Palliative Care in Southern Africa

Review of legislation, policy documentation and implementation guidelines in ten Southern African countries
Acknowledgements

The African Palliative Care Association (APCA) extends sincere gratitude to the national governments of Angola, Botswana, the Democratic Republic of Congo (DRC), Lesotho, Malawi, Mozambique, Namibia, Swaziland, Zambia, and Zimbabwe, and particularly their ministries of health, social services, and welfare, for allowing APCA to undertake a review of their national policies and national implementation frameworks. In addition, APCA thanks the in-country partners who provided local support and logistics for the project.
Foreword

With the huge burden of cancer, HIV, and other life-limiting illnesses across Africa, a clear public health argument exists for the availability of pain- and symptom-relieving drugs to improve the quality of life of millions of people, to maximise clinical benefit from available treatments, and to ensure freedom from unnecessary suffering. Despite this, many barriers exist that prevent access to palliative care on the continent. In particular, effective pain medication is not adequately available to people who need it.

In 1995 the International Narcotics Control Board surveyed government drug control authorities. It identified multiple barriers, similar to the barriers being identified today, including:
- excessively strict national laws and regulations;
- fear of addiction, tolerance, and side-effects;
- poorly developed health care systems and supply; and,
- lack of knowledge on the part of health-care professionals, the public, and policy-makers.

While these barriers pose a great challenge not only to accessing pain medication, the absence of national policies and the lack of government understanding about the importance of pain medication exacerbates them. The Open Society Foundations (OSF), based in New York, and the Open Society Initiative for Southern Africa (OSISA) funded the African Palliative Care Association (APCA) to undertake a review of national policies and national implementation documents across ten African countries, to assess the extent to which palliative care pain medication and associated gender issues are addressed. The review looked at opportunities to increase access to palliative care for all those who need it.

This report provides useful insights into how the issues reviewed have been addressed in Angola, Botswana, the Democratic Republic of Congo (DRC), Lesotho, Malawi, Mozambique, Namibia, Swaziland, Zambia, and Zimbabwe, and offers suggestions on how governments can address these challenges at the policy level. While this report does not provide a review of all the possible national policies in each country, it offers some useful findings from key documents that could be relevant in palliative care development in the region.

APCA, OSF, and OSISA strongly recommend the inclusion of palliative care in national policies so as to ensure:
- identification and setting of priorities for palliative care development in each country;
- identification and allocation of resources needed to support these priorities and to provide a basis for resource mobilisation;
- collaboration between relevant stakeholders, including governments, civil society, institutions of higher learning, and private agencies; and,
- a framework for standards that can underpin access to effective palliative care, and appropriate planning.

We hope that this report will encourage southern African governments, other national stakeholders, and palliative care providers to work together to establish policies that will meet the palliative care needs of patients with life-threatening illnesses, reducing unnecessary pain and suffering in the region.

Faith Mwangi-Powell, Mary Callaway and Vicci Tallis
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## List of acronyms

<table>
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<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ANEMO</td>
<td>Mozambique Association of Nurses</td>
</tr>
<tr>
<td>APCA</td>
<td>African Palliative Care Association</td>
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<tr>
<td>ARV</td>
<td>Anti-Retroviral</td>
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<tr>
<td>CDC</td>
<td>Center for Disease Control</td>
</tr>
<tr>
<td>CHBC</td>
<td>Community Home-Based Care</td>
</tr>
<tr>
<td>DDA</td>
<td>Dangerous Drugs Act</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development (UK)</td>
</tr>
<tr>
<td>DRC</td>
<td>Democratic Republic of Congo</td>
</tr>
<tr>
<td>FGH</td>
<td>Friends for Global Health</td>
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<tr>
<td>FHI</td>
<td>Family Health International</td>
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<tr>
<td>GBV</td>
<td>Gender-Based Violence</td>
</tr>
<tr>
<td>HBC</td>
<td>Home-Based Care</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HOSPAZ</td>
<td>Hospice and Palliative Care Association of Zimbabwe</td>
</tr>
<tr>
<td>IPCI</td>
<td>International Palliative Care Initiative</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NAC</td>
<td>National AIDS Control</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<tr>
<td>NMP</td>
<td>National Medicine Policy (Namibia)</td>
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<td>NPMP</td>
<td>National Pharmaceutical Master Plan (Namibia)</td>
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<td>OSF</td>
<td>Open Society Foundations</td>
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<td>OSISA</td>
<td>Open Society Initiative for Southern Africa</td>
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<td>PACAM</td>
<td>Palliative Care Association of Malawi</td>
</tr>
<tr>
<td>PCAZ</td>
<td>Palliative Care Association of Zambia</td>
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<tr>
<td>PLWHA</td>
<td>People Living with HIV or AIDS</td>
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<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
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<tr>
<td>SHAH</td>
<td>Swaziland Hospice at Home</td>
</tr>
<tr>
<td>SNAP</td>
<td>Swaziland National AIDS Programme</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>ZNASP</td>
<td>Zimbabwe National HIV and AIDS Strategic Plan</td>
</tr>
</tbody>
</table>
1. The review process

This document reviews the opportunities, gaps, strengths and weaknesses, and gender issues that can be addressed to support palliative care at national level in Southern Africa.

The review was undertaken using an evidence-based review tool developed through a consultation process, using information generated from existing literature and from rapid appraisals conducted in Kenya, Uganda, Zambia and Zimbabwe (see tool at www.africanpalliativecare.org).

The tool uses pre-determined questions in a number of key thematic domains (general issues, gender issues, human rights, legal opioid availability). This tool was accompanied by clear instructions and relevant definitions to ensure that the review process was undertaken in a consistent manner by the multiple reviewers.

The first stage of the review included the identification of existing national policy documents that have currency (i.e. they are actively being followed by governments, rather than being historical in nature).

2. The document review tool

The review tool has pre-determined questions under five thematic domains (or sections).

Section 1:

A. Document development

Under this domain the reviewer was expected to assess whether there was a rationale to the document, (policy, strategy or otherwise), looking at whether it is a response to an identified need, and if there is evidence of the need. In addition, the review was expected to assess the document development process to examine whether there was wide consultation with a range of stakeholders (including clients, affected communities, service providers, etc.) and with a range of government ministries (health, agriculture, gender, finance, etc.). This is important as it demonstrates the documents’ ownership and could influence its implementation.

B. Document ease of implementation

The questions under this section relate to the implementation of the document, and seek to understand what the individual policies are which have given rise to the strategies or activities described in the document. It looks at the level of practical information available on how the policy statements can be realised, or (at a minimum) reference to other existing documentation, or future planned guidance on how to implement the policy. Such considerations include evidence of a monitoring and evaluation strategy, or commitment by the government to financially support implementation. This then relates to the clarity of the document and the use of language which encourages implementation, such as the use of simple terms and the inclusion of a glossary where necessary.
C. Language

The documents were reviewed for evidence of translation which makes them more accessible to all stakeholder groups in the country. If the document has been translated but this is not evident, then a recommendation is provided but no assumptions were made. The language used was reviewed for evidence that the document had been written in active and committal language (such as “The government will” or “must” (active), instead of “The government will consider”, “may” etc.).

D. Inclusivity

Inclusivity relates to the groups of people that are mentioned or addressed by the documents. This includes evidence of inclusivity across ages (i.e. children, adolescents, adults), genders, diseases (particularly important for generic health documents), ethnic groups, religious groups, sexual orientations, and special needs or neglected groups (prisoners, refugees etc.).

Section 2:

A. Gender

The documents were reviewed for evidence of gender-neutral terms, including ‘he/she’ or other generic terms such as ‘they’, ‘them’, ‘the client’ and ‘the patient’. It is important for there to be key statements relating to gender to give a general understanding of the concept. In view of this, the reviewer looked for evidence that the culturally accepted roles and responsibilities of men and women at a community level are identified, and that the implications of these on both men and women are recognised. Gender stereotypes around socially expected roles of men and women were reviewed to see if they were reinforced throughout the document or if there was a commitment to counter them. It is also important for gender-based violence to be understood and reflected throughout the documents. The term gender-based violence (GBV) is used to distinguish violence that targets individuals or groups of individuals on the basis of their gender from other forms of violence. It includes any act which results in, or is likely to result in, physical, sexual or psychological harm. GBV includes violent acts such as rape, torture, mutilation, sexual slavery, forced impregnation and murder. It also defines threats of these acts as a form of violence.

Section 3:

A. Palliative care

The document was reviewed to assess if there is inclusion of palliative care or any other equivalent terms (such as end-of-life or terminal care). The reviewer then looked for key areas where palliative care could be integrated within the document, such as using committal language, including and referring to the definition of palliative care, and identifying components of palliative care (such as physical, spiritual, emotional and social pain) to represent the holistic approach to care. The document was then reviewed for information relating to the importance of drug availability, including reference to essential drug lists or their equivalent, the need for palliative care training and skills development, and a description of how care is to be provided through an inter-disciplinary approach. It is very important to focus on who will benefit from the care and access at different levels of care. This needs to be reflected within the document as an implementation strategy, alongside a monitoring plan and the identification of stakeholder
involvement and a responsible body coordinating the care. The policy document needs to clearly reflect the legal and ethical issues within palliative care, including any issues around confidentiality and stigma. The relief from pain as a human right is a key statement, and each document was reviewed in this light.

Section 4:

A. Opioids control

A review of the reference to opioid control was completed in relation to whether opioids are controlled drugs, and the rules and the controlling bodies involved in this. The document was then reviewed for reference to tax laws related to the importation and movement of drugs, and particularly with regards to whether drugs are tax exempt, and (if not) who is liable to pay the tax (providers or patients).

B. Opioids practice

Evidence and explanations of which disciplines are allowed to prescribe opioids (in particular morphine) were reviewed, specifically looking at which health disciplines are allowed to prescribe each category of opioid, and which outlets are allowed to dispense them (e.g. hospices, hospitals, clinics, pharmacies). The documents were then reviewed with reference to pharmacy regulations and the guidelines that are in place, including the professional codes and standards regarding opioid use.

C. Opioids and human rights

Relief from pain is a human right, and this needs to be reflected within the documents. The review looked for references to patient confidentiality issues, handling of personal data, stigma, and anti-discrimination.

3. Document selection criteria

APCA generated a list of possible policies that could be relevant to palliative care development across Africa, and used this list as criteria for selecting the documents that would be reviewed in each country.

The list was based on identification of all relevant national health-related policies as outlined below:

- National AIDS strategy
- National cancer plan
- National palliative care policy
- National health policy
- National gender policy
- National home based care policy
- Essential drug list
- Maternal or child health care and reproductive health policies.
I. Documents reviewed in Angola

Policy documents in Angola are not easily available to the public. Therefore, we had to work closely with in-country partners who were themselves able to get very few documents. The two documents identified were written in Portuguese and were available only as hard copies. They were reviewed by a Portuguese-speaker.

We were able to obtain the following documents at the time of the review:

- Regulations on HIV and AIDS work and providing training and professional law (2009)

1.1 List of policies reviewed

<table>
<thead>
<tr>
<th>Document name</th>
<th>Scope of document</th>
<th>Type of document</th>
<th>Funder(s) of the policy</th>
<th>Original publication date</th>
<th>Latest revision date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreto no 43/03, de 4 de Julho Regulamento sobre HIV/SIDA, Emprego e Formação Profissional e lei de Bases do Primeiro Emprego</td>
<td>HIV and AIDS</td>
<td>Legal document</td>
<td>Not specified</td>
<td>01.04.2009 (laws in place 03 and 06)</td>
<td>01.04.2009</td>
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<tr>
<td>Plano Estratégico Nacional para o Controlo das Infecções de Transmissão Sexual, VIH e SIDA 2007 a 2010</td>
<td>HIV and AIDS</td>
<td>Strategic plan</td>
<td>Not specified</td>
<td>01 Dec 2006</td>
<td>01 Dec 2012</td>
</tr>
</tbody>
</table>

2. General findings

The reviewed documents are well-written and to some extent cover the core areas under review. They were developed through due process and have clear and implementable plans providing ease of implementation. The tone and language throughout is gender-neutral. However, palliative care is not mentioned in the two documents, and neither is pain management or the use of opioids. Both documents focus on HIV and AIDS care and the rights of people living with HIV or AIDS (PLWHA), which would easily allow for the integration of palliative care as part of the essential care package for PLWHA.
3. Specific findings

3.1 Regulation for HIV and AIDS in the workplace, professional training and laws governing first jobs, 2009

Palliative care is not mentioned in this document. In addition, terms such as ‘holistic’, ‘palliative’ or ‘care’ are not mentioned. However, the policy is gender-neutral and does not reinforce any gender stereotypes. There is no mention of opioids or opioid practice (prescribing, availability, etc.). However, it does acknowledge relief from pain as a human right in relation to HIV and AIDS treatment and care. Given that the focus of this document is management of HIV and AIDS, it is appropriate for it to include palliative care, and there is some opportunity to include risk behaviours in relation to HIV and AIDS in the workplace and for youth and other special-needs populations. Confidentiality and stigma is addressed and written into law as a means of protection for PLWHA.

3.2 National Strategic Plan for the control of sexually transmitted diseases and HIV and AIDS 2007-2010

Palliative care is omitted from this document. The document is gender-neutral, although it does not specifically address gender issues. Anti-discrimination is well addressed but other areas such as confidentiality have not yet been addressed. There are several opportunities in the document to integrate palliative care, especially under the control of HIV and AIDS/STI strategies. A need to be more explicit regarding gender issues was identified. The policy acknowledges that basic healthcare is a human right as well as ‘life and dignity’ but it is unclear in what respect.

4. Recommendations

Documents were developed through due process. The same process should be extended to incorporate palliative care into the documents, in particular with healthcare professionals. The language used in the documents demonstrates a commitment to improve the quality of life for PLWHA. This creates an opportunity for integrating palliative care into the document, since palliative care is crucial in improving the quality of life for PLWHA. The workplace regulation is a legal document and should include the offer of palliative care as an essential care package to PLWHA. The strategy should integrate palliative care in general as one of the options for PLWHA. During our various discussions we spoke about including the WHO definition of palliative care into all national policy and strategy documents.

Other broader recommendations include:
- Develop a palliative care education programme for health care professionals;
- Identify national champions for palliative care to lead the process; and,
- Develop the necessary policies to ensure the availability of opioids for pain management.

5. Conclusion

The two reviewed documents offer no information on palliative care or pain management. Although the documents are gender-neutral, they are weak on gender issues in general. Having said this, there is strong evidence that the documents are underpinned by international best practice and standards of care, and this should be extended to palliative care.
I. Documents reviewed from Botswana

An informative meeting was requested by the Permanent Secretary in the Ministry of Health to discuss the roll-out of the project and the impact on the Botswana health system. The expected outcomes were put into a document and presented to the Permanent Secretary. After the meeting, the documents were physically collated by the project coordinator on a second visit to Botswana. APCA observed all the protocols around taking the documents to another country for review. Many more documents than requested were made available to APCA, and a letter was provided to formally approve of the project.

The following documents were available in Botswana at the time of the review:

- Acute care
- Botswana draft national port health strategy (2009)
- Botswana national cancer registry (1986-2006)
- Botswana National disability policy
- Botswana national HIV and AIDS treatment guidelines (2008)
- Botswana national policy on HIV and AIDS
- Botswana national strategy for strengthening palliative care services (2003)
- Botswana treatment guide (2007)
- Chronic HIV care with ARV therapy
- Community home based care for people with AIDS in Botswana – Operational guidelines
- Essential drug list (2005)
- General principles of good chronic care
- Information pack on the abolition of marital power act (2004)
- National health policy (1995)
- National occupational health and safety policy guidelines
- Palliative care pocket guide for health care providers
- Palliative care: Symptom management and end of life care
- Policy guidelines and service standards – sexual and reproductive health
- Policy on environmental health
- Policy on non-communicable diseases (2009)
- Policy on women in development
- Report on a review of all laws affecting the status of women in Botswana
- Report on palliative care situational analysis and the patients and caregivers needs assessment in Botswana
- Strategic plan for primary, secondary and tertiary prevention of non-communicable diseases (2009)

Due to the time available for the review of the documents, three key documents were selected. The recommendations in this report are based on a review of these three documents.
1.1 List of policies reviewed

<table>
<thead>
<tr>
<th>Document name</th>
<th>Scope of document</th>
<th>Type of document</th>
<th>Funder(s) of the policy</th>
<th>Original publication date</th>
<th>Latest revision date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Home Based Care for people with AIDS in Botswana</td>
<td>HIV and AIDS</td>
<td>Implementation Guideline</td>
<td>AIDS/STD Unit Ministry of Health</td>
<td>1996</td>
<td>1996</td>
</tr>
</tbody>
</table>

2. General findings

In relation to the documents reviewed, it was evident that they give clear rationale, goals, aims and objectives, as well involving multiple stakeholders. All the documents reviewed have very limited information regarding palliative care, gender, and pain and symptom management (including opioid use). The documents are very old and out-dated (e.g. last revised 1996 or 1998), and they need revision to incorporate palliative care and the use of opioids for pain management, especially in relation to AIDS patients. The government of Botswana’s commitment to the implementation of the documents is a great strength.

3. Specific findings

3.1 Botswana National Policy on HIV and AIDS, 1998

The Botswana government has committed itself through funding, coordination of activities, involvement with other service providers, and working in collaboration with different ministries to develop and implement this policy document. However, the document lacks any sections on palliative care or opioid use (including laws and prescription regulations) for pain and symptom management.

Palliative care in general is not included, although some statements on care, beneficiaries, ethical issues and human rights are documented. Care and support for patients, the involvement of stakeholders in offering services, and coordination specification (including the labour ministry) were identified as strengths throughout the policy.

As a key recommendation, the term ‘palliative care’ and some information relating to the concept should be included, as well as a definition of palliative care. The importance of palliative medicines should be emphasised, and essential palliative care medications should be included.
The document is gender-neutral. Some risk behaviours are addressed but lack clear roles and responsibilities of gender, and the document does not acknowledge that stereotyping is a major concern.

Pain relief is omitted in the document, but confidentiality issues are addressed, which creates an opportunity to address wider human rights issues.

### 3.2 Community home based care for people with AIDS in Botswana (Operational guidelines), 1996

The guidelines have a clear rationale, which specifies interventions, activities and outcomes for a programme committing itself to the inclusion of morphine in community home based care packages. However, information about palliative care and the use of opioids for effective pain relief are missing from the document. The policy is very out-dated and needs urgent review in order to ensure that current challenges are addressed and that the epidemic is controlled using recent data and information.

There is no information about gender or gender roles in the document. Confidentiality issues and patient consent are referred to, but not wider human rights issues, and there is no clarity regarding the implementation of the policy.

### 3.3 Botswana National Strategic Framework for HIV and AIDS, 2003-2009

The policy gives clear goals and objectives, and shows the involvement of all stakeholders, allocation of resources for each goal, and the implementation strategies relating to it. The government is committed to special-group populations and focuses on vulnerable groups without any discrimination. There is a need to specify gender roles and responsibilities. Detailed information on palliative care is completely missing in the document, and there is an opportunity to review the document and include all relevant issues (including gender roles and responsibilities, opioid use for pain relief and holistic palliative care, human rights, strengthening patients’ rights, and consent issues).

### 4. Recommendations

**Development:** The inclusion of a glossary, acronyms and a table of contents are necessary for referencing purposes. All documents should have clear statements on the involvement of partners.

**Language:** Documents should be translated to enable all beneficiaries to understand and have access to the policies in their respective languages.

**Implementation inclusivity:** Statements such as ‘will’ or ‘shall’ should be used to show government’s commitment in the documents.

**Gender:** Gender issues need to be strengthened in all documents, including reference to gender roles and responsibilities regarding palliative care. There is a need to cross-check with other government policies whether gender issues are catered for.
Palliative care: On review of the documents, policy-makers should include palliative care as soon as possible. This will create room for inclusion of the missing information. All stakeholders working in the area of palliative care service delivery should be consulted and included in the review of the documents. This will be an opportunity to include palliative care in the documents for AIDS patients.

Opioids: Use of opioids as well as laws and regulations that relate to the importation and movement of opioids need to be incorporated into all documents, which only mention opioids among drugs used.

5. Conclusion

Through the review of these documents, it is evident that opportunities are available to include palliative care in all national policies if the government shows commitment to include palliative care. All stakeholders involved in palliative care service delivery should be consulted and included in the review of the documents. Gender issues need to be strengthened in all the documents, including gender roles and responsibilities with regards to palliative care.

The use of opioids as well as laws and regulations that relate to the importation and movement of opioids need to be incorporated in all the documents.

We encourage the government of Botswana to incorporate palliative care into the reviewed policy documents. The recently developed first edition of Africa's palliative care standards could be utilised as a guide to the government in developing and integrating palliative care into policies.
THE DEMOCRATIC REPUBLIC OF CONGO (DRC)
I. Documents reviewed from the DRC

It was difficult to get hold of the relevant policy documents. None of the documents are freely and easily available to the public, and APCA had no previous strong links with the DRC. Once in-country contacts had been developed and partnerships formed with FHI and the Ministry of Health, APCA was able to review some documents. All documents were hardcopies and written in French. They were reviewed by a French-speaker. After much investigation and research, only the following documents were available from DRC at the time of the review:

- *Normes et Directives en Conseil et Depistage du VIH* (Standards and guidelines for HIV counselling and testing)

- *Normes et Directives sur la prise en charge psychosociale des PVVI et des PA en RDC* (Standards and guidelines for the psychosociale care of PLWHA and people affected by HIV in DRC)

- *Soins Palliatifs à Domicile* (Home Based Palliative Care)

### 1.1 List of policies reviewed

<table>
<thead>
<tr>
<th>Document name</th>
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</tr>
</thead>
<tbody>
<tr>
<td><em>Normes et Directives en Conseil et Depistage du VIH</em> (Standards and Guidelines for HIV Counselling and Testing)</td>
<td>HIV and AIDS</td>
<td>Standards</td>
<td>USAID, CDC, OMS, FHI</td>
<td>unknown</td>
<td>November 2009 - revised version but does not state original date</td>
</tr>
<tr>
<td><em>Normes et Directives sur la prise en charge psychosociale des PVVI et des PA en RDC</em> (Standards and Guidelines for the psychosociale care of PLWHA and People Affected by HIV in DRC)</td>
<td>HIV and AIDS</td>
<td>Standards</td>
<td>Bristol Meyer Squibb</td>
<td>01 Mar 2010</td>
<td>01 Mar 2010</td>
</tr>
<tr>
<td><em>Soins Palliatifs à Domicile</em> (Home Based Palliative Care)</td>
<td>Palliative Care</td>
<td>Implementation Guideline</td>
<td>La Cooperation Technique Belge (CTB/Belgian Technical Cooperation)</td>
<td>01 Jan 2006</td>
<td>01 Jan 2006</td>
</tr>
</tbody>
</table>
2. General findings

The reviewed documents focused predominantly on HIV and AIDS care and associated services. While home based care and holistic care are mentioned, they are not based on the WHO definition of palliative care, and pain management does not feature. Much of the focus for palliative care is on care of the dying (end-of-life care). The documents address the issues to some extent, but do not go far enough in the exploration of palliative care or holistic services. Nonetheless, the documents are clearly written, understandable and explicit to an appropriate level for the nature of the documents. Although the documents were reviewed in French, some are also available in English.

Gender issues are to some extent addressed in the reviewed documents. The documents are gender-neutral and do not reinforce gender stereotypes, but there is a need to explore gender issues further. There is a major gap in the lack of discussion on gender violence, especially in relation to HIV and AIDS psychosocial support. This may be due to the fact that the DRC has a separate (and strong) policy that deals with gender violence and gender issues, and the topic (although closely linked to the reviewed documents) is outside the scope of these documents.

The reviewed documents do not give explicit information on opioid control or tax law in relation to the movement of drugs. Nor do they address the practice of opioid use, which is not discussed in the reviewed documents. However, the topic could be introduced once palliative care is integrated into the documents, especially if access to opioids could be included in the list of rights for PLWHA.

3. Specific findings

3.1 Standards and guidelines for HIV counselling and testing, 2009

Palliative care is not addressed in this document although many opportunities to include palliative care exist. The document is gender-neutral and does not reinforce gender stereotypes, but there is no upfront statement addressing gender issues. It is advisable that the guidelines explicitly emphasise gender issues.

Some human rights issues are addressed (e.g. confidentiality, patient consent, relief from pain and the right to health care). This offers all citizens of the DRC the right to health care regardless of age or status, but there is no mention of access to essential drugs such as opioids.

3.2 Standards and guidelines for the psychosocial care of PLWHA and people affected by HIV in DRC, 2010

The document does not explicitly discuss palliative care, but it does mention holistic care and many of the components of palliative care are covered in the psychosocial care section. However, pain management is not mentioned at all. The psychosocial care described in the document is close to palliative care, and the concept of holistic care underpins the document. A definition of palliative care could be easily integrated into this document, and there is an opportunity for advocacy to this end.

The document is gender-neutral but does not discuss gender issues in any detail. There are no major strengths in the document in relation to gender. A significant gap is the lack of discussion on gender violence, especially in relation to HIV and AIDS psychosocial support (maybe because the DRC has a separate policy that deals with gender violence and gender issues). It is recommended that the remit of the document be extended to include pertinent standards and guidelines for pain management that would include opioids. Palliative care (including pain management) could be written into the list of rights for PLWHA.
3.3 Home based palliative care, 2006

The document sets out to be a palliative care manual for HBC volunteers. The language is basic and the whole document is simple and easy to understand with images to reinforce. However, despite being active and committed to palliative care, it portrays the very narrow view of palliative care as being for terminal or dying patients, and therefore does not adhere to the WHO definition. Nor does it address training, legal issues or human rights. Apart from this, it defines palliative care very well.

There is an opportunity to include the WHO definition of palliative care in the document, and there is a need to expand the document to include pain management. The document on the whole is gender-sensitive but it does reinforce some gender and cultural stereotypes. Gender needs to be addressed more comprehensively. Pain management and the importance of opioid analgesics should be included in the document. The document stresses the importance of confidentiality, and stigma is to some extent addressed.

4. Recommendations

The three documents reviewed were well-developed through due process. They are underpinned by WHO and UNAIDS strategies, although palliative care is not always included. Therefore, an opportunity to include palliative care has been missed and this could be easily addressed.

The language in the documents is clear and concise and easy to understand. There is evidence that documents are (or will) be translated into other languages (including English and local languages), facilitating access for health care professionals across the DRC. Clear instructions exist for implementation of the projects and strategies. These implementation plans have been well developed for ease of implementation. The documents are broadly inclusive of all areas under review, but they could be improved upon as they are focussed on HIV and AIDS.

Although the government of DRC has elaborated an essential list of rights for PLWHA, palliative care is not included. This could be changed, and palliative care could be included as part of the essential care package, especially for PLWHA.

Opioids and their management are not mentioned in the documents, but could easily be addressed under pain management within a palliative care context.
All documents are gender-sensitive, but gender issues in general could be strengthened throughout.

5. Conclusion

The government of DRC has demonstrated a commitment to improving the quality of life and health care for its population. There is a list of basic rights for PLWHA, which becomes part of an essential care package for all in need of care. Palliative care could be integrated into this list of basic rights, especially as the concept of holistic and psychosocial care is already in place (although without the pain management component).
1. Documents reviewed from Lesotho

APCA wrote to the Lesotho Ministry of Health informing it about the policy review project. A detailed project description was submitted and APCA received approval from the Ministry to use documents for the review. All documents were written in English and hardcopies were available.

The following documents were available from Lesotho at the time of the review:

- Gender and development policy
- Health and social welfare policy
- National HIV and AIDS strategic plan
- National medicines policy
- National reproductive health policy

### 1.1 List of policies reviewed

<table>
<thead>
<tr>
<th>Document name</th>
<th>Scope of document</th>
<th>Type of document</th>
<th>Funder(s) of the policy</th>
<th>Original publication date</th>
<th>Latest revision date</th>
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<tr>
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<td>Policy</td>
<td>Ministry of Health and Social Welfare</td>
<td>01 Jul 195</td>
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</table>
2. General findings

The review of the documents showed that they varied in their degree of comprehensiveness, inclusivity and description of their development process (including stakeholder involvement). While the national medicines and reproductive health policies as well as the national HIV and AIDS policy have to a large extent been developed through wide stakeholder involvement and have clearly defined rationale, the health and social welfare policy and the gender and development policies are not as comprehensive, thus providing opportunities to make the policies better.

3. Specific findings

3.1 Health and Social Welfare Policy, 2004

The Health and Social Welfare Policy is underpinned by a clear rationale and has involved wide stakeholder consultation. There is no mention of translation and there is little mention of gender and HIV and AIDS. The policy includes communicable and non-communicable diseases, which could provide opportunities for palliative care integration. In addition, the section on pharmaceuticals provides opportunities for the inclusion of opioids.

The document is gender-neutral and it has some statements that show gender recognition. It is not gender-biased but there is little mention of gender issues and this need to be strengthened.

There is mention of essential medication, and this can be used an opportunity to address opioid availability (which could be included under essential medicines and the supply of medicines). This is not addressed specifically, but the section on pharmaceuticals can be used as a point of entry for advocacy.

There is mention of government addressing issues with regard to the distribution of medicines, and this could include opioids. Medicine practice can be addressed in relation to issues around the development of pharmaceutical services.

There is no mention of pain management as a human right, but this is linked to reproductive health. International collaboration can be used to incorporate international laws. There are opportunities to expand the issues of rights beyond reproductive health rights to general human rights covenants.

3.2 National Medicines Policy, 2005

The National Medicines Policy is underpinned by a clear rationale, is well-written and has active and committal language. It is fairly inclusive in that it talks about access to medicines for all baSotho, but it needs to be strengthened in terms of monitoring and evaluation. There is no mention of palliative care or human rights, but there are several places where this could be included since the document is about access to drugs in general.

The language of the document is gender-neutral. It talks of people, communities and baSotho. It neither counters nor reinforces gender stereotypes. There is little mention of gender in the document. Since it is a drug policy, the recognition that it is for all in Lesotho means that it cuts across gender.
The document is not specific on opioid control, but it does mention issues with regard to taxation in general. There are clauses that support the regulation and legislation of drugs that could apply to opioids. There is mention of prescribers in general, and this can be expanded to include the prescription of opioids. The document does not specify the prescribers, but to some extent it does talk about licensing and the development of standards, and a medical council of Lesotho that will oversee these standards.

There is no mention of human rights, but there is mention of international collaboration with regard to drug availability, and this could be an opportunity to introduce international laws.

### 3.3 National Reproductive Health Policy, 1995
The National Reproductive Health Policy is underpinned by a clear rationale. It is well written and has active and committal language. It is fairly inclusive in that it talks about access to reproductive health for all baSotho. It needs to be strengthened in terms of monitoring and evaluation and makes no mention of palliative care, but the inclusion of HIV and AIDS provides an opportunity to include care for PLWHA. This section could be expanded to address care issues as has been done for post-abortion care.

The document is gender-neutral, has a key objective with regard to gender, and addresses roles and responsibilities between men and women. It counters gender stereotypes by introducing male involvement in reproductive health issues. The policy has a good understanding of gender, addressing many aspects (including roles, male involvement in care, and gender-based violence).

There is no mention of opioids in the document, but these can be included if the issue of care is included. The document does not specify the prescribers, but to some extent it does talk about licensing and development of standards, and a medical council of Lesotho.

Pain control deserves attention, but there is mention of reproductive health as a human right issue, and this could be expanded to include care for people suffering from HIV and AIDS.

### 3.4 Gender and Development Policy, 2003
The Gender and Development Policy has a clear rationale and is backed by a very good understanding of gender issues across all sectors in Lesotho, including the health, economic and the cultural arenas. It is a very inclusive document and it cuts across all ages and all groups, including special populations and vulnerable groups. There is no mention of palliative care, but it does mention home based care and this can be an avenue through which palliative care is strengthened in this document. Home based care delivery services provide a good opportunity to strengthen the inclusion of palliative care.

It includes a section on HIV and AIDS, and this section could be expanded to include palliative care and gender issues. The policy talks about gender mainstreaming across several areas (education, culture, health, politics and power and decision-making) and has a very good grasp of gender issues. It has comprehensive information on gender issues, and provides a good opportunity for access to these debates by all of the population.

There is no mention of opioids (or any drugs) and this might be included in the section on HIV and AIDS if palliative care is included under home based care.

There some mention of human rights, but issues such as confidentiality and non-discrimination are not mentioned. It recognises the rights of women and girls with regard to control of credit, and this could be expanded to include other rights.
3.5 National HIV and AIDS strategic plan, 2006 – 2009

The National HIV and AIDS strategic plan has clear strategic objectives and is written in an active and committal language. It includes a good recognition of gender issues in HIV and AIDS care and management. It does not mention palliative care, but provides extensive opportunities for its inclusion. It does not mention pain relief as a human right, but it does mention the rights of PLWHA and links these to international laws. There is a comprehensive section on care, treatment and support, which talks about home based care, quality care and access to care at all levels, and could include palliative care.

The document has a good understanding of gender issues. It counters gender stereotypes, includes a comprehensive section on gender-based violence, and addresses risky behaviours (for both men and women) that can contribute to the spread of HIV and AIDS. It is very gender-aware, and covers the issues of gender comprehensively. It recognises the rights of women and girls.

There is no mention of controlling opioids, but the document deals with drug supply and management, and this is a good opportunity to introduce the availability of opioids. It is not specific on opioid control, but it does mention issues with regard to taxation in general.

Prescribers are not specified, but to some extent it does talk about licensing and development of standards and a medical council of Lesotho to oversee the standards. There is no mention of the practice of opioids, but the section on treatment and care could be strengthened to address this.

There is no mention of pain-relief as a human right, but the document addresses the issues of confidentiality, discrimination, and patient consent and links very well with international law.

4. Recommendations

The following recommendations can be made generally across all the documents reviewed:

Document development: All the documents reviewed are underpinned by a clear rationale. They are well-written, but there were varying degrees of stakeholder consultation in the development process and this could be improved across all the documents. It is also advisable to have a list of stakeholders involved in the development process attached in an appendix as this would add credibility to the documents.

Ease of Implementation: There are clear implementation frameworks across the documents, but the sections on monitoring and evaluation need to be expanded to include precise measurements that can be used to ensure the success of the implementation frameworks.

Language: The policy documents are written in a clear and understandable manner, and have active and committal language, but would benefit from translation to enhance wider accessibility among stakeholders.

Inclusivity: The level of inclusivity varies across the documents. For example, the health and social welfare policy, gender and development policy and the national HIV and AIDS strategic plan are fairly inclusive, and the recommendation is that other policy documents should follow the formats in these three documents to ensure wider inclusivity.
Gender: Some of the documents show a good understanding of gender, while others do not mention gender at all. However, given that there is a stand-alone gender and development policy in Lesotho, it would be useful if other policies made cross-references to this.

Palliative care: There is no mention of palliative care or the use of opioids in the documents, but several opportunities have been identified for including palliative care and opioid availability. For example, the section in the HIV and AIDS policy that addresses the issue of care for people living with HIV and AIDS could be expanded to include palliative care.

5. Conclusion

The documents from Lesotho provided mixed results. However, a key finding is that the documents provide a good foundation on which palliative care can be developed. Indeed, there are various opportunities that, if strengthened, can support the integration of palliative care at the national level. In this regard, APCA can provide policy clauses and language that could be included in the documents to address this gap.

With regard to opioid accessibility and control, APCA has developed generic guidelines for the use and control of opioids. These can be used to provide relevant policy information that could be incorporated into the documents.
I. Documents reviewed in Malawi

APCA worked closely with PACAM, which made it very easy to collate policy documents in Malawi. Most of them were available in soft copy and could be distributed to anyone who showed interest.

The following documents were available from Malawi at the time of the review:

- Malawi HIV and AIDS national action framework 2005-2009
- Malawi standard treatment guidelines and essential drug list
- Ministry of health strategic plan 2007-2011
- National gender policy
- National health policy (2009)
- National HIV and AIDS policy
- National home based care policy

Due to the time available for the review of the documents, three key documents were selected. The recommendations within this report are based on the review of these three documents.

1.1 List of policies reviewed

<table>
<thead>
<tr>
<th>Document name</th>
<th>Scope of document</th>
<th>Type of document</th>
<th>Funder(s) of the policy</th>
<th>Original publication date</th>
<th>Latest revision date</th>
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<td>Policy</td>
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2. General findings

The documents reviewed are underpinned by a clear rationale, are inclusive, understandable and contain guidance on implementation. They are gender-sensitive to some extent, and they do not reinforce gender stereotypes. No mention is made of any translation of these documents into local languages, which may limit their usability. Palliative care is only mentioned in the home based care policy tool. No tax laws on opioid importation and movement are mentioned at all in any of the documents.

Since the community home based care policy and guidelines mention palliative care, this provides a good opportunity to expand and include wider aspects of palliative care in the document. The HIV and AIDS policy document mentions holistic care, which provides an opportunity to develop palliative care further. In the national gender policy, palliative care can be included under the roles and responsibility of men and women, and under the section on HIV and AIDS and gender issues.
Overall, there is a good understanding of gender issues. For example, one document addresses issues facing women such as gender-based violence and roles and responsibilities. In two other documents, there are opportunities to counter gender stereotypes, including recognition of risk behaviours as endangering both genders (and not only women). With one exception, the documents do not have a key gender policy statement, and this can be addressed by building upon the issues they have addressed with regard to gender.

In general, there is an overall lack of explicit information on opioid control and tax laws related to the movement of drugs. There is no mention of laws through which health disciplines, outlets, pharmacies and professional bodies are allowed to prescribe morphine, and standards are not in place to aid the importation and movement of opioids. Pain relief as a human right does not appear in the documents. However, there are opportunities to address this under the section on holistic care in the HIV and AIDS policy. Other opportunities include the expansion of palliative care in the community home based care policy and guidelines.

3. Specific findings

3.1 National HIV and AIDS Policy, 2003

The document’s development is underpinned by a clear rationale and is inclusive. It is clear and understandable, and contains guidance on implementation. No mention is made of translation into local languages. It is gender-sensitive and does not reinforce gender stereotypes. Palliative care or similar terms are not mentioned. Neither are tax laws on opioid importation and movement.

Palliative care is not defined in the document. It mentions holistic care components, but no holistic care terms are mentioned. No mention is made of opioid availability or the importation or movement of opioids. Beneficiaries and stakeholders are acknowledged. To some extent, different levels of care, referral networks and human rights are mentioned in the policy.

There is an opportunity to include palliative care along with WHO definitions and equivalent palliative care terms, the interdisciplinary approach to levels of care, and relevant referral networks. The exclusion of opioid or drug availability, education and training on palliative care were identified as gaps and opportunities, as well as legal and ethical issues and pain relief as a human right.

The document is gender-sensitive. It neither counters nor reinforces gender stereotypes, and it addresses gender-based violence, but there are no up-front statements addressing other gender issues. There are opportunities to include a key gender statement, including gender roles and responsibilities, countering gender stereotypes, and recognising risk behaviours as exposing both genders.

No explicit information is given on opioid control and tax laws related to the movement of drugs or their importation, dispensing, standards or pharmacy regulations. There is an opportunity to include laws by which health disciplines, outlets, pharmacies and professional codes and standards will aid the importation and movement of opioids.

There is no mention of pain-relief as a human right. Confidentiality and non-discrimination are addressed within the document, but no mention is made of patient consent.

3.2 National Gender Policy, 2000

The document is underpinned by a clear rationale and is inclusive across stakeholders and ministries. It is clear and understandable, and contains guidance on implementation strategies. It is inclusive of different ages, gender, diseases and marginalised groups. There is no mention of palliative care or laws on the movement of opioids. It does not refer to pain-relief as a human right.
Strengths of the document are the inclusion of education and training or skills development on gender, identification of beneficiaries, inclusion of monitoring and evaluation, involvement of stakeholders, a coordinating body, and the inclusion of human rights.

There is an opportunity to include palliative care, holistic care, WHO definitions, laws on the availability and movement of opioids, different levels of care, referral networks, legal and ethical issues, and international human rights.

The document is gender-sensitive and counters gender stereotypes. It addresses gender-based violence and is underpinned by an up-front statement on gender issues. It addresses gender roles and responsibilities.

There is no explicit information on opioid control or tax laws related to the movement of drugs. The lack of any mention of opioid control in the reproductive health care section is a gap.

No explicit information is given on practice issues with regards to opioids (e.g. dispensing and prescribing laws, pharmacy regulations and national codes and standards). There are opportunities that can be explored, such as the inclusion of laws on availability and movement of opioids in the country.

There is no mention of health care as a human right. Although it does not specify pain-relief as a human right, the document addresses anti-discriminatory issues. No reference is made to confidentiality. There is an opportunity to address confidentiality issues, including patient consent and the right to refuse services.

3.3 National Community Home Based Care Policy and Guidelines, 2005.

The document’s development is underpinned by a clear rationale, and is inclusive across stakeholders and ministries. It is clear and understandable, and contains policy statements and strategies. It is inclusive to some extent, except for gender issues. Palliative care is mentioned, but no explicit information is given regarding opioids or their importation and movement. Pain-relief is mentioned, but not as a human right.

Palliative care is mentioned, but not its equivalent terms. The document is active and committal in tone. It shows a clear understanding of palliative care, but it is not based on the WHO definition. The guidelines address holistic care, training, and drug availability, but exclude opioids and accompanying legal issues. Human rights are mentioned, but without recognition of international human rights.

Exclusion of the WHO definition of palliative care, opioids in the drug list for HBC, an interdisciplinary approach to care, and a referral network at all levels of care were identified as gaps in the document.

The document is gender-sensitive with a key gender statement. There are no defined roles and responsibilities of gender but the document does not counter stereotypes and neither does it address gender-based violence or the impact of risky behaviours exposing both genders to life-threatening illnesses.

There is no explicit information on practice issues with regard to opioids (e.g. dispensing and prescribing laws, pharmacy regulations and national codes and standards). There is an opportunity to include laws regarding health disciplines that are allowed to prescribe morphine, the outlets licensed to dispense, the pharmacy regulations on its prescriptions, and which professional codes and standards are related to its use.
4. Recommendations

The documents were developed in a fairly consultative manner and are all underpinned by a clear rationale. The development process could be strengthened by wider consultation with beneficiaries, especially people living with HIV and AIDS. The language used in all documents is active and committal and they are easy to read. However, the documents would be strengthened by including a glossary of terms to guide the reader. In addition, it is not indicated whether the documents have been translated into other languages, which would make the documents accessible to many more people within Malawi.

The documents have clear implementation strategies but they lack detail with regard to the funding mechanisms and monitoring and evaluation (M&E). A funding mechanism and an M&E framework would strengthen the documents and would make implementation easier.

The documents are to some extent gender-neutral since they do not reinforce or counter gender stereotypes. However, there is a general weakness in gender coverage in the documents, except for the national gender policy. The gender policy itself is comprehensive and shows a good understanding of gender issues. This policy can be used to strengthen the other policies in Malawi, either by cross-referencing or by using the information and integrating it into relevant sections of the other policy documents.

There is little mention of palliative care in the documents reviewed. Only the community home based care policy and guidelines mention palliative care, but it is neither defined nor expanded upon. This provides a good opportunity to expand on and include wider aspects of palliative care in the document. The HIV and AIDS policy mentions holistic care, which provides an opportunity to develop palliative care, while palliative care could be included in the national gender policy under the roles and responsibilities of men and women, as well as the section on HIV and AIDS and gender issues.

Opioids are not mentioned in documents. However, in each policy the issue of access to services (and holistic care in the HIV and AIDS policy) provides an opportunity to address this gap. There is an opportunity to include opioids in the HBC drug list.

5. Conclusion

Although the policy and implementation documents reviewed were developed using a fairly wide consultation process and did involve a range of stakeholders, there are several areas that can be strengthened to ensure integration of palliative care. For example, the home based care policy mentions palliative care, and this could be expanded to include all aspects of palliative care.

In relation to opioids, while this can be included in the palliative care section mentioned above, it would be good if the Ministry of Health considers developing national guidelines for opioid use in line with WHO recommendations to ensure safe and effective use of opioids in Malawi. APCA is developing standard guidelines on this and will be happy to make the guidelines available for adaptation.

To improve accessibility of these documents a glossary of terms should be included and the documents should be translated into commonly used local languages. Regarding gender issues, it is important that other policies make cross-references to the gender policy or include key gender statements that demonstrate recognition of risky behaviour that exposes people to illnesses such as HIV and AIDS.
1. Documents reviewed from Mozambique

All the documents had to be purchased through a local organisation doing social development work in Mozambique. The documents are in Portuguese and available as hardcopies. They were reviewed by a Portuguese-speaker.

After much investigation and research, only the following documents were available from Mozambique at the time of the review:

- Assembly of the Republic (including supplement)
- National AIDS strategy
- National home based care policy
- Reproductive health policy
- Strategic plan human resources

Due to the time available, two documents were selected for review. The recommendations in this report are based on the review of these two documents.

### 1.1 List of policies reviewed

<table>
<thead>
<tr>
<th>Document name</th>
<th>Scope of document</th>
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<th>Funder(s) of the policy</th>
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<th>Latest revision date</th>
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</table>
2. General findings

The reviewed documents are strong guiding documents for gender and HIV and AIDS care in Mozambique. They are well-written in concise language that gives clear guidelines for implementation. Palliative care, opioid availability and practice, and pain management are not addressed but could be easily integrated into the documents. These are very strong guiding policy documents for gender in Mozambique, where there is obvious government commitment to the cause.

The three interconnected documents (strategic plan for the fight against HIV and AIDS I, II and III) are strong and well-written documents, including a comprehensive situational analysis. It is unfortunate that palliative care is not mentioned anywhere despite the documents showing a strong commitment to improving the quality of life for PLWHA.

There is a very strong gender policy in Mozambique that underlines all documents. The language is gender-sensitive throughout and aims to empower women. There is a definite attempt to avoid reinforcing gender stereotypes. Opioids, their control, practice, and tax-related law governing the movement of drugs in Mozambique are not addressed in the reviewed documents. However, there is a commitment to international human rights and best practices, which could assist the integration of palliative care, pain management, availability of opioids and their usage.

3. Specific findings


Palliative care (including pain and symptom management) and human rights are not mentioned in this document, and health care is barely touched upon. Palliative care is outside the scope of this document. The policy is gender-sensitive. It is a strong governing document for gender in Mozambique, but palliative care could be incorporated. Issues such as confidentiality, anti-discrimination, and international human rights laws are frequently referred to.

3.2 National strategic plan for the fight against HIV and AIDS (books i, ii, & iii, 2004-2009)

Although these are strong strategic documents, palliative care (including pain and symptom management) and human rights are not alluded to at any point, although they could be easily integrated. The Mozambique government’s commitment to improve the quality of life for PLWHA is evident throughout. The documents are gender-neutral and offer an understanding of gender roles and issues in Mozambique. Gender stereotypes are not reinforced and gender-based violence is addressed in the overall strategy. Human rights based on international best practice are important in the documents, even though palliative care is not mentioned. The document has a strong human rights ethos and palliative care could be easily integrated.
4. Recommendations

The review of documents from Mozambique has revealed a strong commitment from the government and ministries to improve the quality of life of Mozambicans. The reviewed documents are well-written and developed through due process. The multi-stakeholder approach should be extended to advocate for the integration of palliative care in Mozambique. The language is clear and understandable, which is very evident in the M&E and implementation plans. Palliative care should be incorporated into these and considered to be a priority area for health care. Opioid accessibility and practice has not been mentioned in the documents, but there is a strong human rights component and pain management and palliative care could be included as a basic human right for people with life-threatening illnesses.

5. Conclusion

Mozambique has a strong commitment to providing gender-sensitive quality care for its citizens. There are strong and well developed implementation plans in place for improving the quality of life of the population. It will not take much to integrate palliative care into the current health and gender strategies. Key ways forward will be to:

- integrate palliative care into existing strategies for gender, HIV and AIDS, and paediatric care;
- include palliative care as one of the priority areas for HIV and AIDS prevention, treatment and care;
- develop a palliative care training programme for healthcare professionals; and,
- look at current tax laws on the movement of drugs in Mozambique and relate these to the use of opioids.
NAMIBIA
I. Documents reviewed from Namibia

The in-country African Palliative Care Association (APCA) office in Namibia worked closely with their partners to request authorisation from the ministry of health (MOH) to review national policies. The ministry responded, requesting more details about the review to avoid duplication of work. More details were given and the MOH asked APCA to review more than the requested documents.

The following documents were available from Namibia at the time of the review:

- Gender and the Labour Act 11 of 2007 (Legal assistance centre, Namibia)
- Namibia essential medicine list (2008)
- National policy on HIV and AIDS (2007)
- National strategic framework for HIV and AIDS: April 2010-March 2015 (Final draft)
- Policy on community based health care (2008)

The MOH requested that the following documents be reviewed after the initial review had been completed.

- National medicine policy (second edition draft)
- National Pharmaceutical Master Plan (second edition third draft)

Due to the time available for the review of the documents, five documents were selected. In addition to these five documents, the MOH requested that the review be extended to include the national medicine policy and the national pharmaceutical master plan. The recommendations in this report are based on a review of these seven documents.
### 1.1 List of policies reviewed

<table>
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<tr>
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<td>Gender and the Labour Act 11 of 2007</td>
<td>Gender</td>
<td>Legal Document</td>
<td>Legal Assistance Centre</td>
<td>01 Jan 2007</td>
<td>01 Jan 2009</td>
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<tr>
<td>Guidelines for Implementing Community Based Health Care</td>
<td>Home Based Care</td>
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<td>Government of Republic of Namibia</td>
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<td>National Medicine Policy Second Edition (draft)</td>
<td>Opioids/ Medicines</td>
<td>Policy</td>
<td>Ministry of Health and Social Services</td>
<td>01 April 2010</td>
<td>Not specified</td>
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<td>National Pharmaceutical Master Plan Second Edition Third Draft</td>
<td>Opioids/ Medicines</td>
<td>Strategic Plan</td>
<td>Ministry of Health and Social Services</td>
<td>01 June 2000</td>
<td>01 May 2010</td>
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<td>National Policy on Community Based Health Care</td>
<td>Home Based Care</td>
<td>Policy</td>
<td>Government of the Republic of Namibia</td>
<td>01 Mar 2008</td>
<td>N/A</td>
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</table>
2. General findings

Namibia has begun to integrate palliative care into the overall health care infrastructure but there is significant opportunity for improvement. More recent documents tend to have more holistic inclusion of palliative care. Overall strengths of the documents are that they were developed through a consultative process and have clear language. The national HIV policy and the National Strategic Framework (NSF) clearly articulate the need for palliative care, and the NSF embraces a holistic approach. The medicines policy mentions palliative care services, while the pharmaceutical master plan (which implements the policy) has no reference to anything palliative. Overall weaknesses are gender exclusion, the absence of opioid control and practice, and no mention of pain-relief as a human right. These are areas that should be improved.

3. Specific findings

3.1 National Policy on HIV and AIDS
The document is well developed with clear policy statements and implementation strategies. It has a committal tone. The policy lacks inclusiveness of gender and ethnic groups, which may hinder successful implementation in terms of gender balance. There is also too little information on the disciplines and licensing laws regarding opioids, and there is no mention of pain-relief as a human right or access to essential medication (such as opioids). However, given that it is a policy on HIV and AIDS, it provides an opportunity to integrate palliative care. Given that palliative care as discipline is relatively new in Namibia, this omission is understandable.

3.2 National Policy on Community Based Health Care
This policy was fairly well developed with due consultation processes, and is inclusive of gender issues and stakeholder involvement. However, it lacks content on palliative care and its integration. There is an opportunity to broaden this document to include issues around palliative care. While the document recognises the need to provide care at home, it does not stipulate how clinical care (such as pain and symptom management) should be provided. In addition, it does not mention the management of pain as a human right.

3.3 Guidelines for Implementing Community Based Health Care
The guidelines are well developed but may need improvement in terms of inclusivity (i.e. gender issues, multi-ministerial involvement and patient rights). The language used is committal. It gives little information on opioid use and availability, and it does not mention anything with regard to human rights or the need for pain and symptom management. The guidelines have strong monitoring and evaluation strategies. Consultation on the development of the guidelines should be broadened to include experts in palliative care. Integration of palliative care into the current community-based care curriculum is strongly advised. The guidelines should be updated to include areas of opioid use, control of opioids, inclusivity and gender issues so that all levels of service providers know how to implement the guidelines.

3.4 Gender and the Labour Act 11 of 2007
This is an educational document and provides a concise summary of the Labour Act. Sexual orientation should be incorporated, while including other gender groups (particularly in the area of sexual harassment) would be beneficial, and the document should acknowledge minority groups in need of holistic care. This document is focused solely on gender, and does not mention issues such as pain and symptom management, palliative care, human rights or opioids. It is a document with a very narrow focus but it could be expanded to include wider issues around palliative care.
3.5 National Strategic Framework for HIV and AIDS April 2010 - March 2015
It is obvious that a lot of thought went into the development of this document. The commitment is demonstrated by having the president providing the introduction. This is the first time that palliative care is included in the HIV and AIDS plan for Namibia. This is a national accomplishment, although the relevant sections do not elaborate on what palliative care is and there is no mention of pain-relief, human rights or opioids. However, the fact that palliative care is mentioned provides an opportunity to include these issues. The document includes information on response management and monitoring, which is crucial for effective public health initiatives. The elderly and children who need palliative care are not included sufficiently and should be mentioned in the palliative care section. To expand on gender would increase the acknowledgement of and sensitisation around specific minority groups.

3.6 National Pharmaceutical Master Plan (NPMP)
This document is a master plan to implement the National Medicine Policy (NMP). As such it has included the same broad stakeholder involvement, and has used the same basic principles and rationale as the NMP. The document is written in clear English with no stated intention to have the document translated. It is stated that the population of Namibia is the target recipient group and it is inclusive (without being specific) of all Namibians. It has clear objectives and principles. The reference to palliative services in the NMP has been deleted in this document, rendering the plan free of any mention of palliative care. Consequently there are no details relating to opioids and no mention of any rights to pain-relief.

The document could benefit from defining palliative care in a similar manner to the NMP. Once palliative care is mentioned as one of several health services, there is direct relevance to specifying what is required in terms of medicines, legislation, controls and practice regulations. Similarly, the generalist tone of the document regarding the target beneficiaries could be more explicit by including a broad gender definition, stipulating any gender-specific situations for medicines and ensuring that vulnerable groups (including children) are not ignored. Finally, there are opportunities to expand upon the concept of patients’ rights to information and to explore medicines-related human rights (including the right to pain-relief, health care in general and palliative care in particular).

3.7 National Medicine Policy (NMP)
This document reads well and is clear and concise. It relates to all Namibians and does not favour any particular gender, disease or age. Although there is an emphasis on the need for medicinal treatments for HIV, it advocates for effective medicines for all conditions. It does not specify palliative medicines, although it does mention palliative services as one of many health services, paving the way for more in-depth inclusion of palliative care if it were to be reviewed. If palliative care were to be included, there would be opportunities for information concerning legislation for opioids, details for licensing, prescribing and dispensing opioids, and generally managing pain related to terminal illnesses.

It would be pertinent to summarise the need for updated material from the first edition. The progress made in HIV treatments may be one of the updated areas and it would be wise to integrate updated materials in a further revision on palliative care, and the need for effective pain control for all palliative situations. It is possible that some of the medicines required for palliation may be detailed in the Second National Pharmaceutical Policy, which is to be read together with this policy and which is responsible for implementation of this policy. The opportunity to integrate and expand the concept of palliative care in this document is enormous, and should be capitalised upon during the next review. Should this happen, it is recommended that general information be included on pain relief as a human right as well as relating the broad spectrum of palliative care drugs to all aspects of the policy.
4. Recommendations

Stakeholders from all sectors should be included in the development of policies relating to palliative care and gender. Beneficiaries should be seen as critical to this process since their input needs to be considered. Beneficiaries should include patients, family members and (when relevant) children. National legislation and policy documentation as they relate to cancer, HIV and gender is not the sole responsibility of a single group or one government branch, but requires a multi-sectoral approach so that cross-cutting strategies can be developed and implemented effectively.

Simple language versions of relevant national legislation and policy documentation are required so that citizens are aware of their rights and are empowered to become custodians of their own well-being. The HIV and AIDS policy clearly articulates the response to the HIV epidemic and includes the protection of those who are affected. According to the NPMP there is no intention to translate the document into local languages. In addition to the strong attempt to address issues on palliative care, the guidelines for implementing home-based health care include very strong monitoring and evaluation strategies. This can be used as an opportunity to integrate palliative care into the home-based care curriculum. Simple abbreviated documents outlining the main points of national policy are recommended. Within the gender and labour act, sexual orientation should be included.

Policy and legislative issues specific to children are not addressed. Children are affected by the same issues as adults, yet they have unique needs and these should be addressed throughout all policy documents. Sexual orientation and preference are not addressed, although they are relevant to caretaking, receipt of care and care provision.

While gender issues are highlighted in some of the policies, a traditional viewpoint is expressed. Policies should be gender-neutral. Policies have a role in countering stereotypes by encouraging participation when appropriate. One way to address this is to include other gender groups, particularly in the area of sexual harassment. Caring by male care-givers is another area of concern, as there is a serious gender imbalance among care-givers. Gender can also be expanded to relate to certain sexual orientation groups and how they obtain access to care services and drugs.

Palliative care needs to be mainstreamed into the overarching health care infrastructure at both the community and facility levels. Palliative care should be included in all polices discussing HIV and AIDS, cancer and care in general. There is a need to raise awareness of palliative care and its role in health care. Palliative care is appropriate for HIV and AIDS patients. Pain and symptom management is critical given the unpredictable course of illnesses linked to HIV, and clinicians should be encouraged to prescribe and increase the use of opioids for patients in severe pain. Clinicians should be trained in the use, control and advocacy of opioid analgesia. The NMP does not include any information on opioids or even mention the need for pain-relief. If palliative care were to be included within the NMP, there would be opportunities to define the legislation relating to opioids and their prescription. Many documents do not include strategies for the training of clinicians in the use, control and advocacy of opioids.
5. Conclusion

Namibia is making strides in addressing the need for palliative care. This is apparent in more recent national documents. There is a place for palliative care in all documents related to the care and protection of patients with life-limiting conditions and their families. This review identifies policies (and sections within these policies) where the inclusion of palliative care issues could enhance policies relating to health care and pain management. Not all policies need to integrate details on palliative care but a clear definition (as a minimum requirement) would assist implementation of related policies. Where the policy is directly relevant to chronic illness, further detail and guidance on palliative care would benefit Namibians. Alongside this is a clear need to expand policy statements on gender and human rights to ensure clear frameworks for non-discriminatory practice. Integration of palliative care into all community- and facility-based care is essential for long-term sustainability and accessibility. National palliative care policy and guidelines would help to roll out palliative care by clearly articulating the government’s vision of national palliative care development. It would also empower clinicians, community health workers and patients to supply and demand quality palliative care.

General knowledge regarding palliative care would be improved by awareness campaigns and the creation of information, education, and communication materials on the subject. Health care workers need to be trained in palliative care with a specific focus on pain medication usage and necessity.

Gender forms societal norms and expectations and therefore cannot be ignored in providing holistic care. Palliative care training should include issues around gender and promote gender neutrality where necessary.

Pain-relief is a basic human right which greatly impacts on quality of life. Pain medication should be made available to all patients with life-limiting conditions throughout the trajectory of their disease. HIV and AIDS-related policies should advocate for the need for pain medication for patients. National palliative care policies, guidelines and standards should address issues regarding the control and use of opioids. With adaptation, Namibia’s wide-ranging policy documents have the capacity to ensure equitable and effective health care support for all citizens.
1. Documents reviewed from Swaziland

In order to collect the national policy documents in Swaziland, APCA wrote to the Ministry of Health with the assistance of a palliative care officer and the HIV and AIDS programme coordinator for the government. The letter was received by the ministry, and it took approximately three weeks to receive the approval and to supply APCA’s in-country office with the documents. All the documents were hardcopies and were written in English.

The following documents were available from Swaziland at the time of the review:

- Essential medicine list (2005)
- National guidelines – Community home based care and support (2006)
- National health policy (2007)
- National NGO policy (2005)

Four documents were selected, and the recommendations within this report are based on a review of these four documents.

### 1.1 List of policies reviewed

<table>
<thead>
<tr>
<th>Document name</th>
<th>Scope of document</th>
<th>Type of document</th>
<th>Funder(s) of the policy</th>
<th>Original publication date</th>
<th>Latest revision date</th>
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<td>Clinical Protocol</td>
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</table>
2. General findings

All the documents cover their core areas to a great extent. Some of the documents were developed through a clear process with mention of who was involved in their development, whereas others are not clear on how they were developed. They are inclusive of the general population and of some specific groups. Some of the documents are gender sensitive (at least to a certain extent) and others are not. Opioid and palliative care issues are not integrated at all and only one document defines palliative care. Palliative care and opioid use are omitted, although there is great need for both considering the HIV statistics and the number of patients in need of home-based care. The documents can be strengthened to include palliative care and pain and symptom management, as well as human rights issues in relation to pain and symptom management.

3. Specific findings

3.1 Community Based Care and Support Guidelines

Although this document recognises the beneficiaries (PLWHA), it does not mention palliative care, pain and symptom management, opioids or human rights issues. However, the fact that it recognises the beneficiaries is an opportunity to integrate palliative care and it could also be strengthened to show that beneficiaries can be involved in the implementation of the guidelines. The clear monitoring and evaluation plan is useful for measuring implementation.

Overall this is a good document. It covers a great deal and there is potential to use this document to support palliative care development. To make the document more supportive of palliative care, it would be good to include the policy development process, incorporate palliative care as well pain and symptom management under medical care and psychosocial support, and strengthen the section on gender-based violence.

3.2 National HIV and AIDS Clinical Care Guidelines

The national HIV and AIDS clinical care guidelines present a great opportunity to include palliative care, addressing the issues of pain and symptom management as well as human rights issues. It is a great omission that these issues are not covered in the document. It is stated that with the availability of new information it the document will be reviewed, creating an opportunity to integrate palliative care. As it stands, there is an opportunity to include palliative care under medical care and psychosocial support, and to strengthen the section on gender-based violence and overall gender issues.

3.3 National Health Policy

The national health policy provides a framework for health provision in Swaziland. There is no mention of palliative care, pain and symptom management, or opioid use. The mention of the essential medicine list, community- or home-based care and human rights (though without extensive details) provides an opportunity to include palliative care in this policy. In addition, to make the policy stronger, it would be good to include the policy development process, incorporate palliative care under medical care and psychosocial support, strengthen the section on human rights and address gender-based violence.

Overall, this is a good policy document, covering a great deal of general health issues. However, it does not mention anything on palliative care and opioid availability, and there is a need to develop a palliative care policy to address the gaps identified but there is potential to use this document to support palliative care.
3.4 National Multi-sectoral HIV and AIDS Policy
The document does not explicitly mention palliative care or pain and symptom management. There are opportunities where these could be integrated, especially under psychosocial support. The greatest strength of this document is the recognition of the beneficiaries, (PLWHA) and their involvement in the implementation of the policy. The clear monitoring and evaluation plan is useful for measuring implementation.

3. Recommendations

**Development:** There is a need to mention in some of the documents who was involved in their development. There is also a need to state when the documents will be reviewed.

**Language:** There is a need to translate the documents into the local language so that they are accessible to all and to sensitise the nation about the availability of such documents and related services.

**Implementation:** Some of the documents need to state how the beneficiaries will be involved in the implementation phase. Funders or resource sources for the implementation of the documents should also be specified so that there is someone who can be held accountable. There is a need to show how the implementation will be monitored and evaluated.

**Gender:** Gender issues are not well dealt with in some of the documents. There is mention of human rights in some of the documents and this should be used to strengthen the gender component.

**Palliative care:** This has been omitted in all the documents. There is an opportunity to include palliative care in all the documents reviewed. Palliative care should be regarded as a priority and be addressed immediately, considering the current HIV and AIDS situation in the country.

**Opioids:** None of the documents mentions anything about opioids. There is an opportunity to integrate opioids into the documents since some of them mention narcotics and the need to control ART side-effects. Opioids should be well dealt with, especially regarding issues of availability, accessibility, prescription and dispensing, monitoring and evaluation of drugs.

4. Conclusion

It is evident that many opportunities are available to include palliative care in policy. Since this study was conducted, the national palliative care policy has been passed. There is a need to develop a strategic plan with palliative care guidelines and all associated materials (such as training manuals).

It is evident that there needs to be a clearer advocacy strategy for palliative care issues, especially opioids availability and accessibility at all levels of care. There is a great need to involve government at all levels for buy-in purposes and to hold government accountable for implementation.

The review has highlighted the need for sensitisation regarding human rights and gender issues in the provision of palliative care.
I. Documents reviewed in Zambia

In collaboration with the Palliative Care Association of Zambia, the relevant documents were requested from the government of Zambia through the office of the Permanent Secretary.

The following documents were available in Zambia at the time of the review:

- Essential medicines list and essential laboratory supplies list for Zambia (2009)
- National health strategic plan (2006-2010)
- National HIV and AIDS, STI and TB policy (2005)
- Standard treatment guidelines,
- Zambian palliative care situational analysis (2007)

Four documents were selected, and the recommendations in this report are based on a review of these four documents.

I.1 List of policies reviewed

<table>
<thead>
<tr>
<th>Document name</th>
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<th>Type of document</th>
<th>Funder(s) of the policy</th>
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<td>Policy</td>
<td>OSISA / DFID</td>
<td>01 Jan 2005</td>
<td>N/A</td>
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<td>Implementation guideline</td>
<td>OSISA / DFID</td>
<td>Unknown</td>
<td>01 Jan 2009</td>
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2. General findings

The documents reviewed are fairly inclusive in terms of gender, race and ethnicity. They cover key aspects of health, serving as a comprehensive tool for health services implementation in Zambia. None of the documents acknowledge sexual orientation or discuss marginalised populations and their rights to health care. Palliative care integration in these documents is minimal or absent altogether. The term is not defined clearly and it is not included in the response to the HIV and AIDS pandemic.

The standard treatment guidelines, essential medicines list and essential laboratory supplies document is comprehensive in terms of drugs and their use for certain diseases, but it does not give much detail about gender or human rights issues pertaining to certain drugs. It does not include any palliative care drugs or acknowledge that palliative care is a human right that should be made available to all who need it.

The HIV and AIDS/STI/TB policy is a very detailed, well-developed document. It focuses on the rights of the patient and PLWHA. It includes clear policy statements and guidelines for implementation. Consultation with the relevant stakeholders took place and their input was evaluated and included in the document. This is a very well-rounded document, which needs to include palliative care and which has the potential to become a model policy for other developing countries.

The gender policy is a good policy document. It includes all relevant gender issues and acknowledges basic human rights.

The national health strategic plan is clear and reads easily. It is inclusive of all genders, races and ethnicities. It mentions palliative care twice but without defining the term and it fails to link human rights with patients’ rights. Major concerns are standards, guidelines, prescription regulations and pharmacy regulations relating to opioids.

3. Specific findings

3.1 Standard treatment guidelines, essential medicines list and essential laboratory supplies for Zambia, 2009

Despite giving guidelines for treatment, this document does not deal with palliative care, pain and symptom management, opioids or human rights. The document would be stronger if it included a section on cancer and HIV and AIDS together with some of the relevant medications for these conditions. The omission of gender may be attributed the fact that this document focuses specifically on treatment protocols rather than wider health issues (such as gender and health).

3.2 National HIV and AIDS/STI/TB Policy, 2005

This policy includes one statement about palliative care and hospice services. Apart from that, no mention is made of palliative care and the existing statement is brief and does not mention pain or symptom management, opioids, human rights or gender issues. Sections that could benefit from the inclusion of palliative care are:
- promotion of HIV and AIDS research and development;
- strengthening and expansion of voluntary counselling and testing (VCT);
- support those infected or affected by HIV;
- treatment of opportunistic infections; and,
- human resource development and training and the education sector.
The policy is gender-sensitive but it lacks any acknowledgement of marginalised populations. It focuses on cross-cutting issues (such as rape and gender-based violence), which contribute to the spread of HIV and AIDS, differentiating between socially constructed gender norms and ways in which those norms can be broken down.

A key recommendation would be to address the stigma that contributes to the fear of prescribing morphine for effectively managing pain. It would be useful to add more details and to include the rights of the patient to healthcare, as well as the consequences of non-adherence to the patient’s request not to be treated.

3.3 National Gender Policy, 2000
No reference to palliative care is made in this document and it does not mention pain or symptom management, opioids, human rights or gender issues. The policy is gender-sensitive (including women, men, boys and girls) and does not reinforce gender stereotypes. It mentions gender-based violence and other gender issues, and this provides an opportunity to strengthen gender in the policy.

The gender policy focuses mainly on women. It should be more gender-neutral and updated with recent developments and advances made from gender perspectives. We can make use of the gender policy to describe what pain medication should be made available to both men and women (equally).

3.4 National Health Strategic Plan 2006-2010
Palliative care is mentioned twice in this document but it is not defined and no other palliative care terms are used in the document. Opioids are not mentioned at all, and neither is any other pain-relieving drug or its distribution or regulation.

A national health strategic plan should include a definition of palliative care, which makes use of the WHO terms. It should address legal reforms around opioids and their availability, and provide standards and codes of procedure to ensure the effective implementation of palliative care. The plan does include key gender statements and addresses key gender issues but it should include gender in more detail and acknowledge that different genders have different needs. It is critical that the government recognises that each individual has different needs. The plan should also acknowledge the impact of gender on the spread of HIV and the prevalence of other non-communicable diseases.

Standards should be developed to guide opioid practices in the country and to clarify how opioids are controlled in Zambia, including their distribution, availability and pharmacy regulations. Lastly, there is a lack of a human rights approach to health service delivery. Patients’ rights and international human rights norms should guide implementation.
4. Recommendations

**Development:** The documents reviewed lack recent statistics or reference to social, economic and situational circumstances. They are not kept up to date with the country’s development, economy or health situation. Overall health and development statistics are discussed within all the documents but very little attention is given to the development of measures to overcome social and health barriers.

**Language:** All documents are available in English. It is very difficult to acquire the policy documents in local languages.

**Implementation inclusivity:** General implementation strategies are discussed. No details are given as to timelines, the impact of certain activities or the contribution these would make to the development of the national health system. Documents should focus more on detailed ways to implement policy statements and guidelines. There is a significant lack of adherence to government policy documents. Penalties for non-compliance are not discussed, which leads to the general assumption that no harm will come to those who do not apply national legislation within their organisations or government departments.

**Gender:** Gender issues need to be strengthened in all the documents, including gender roles and responsibilities in relation to palliative care. There is a need to cross-check with other government policies and documents to determine whether gender issues are catered for.

**Palliative care:** No definition of palliative care is supplied in any of the documents. There is a lack of integration of palliative care with other support services. Palliative care should form part of the general development of health care services for those who suffer and need it most.

**Opioids:** No palliative care drugs are included in the essential drug list or in any other documents provided by the Zambian government. Opioids such as morphine are regarded as dangerous drugs and are not available even for those who suffer intense pain due to their illness or health status.

5. Conclusion

Zambia has the correct foundation for palliative care integration into existing national policy documents. With regards to development, many areas exist that can be used to identify the need for palliative care inclusion and development.

A recent morphine fact book has been piloted in Zambia to educate health care professionals on the basic facts of morphine and other drugs used for pain management. Measures such as these should continue.
I. Documents reviewed from Zimbabwe

A project proposal and description were developed and sent to the Medical Ethics Commission of Zimbabwe for approval to review the policy documents. Once approval was given, it was relatively easy to collect the documents with assistance from the HOSPAZ.

The following documents were available from Zimbabwe at the time of the review:

- Community home based care policy (2001)
- Essential drugs list (2006)
- National gender policy
- National HIV and AIDS policy (1999)
- PMTCT and paediatric HIV prevention, treatment and care national plan (2006-2010)
- Zimbabwe national HIV and AIDS strategic plan (2006-2010)

Three documents were selected, and the recommendations within this report are based on a review of these three documents.

I.1 List of policies reviewed

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<td>Policy</td>
<td>Government of Zimbabwe</td>
<td>01 Dec 1999</td>
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</tbody>
</table>
2. General findings

The documents that were reviewed reveal minimal coverage of palliative care issues and nothing concerning opioid availability. Although one document specifically focuses on female gender issues, in general the documents fail to embrace the needs of different genders and minority groups, although gender stereotypes are not reinforced. There is variable evidence of due process in the development of the documents. The documents are clear and easy to read but practical implementation strategies are lacking.

The National Gender Policy is specifically focused on redressing gender inequalities and promotes the advancement of women (especially in areas of social and economic activities). Although there is no evidence of multi-sectoral consultation in the development of the policy, the document refers to the policies of several ministries that could be adapted to promote the rights of women. The policy is written in English and would benefit from translation into local languages if the ideals are to be achieved and implemented effectively. There is no mention of palliative care or the drugs associated with the field and there is limited scope for inclusion of palliative care in this document. If palliative care was included within the health sector, the document would need to be adapted substantially to incorporate the palliative care needs of men, women and hidden gender populations. It is indicated that women tend not to seek health care rapidly and that they bear the burden of care-giving in the HIV epidemic. Incorporation of palliative care at this level would link the health needs of the community with the greater picture of health needs for all.

The national cancer plan for Zimbabwe has a clear rationale that underpins the document and that is supported by statistical evidence of alarming cancer rates in the country. It is written in easily-read English and there is no indication that translation into any other language is required or intended. The plan is cancer-specific, although it mentions HIV in connection with related cancers. There is no gender statement but the document is gender-neutral and does not reinforce gender stereotypes. Palliative care is embedded in the document as one of the four priority areas. Although palliative care is an approach to be used for incurable cancer, there are no details in the document about opioid sources, control or prescribing mechanisms. There is no confirmation of human rights in respect of health care, palliative care or pain control.

The national policy on HIV and AIDS is underpinned by a clear rationale and has policy statements embedded in its guiding principles. There is no indication that translations are necessary and the tone of the document is clear and determined in its quest to arrest the spread of HIV. The plan is inclusive of all ages, with children’s needs directly addressed. Although the document does not make a specific gender statement, it is gender-neutral. Palliative care is not mentioned, although some reference is made to terminal care in HBC. There is no mention of opioid provision, controls or tax laws, prescribers of morphine, or the laws pertaining to DDA licensing. The right to pain-relief is not specifically mentioned, although the right to health care in general is embedded.

3. Specific findings

3.1 National Gender policy

Palliative care is not mentioned in the document and nor are any similar terms. There is no relation to palliative care in language, definitions, mention of drugs or any other aspect of the document. Neither palliative care nor health is identified as a human right.
The concept of palliative care could be incorporated into the health section of the document. A simple explanation of palliative care and the expansion of women’s roles as care-givers (especially with the HIV burden) would feed automatically into better health care for all. It would be helpful to define palliative care as a human right and also to specify pain-control as a human right.

The policy makes a key gender statement that women need to be promoted in social and economic affairs. Although the document strongly advances women, men are included in much of the document. Roles and responsibilities are defined in relation to redressing past imbalances. The document strives to counter negative stereotypes of women and works against reinforcing them. Gender-based violence is only briefly mentioned as is the risk of HIV exposure for men and women.

The document provides a clear rationale for its creation due to women having been discriminated against socially and economically because of their gender. This document attempts to redress those imbalances by suggesting strategies that enhance the role and place of women in society. Women’s health issues are not examined in depth and the document tends to focus on their role as care-givers (especially in relation to the HIV epidemic).

Wider application of the term ‘gender’ and better representation of men, women and hidden gender populations would enhance the document.

There is no mention of opioids or taxes pertaining to the importation of palliative care drugs. There is no reference to prescribing disciplines, licensing laws, pharmacy regulations or standards relating to palliative care drugs.

It is indicated that women do not exercise their right to health care as well as they might, although issues of confidentiality, patient consent and anti-discrimination regarding HIV are all excluded. At the beginning of the document there is a list of international conventions and declarations that have provided parameters for the policy.

Palliative care is recognised as integral to the cancer control plan and the document indicates a full understanding of the meaning of palliative care, including the need for holistic or total care. The need for palliative care is described as being when cancer is incurable or when late presentation makes curative treatment impossible. The oncology committee revised the essential drugs list, which includes opioids. Palliative care education is to be integrated into medical and nursing schools and disseminated elsewhere by means of workshops and implementing the WHO analgesic ladder. Inclusion of traditional healers recognises their role in the community. Palliative care is to be provided by a wide range of providers and includes in-patient units and HBC approaches. Some evaluation indicators provide a baseline for assessing progress.

Palliative care is mentioned throughout the document as part of the care plan for incurable or late referral cancers. It is seen as a credible and needed approach as part of the overall plan and one that is already well-established in Zimbabwe. Although the WHO definition is not used, certain aspects (such as mention of the multi-disciplinary team and holistic care) are described briefly. The need for morphine is confirmed before training begins to extend palliative care coverage. The different models of palliative care are not mentioned, and there is no monitoring and evaluation strategy for palliative care. Mention is made of various committees and organisations that have something to offer in palliative care, although coordination and referral details are scanty. Legal, ethical and human rights issues are not addressed.
The current document is out-dated and expired in 2004. Consequently much of the information concerning palliative care services and the implementation of a palliative care programme is inaccurate. When it is revised it would be helpful to include the WHO definition, which would provide an accurate and in-depth explanation of palliative care. All drugs required for palliative care on the WHO analgesic ladder should be included. Training at pre-service institutions should include the School of Social Work, and the multi-disciplinary team should be broadened to include social workers, spiritual care advisors and volunteer care-givers. The patient and family should be emphasised as the unit of care, and the different models of care could be included. The document would benefit from consistent use of evaluation indicators for progress. The national palliative care organisation needs to be mentioned as a coordinating body and note made of the trend towards integrating palliative care into HBC activities. Ethics drawn from the medical field should be included as relevant to palliative care and mention made that this is a human right (along with the right to health care generally).

Although there is no specific gender statement, the document is strongly gender-neutral and is careful to not reinforce gender stereotypes (although it does not actively counter them). Gender-based violence is not addressed. Certain risk behaviours are mentioned (such as sun exposure, heavy drinking, smoking, sexual "promiscuity" and poor diet), but these are mainly not gender-specific. By using the third person (e.g. the public, children, adults) the document avoids stereotyping and promotes universality to cancer risk rather than apportioning blame due to gender. There may be opportunities to expand on gender-specific cancers and further analysis by gender would be helpful (without reinforcing stereotypes).

There is no information on the disciplines allowed to prescribe morphine, nor any licensing laws, pharmacy regulations or standards. Although the document states that morphine needs to be available before training workshops on palliative care commence, more information is required on how the drug is ordered, supplied and distributed to ensure safety and accessibility. Information on prescribers and procedures would enhance the document. A statement on the right to a pain-free death would inform ethical considerations.

Human rights are not mentioned and those relating to the right to health care, palliative care and pain-relief are not included in this plan. Issues of confidentiality and patient consent are absent. Human rights relating to health care, palliative care and relief from pain should be embedded in the document. The issues of confidentiality, patient self-determination and patients’ rights should be explicit along with other protective mechanisms, such as working against stigma and discrimination.

3.3 National Policy on HIV and AIDS for the Republic of Zimbabwe, 1999
Palliative care is not mentioned in the document, although minimal comment is made about care for the terminally ill and those with chronic illnesses. The WHO definition of palliative care is not included and while the term ‘holistic care’ is used it is not fully explained or embedded in the document. Education and training is an issue but more in terms of sexual health and HIV information and it does not include palliative care techniques. The interdisciplinary approach is referred to briefly but encompasses only nurses, traditional healers and the community. Those who will benefit from the plan are identified and different levels of care are described as hospital and HBC. There is some information regarding stakeholders as members of the community, NGOs, government ministries, churches and community groups. Responsibility for coordination is assigned to the NAC but clear monitoring and evaluation strategies and coordination approaches are not described. Referral networks are alluded to and legal aspects are clearly addressed with legal statutes itemised as an appendix. Human rights are embedded in the document and form the foundation for some of the guiding principles.
The plan talks of a continuum of care but does not explain fully what this means, although there is acknowledgement that holistic care is required for PLWHA. The need for effective communication and information regarding HIV is addressed. Some aspects of the interdisciplinary approach are included and the inclusion of traditional healers is welcome. There is an understanding that HIV does not only impact on the person with the illness but that families and many others are also affected. Different levels of health care are indicated as needed at hospitals, clinics and in the community with HBC. There is a call for people to take responsibility for their own health and for HBC materials to reflect this. The levels of care are briefly described. There is reference to legal statutes that should apply specifically to those affected by HIV.

Where there is mention of terminal illness or chronic care, palliative care needs to be incorporated. It could be specifically included in the referral and discharge section, where palliative care is a care option for HBC and where HBC providers could refer patients for palliative care within hospitals. A clear definition of palliative care (using the WHO definition and expanding on concepts such as holistic care, multi-disciplinary teamwork, and pain and symptom relief) would greatly enhance the document. Palliative care should also be included in all HIV–related training, with an interdisciplinary approach involving social workers and spiritual care advisers as well as medical workers. As palliative care regards the unit of care as the patient and the family, this needs to be emphasised and the concept would strengthen the information provided on the continuum of care so that referrals and any coordinating mechanism include this approach. Although the document counters stereotypes, the concept of gender could be expanded and could include other genders. There are specific risk factors associated with men who have sex with men, for example. There could be greater emphasis on men taking a more active role in HIV prevention and more detail on care options.

Women are identified as being more exposed to HIV infection due to gender inequalities and sexual disempowerment. There is an understanding of the social and cultural context in which Zimbabwean women live and steps are taken to recommend addressing these issues. The document recommends strengthening the role of women by encouraging education and skills training, as well as informing them how to take care of their sexual health. The document works against reinforcing stereotypes and actively supports an enhanced role in society for women. The issue of uneven sexual power is addressed and by the using the term ‘sexually active people’ the document does not limit its scope to heterosexuals only.

The document is gender-neutral, although it does not make a specific gender statement. Roles and responsibilities for men and women are defined in relation to HIV risk, and the vulnerability of women justifies the women’s empowerment tone of the document. As a result it goes some way towards countering gender stereotypes by promoting women’s education and empowerment. Gender-based violence is addressed to the extent that legal redress should be sought. Risk behaviours are mentioned but not comprehensively.

There is no reference to prescribers of morphine, licensing laws, pharmacy regulations or standards pertaining to DDAs. If pain-relief can be included in the plan then some information about prescribers would be appropriate.

The right to relief from pain is not specifically mentioned, although right to health care is explicit. Confidentiality issues are comprehensively addressed, as are anti-discrimination issues. The right for the patient to have as much information as needed in order to give informed consent about treatment options is clear. There are links with international laws on human rights.
Several human rights underpin the document and many of the strategies refer to these. The general right to health care is embedded in the document, as well as the right to be informed and to make choices about care. The meaning of confidentiality is well explained and is linked with counselling so that issues of safe disclosure can be addressed. There is a clear anti-discrimination message and strategies to this end are provided.

Human rights could extend to palliative care and pain-control, with choices to be made about end-of-life care, hospital admissions and life-saving procedures. The issue of confidentiality could be broadened to include the relationship between health professionals and patients.

4. Recommendations

**Development:** The documents need further development in terms of statistical data, guiding principles, international conventions and human rights declarations. Increased multi-sectoral and stakeholder involvement and updating of the documents would enhance applicability to all sectors of the population. Not all documents are dated and some are in urgent need of review.

**Language:** All documents are written in English, using language that is easy to read and accessible. There is no indication of the need (or the intention) to translate any of the documents, although increased stakeholder involvement could ascertain this. In general, the tone of language indicates commitment to decisive action.

**Implementation inclusivity:** No document addresses the needs of vulnerable populations or minority groups, although specific cancers relating to children are included in the cancer control programme and women's needs are promoted in the gender policy and highlighted in the HIV and AIDS policy.

**Gender:** Gender awareness is limited to the needs of women. No mention is made of the needs of sexual minorities and all documents could benefit from an expanded understanding of gender. However, there is no gender discrimination or reinforcement of gender stereotyping in any of the documents.

**Palliative care:** Palliative care is only included directly in the cancer control programme, where it is integrated throughout as an integral part of care for incurable cancers. It is alluded to in the HIV and AIDS policy in terms of a continuum of care through home-based care, but is not mentioned at all in the gender policy document. All documents could benefit from the addition of a clear definition of palliative care and an explanation of the different models of delivery. In general, palliative care could be included in these documents by introducing a care and support component and relating human rights to the right to health care.

**Opioids:** Opioids are not discussed in any of the reviewed documents. There is no reference to the availability of opioids, or to tax or dispensing regulations pertaining to pain-relieving drugs. The right to pain-relief – and therefore the need for available opioids – must be included where appropriate.
5. Conclusion

The Zimbabwe documents could be enhanced in several ways. An expanded understanding of gender issues to embrace sexual minorities is imperative if the HIV epidemic is to be addressed comprehensively. Risk behaviours of people who have concurrent and multiple sexual partners need to be debated without prejudice or judgement, so that all people at risk are able to access care. Inherent in this is a broadening of the training of all health workers to equip them with regard to sexual behaviours in a constructive manner.

A commitment to human rights needs to be explicit in policy and programme documents to make clear the link between promotion of strategies and activities, and the daily lives of individual people. Explicitly acknowledging the need for confidentiality, respect and non-judgement will encourage effective implementation of policy ideals. Medical ethics can be integrated into the documents.

As women are socially and culturally responsible for much of the care of ill people, it is recommended that this unpaid work be recognised as a valuable asset to health care and that education and support should be provided to care-givers.

Palliative care can be integrated into policies and documents where appropriate, with particular reference to the needs of women, children, vulnerable populations, minorities and all who require a holistic approach to living with life-threatening illnesses.

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About APCA

The African Palliative Care Association (APCA) is a non-profit making pan-African membership-based organisation which was provisionally established in November 2002 and formally established in Arusha, Tanzania, in June 2004. Acknowledging the genesis of modern palliative care within the United Kingdom, APCA strives to adapt it to African traditions, beliefs, cultures and settings, all of which vary between and within communities and countries on the continent. As such, in collaboration with its members and partners, APCA provides African solutions to African problems, articulating them with what is the recognised regional voice for palliative care.

APCA’s vision is to ensure access to palliative care for all in need across Africa, whilst its mission is to ensure palliative care is widely understood, underpinned by evidence, and integrated into all health systems to reduce pain and suffering across Africa. APCA’s broad objectives are to:

- Strengthen health systems through the development and implementation of an information strategy to enhance the understanding of palliative care among all stakeholders;
- Provide leadership and coordination for palliative care integration into health policies, education programmes and health services in Africa;
- Develop an evidence base for palliative care in Africa;
- Ensure good governance, efficient management practices and competent human resources to provide institutional sustainability;
- Position palliative care in the wider global health debate in order to access a wider array of stakeholders and to develop strategic collaborative partnerships, and;
- Diversify the financial resources base to meet APCA’s current funding requirements and to ensure the organisation’s future sustainability.

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