No)	YES	(No)	No	No	3.0
El Salvador	No	No	No	Yes	(No)	Yes	(No)	YES	(No)	No	No	2.0
Guatemala	No	No	No	No	--	Yes	(No)	YES	(No)	No	No	2.0
Honduras	No	No	No	Yes	(No)	Yes	(No)	YES	(No)	No	No	1.3
Mexico	Yes	Yes	No	Yes	(Yes)	Yes	(Yes)	YES	(No)	No	Yes	3.0
Nicaragua	No	No	No	Yes	(Yes)	Yes	(No)	YES	(No)	No	No	1.5
Panama	Yes	Yes	Yes	Yes	(Yes)	Yes	(No)	YES	(Yes)	Yes	No	3.5
Paraguay	No	No	No	No	--	Yes	(No)	YES	(No)	No	No	1.5
Peru	No	Yes[+]	No	Yes	(Yes)	Yes	(No)	YES	(Yes)	Yes	No	3.0
Uruguay	No	No	No	Yes	(Yes)	Yes	(Yes)	YES	(Yes)	No	No	3.7
Venezuela	No*	Yes[+]	Yes	Yes	(Yes)	Yes	(No)	YES	(Yes)	No	No	3.0

* Federal, state or municipal laws exist; [+]Linked to cancer or pain programs; [§]National Cancer Institute Resources.

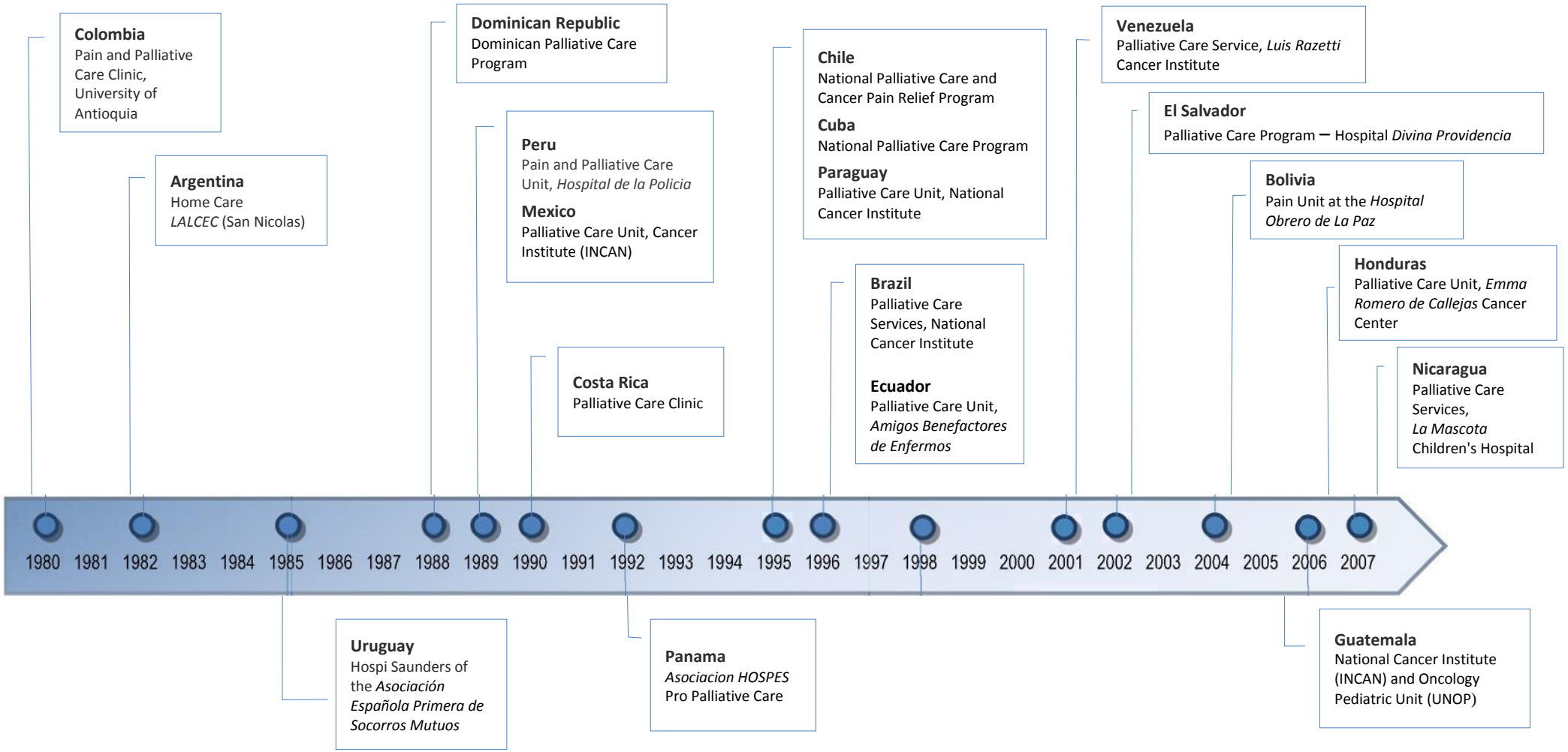

Figure 2: Emergence of Palliative Care in institutions by country and year.