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MINISTRY OF HEALTH-ETHIOPIA
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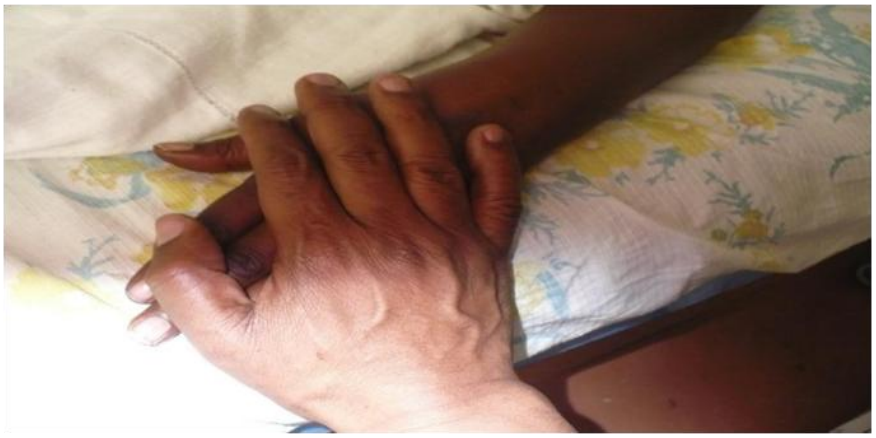
Ministry of Health-Ethiopia

National Palliative Care Strategic Plan (2025 -2029)



High Touch
Low Technology

July, 2025

Addis Ababa, Ethiopia

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Abbreviations and Acronyms

AAU	-	Addis Ababa University
AIDS	-	Acquired Immune Deficiency Syndrome
APCA	-	African Palliative Care Association
CDC	-	Center for Disease Control
EPSA	-	Ethiopian Pharmaceutical Supply Agency
HAPCO	-	HIV/AIDS Prevention and Control Office
HIV	-	Human Immunodeficiency Virus
MOH	-	Ministry of Health
PC	-	Palliative Care
PLWHA	-	People Living With HIV/AIDS
RHB	-	Regional Health Bureau
SMT	-	Senior Management Team
ToR	-	Terms of Reference
UNAIDS	-	The Joint United Nations Program on HIV and AIDS
USAID	-	United States Agency for International Development
WHO	-	World Health Organization
WHPCA	-	World Hospice Palliative Care Alliance

Foreword

As Ethiopia faces a rising burden of life-limiting illnesses, including cancer, HIV/AIDS, and other non-communicable diseases, the need for a compassionate and comprehensive approach to care has never been more urgent. Palliative care is a critical, yet often overlooked, component of our health system, offering holistic support to patients and families during some of the most vulnerable periods of life.

This National Strategic Plan for Palliative Care (2025–2029) represents the Ministry of Health's resolute commitment to ensuring that every Ethiopian, regardless of age, location, or diagnosis, has access to dignified, patient-centered, and equitable palliative care. It builds upon global and regional commitments, including the World Health Assembly resolution of 2014, which recognizes palliative care as a fundamental responsibility of health systems.

The strategic plan is anchored in six interlinked pillars: governance, service access, human resources, medicine availability, information systems, and partnership. Each pillar outlines practical, measurable actions to scale up palliative care across all levels of the health system, from national referral hospitals to community-level services. It also emphasizes local production of essential medications, robust training programs, and enhanced collaboration with communities, academia, and development partners.

We are proud to launch this plan at a pivotal moment in Ethiopia's health journey. With projected demographic growth and shifting disease patterns, now is the time to invest in systems that not only prolong life but also affirm its quality. Through strong political will, sustained financing, and the dedication of healthcare providers and partners, we aim to build a future where no patient suffers needlessly, and no family walks the journey of serious illness alone.

On behalf of the Ministry of Health, I call upon all stakeholders, governmental and non-governmental, public and private, national and international, to work together in solidarity as we implement this strategic plan. Let us ensure that palliative care becomes a reality for all who need it in Ethiopia.

Dr Dereje Duguma Gemeda
State Minister of Health Service and Program Wing
Federal Democratic Republic of Ethiopia

Acknowledgments

The On behalf of the Medical Service Lead Executive Office, I would like to extend my deepest gratitude to all who contributed to the development of the National Palliative Care Strategic Plan (2025–2029).

This document is the outcome of a truly collaborative effort, bringing together the knowledge, dedication, and experience of professionals and institutions from across the health sector. It reflects a shared vision to improve the quality of life for individuals and families facing serious illness through the expansion of accessible, compassionate, and person-centered palliative care services in Ethiopia.

We are particularly grateful to the technical working group members, stakeholders from federal and regional health bureaus, academia, development partners, and civil society organizations who played an integral role in shaping this strategy. Your participation in consultations, validation workshops, and policy discussions was essential in aligning this plan with national priorities and global standards.

We also recognize the critical support provided by service providers, community representatives, and partner institutions whose feedback grounded the strategy in real-world experience and ensured its practicality.

As we move toward implementation, we call upon all stakeholders to maintain this spirit of collaboration and commitment. Together, we can ensure that no one in Ethiopia faces a life-limiting illness without the dignity, comfort, and care they deserve.

Dr Elubabor Buno Teko

Medical Service Lead Executive Officer

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1. Introduction

Palliative care supports the person with a life-limiting illness and their family to offer care and support; it is a concept that not only addresses pain and symptom control but also considers the psychosocial and emotional suffering of the seriously ill person and supports the family as they care for their loved one. Palliative care for children is defined as "*The active total care of the child's body, mind and spirit, and also involves giving support to the family. It begins when illness is diagnosed and continues regardless of whether or not a child receives treatment directed at the disease*" (WHO, 2023).

Palliative care is now an important part of the world health agenda; in 2014, the World Health Assembly passed a resolution which requires that member states address palliative care within the continuum of care (World Health Assembly, 2014). The resolution states unequivocally that relief from pain, whether physical, psychosocial, or spiritual, is the ethical responsibility of health care professionals and the governmental institutions that support health care provision. Therefore, governments are required to include palliative care in the planning and implementation of health care services. This includes having appropriate palliative care policies at the local and national levels, providing budgetary support, ensuring appropriate access to needed medications, and supporting training and ongoing education on palliative care (World Health Assembly, 2014).

The global burden of palliative care is ever-increasing. Almost 57 million patients and families need palliative care annually, with almost 26 million near the end of life (45%) and over 31 million before the last year of life (55%). Palliative care is estimated to be needed for nearly 4 million children (PAHO/WHO, 2020). However, according to this study, approximately 7 million patients received palliative care in 2017 (up from 3 million in 2011), with only about 12% of the need being met globally. Of the people who need palliative care, 69% suffer from non-communicable diseases, and almost 25% suffer from communicable diseases. With regards to global implementation, 64% of countries have no or very limited provision of palliative care, and only 15% of countries have good integration into health care systems. About 83% of the world's countries have low to non-existent access to opioids for pain relief, and only 7% have adequate access (PAHO/WHO, 2020).

It is further estimated that over three-quarters of adults and over 97% of children needing palliative care live in low or middle-income countries (PAHO/WHO, 2020). In sub-Saharan Africa, not only is there the burden of HIV/AIDS, but non-communicable diseases are steadily increasing, with the four most prevalent being cardiovascular diseases, cancers, chronic respiratory disease, and type 2 diabetes. Specific cancer-related problems in African countries include the high percentage related to infection (36%, twice the global average), late presentation to clinical services and limited access to treatment, including opioids, inadequate training of healthcare providers, procurement difficulties, and weak health systems (APCA, 2024).

The need for palliative care in Ethiopia is accelerating rapidly. In 2022, 610,000 people were living with HIV, 8,300 people were newly diagnosed, and 11,000 people died from an AIDS- related illness (UNAIDS, 2022). The number of people with cancer is increasing; the annual incidence is around 60,960 cases, with an annual mortality of over 44,000 (Tekeste et al., 2023). Furthermore, like the rest of sub-Saharan Africa, the number of non-communicable diseases is growing rapidly and is expected to increase by 52% by 2060. The population in Ethiopia is predicted to increase by 171.8 million people by 2050. As the population is growing rapidly, it is imperative that the palliative care service needs grow proportionally, increasing the demand.

This National Strategic Plan for Palliative Care is an MOH strategy that provides a comprehensive implementation framework to increase access to palliative care in Ethiopia by providing quality care for patients and their families living with a life-limiting illness.

2. Rationale for the Strategic Plan

Palliative care is an integral pillar of healthcare that focuses on improving the quality of life for patients facing serious illnesses. In Ethiopia, the growing prevalence of non-communicable diseases (NCDs), including cancer, cardiovascular diseases, and diabetes, has accentuated the urgent need for a nationally coordinated and sustainable approach to palliative care. The development of a five-year strategic plan for palliative care in Ethiopia is therefore essential to address this demand systematically.

Such a plan will facilitate the induction and integration of palliative care services into the conventional healthcare system, meeting the increased demand through equitable access across Ethiopia. It will define goals and strategic directions for service availability, strengthening the quality of care, and institutionalizing training for healthcare professionals. Moreover, the plan will support the development of evidence-based guidelines and protocols that enable a holistic mode of care addressing the physical, emotional, and spiritual dimensions of palliative care needs.

Crucially, the strategic plan will facilitate stakeholder coordination and resource mobilization, catalyzing advocacy efforts and policy reforms that embed palliative care within the health agenda of Ethiopia. This includes securing sustainable financing, enacting regulatory mechanisms, and raising awareness among decision-makers and the public.

In summary, the development of a five-year strategic plan for palliative care in Ethiopia is essential to address the growing need for quality palliative care, end-of-life care, improve access to services, enhance the quality of care provided, strengthen collaboration among stakeholders, and advocate for policy changes.

3. SWOT Analysis

Table 1: SWOT Analysis on current palliative care activity in Ethiopia, 2024.

	Strength	Weakness	Opportunities	Threats
Leadership and Governance	• Availability of guidelines • Getting attention in national road maps and health service transformation documents • MOH ownership on Palliative care service expansion and improvement • Integration of Palliative care services in the health sectors • Government policy to work with private partners • Established TWG	• Lack of awareness • Lack of Training Manuals and protocols • Lack of focus on palliative care relative to other services • No leadership and coordination structure • No formal strategic plan • Poor stakeholder engagement and resource mobilization • Lack of sustainable follow-up from MOH, RHB, and others • Lack of standard guidance on private palliative and hospice care	• Growing attention among higher officials • Presence of Hospice service • Presence of global interest in Palliative care service • Shifting of the disease epidemiology from communicable to NCDs • Government's interest in working with private partners • MOH interest in Palliative care service expansion and improvement	• Shifting attention to competing health agendas. • Inadequate multi-sectorial collaboration among minister • Absence of associations • Absence of donor/partners
Human Resource Education and Training	• Initiatives on palliative care training to health professionals	• Few Palliative care specialists, Diploma or first degree Professionals • No palliative care integrated curriculum • No post-graduate palliative care program • No persistent CME on palliativecare • Lack of in-service training	• Presence of experts who provide technical support and mentor the service • MOHs interest in universities to start education on different levels • Existence of community-based organizations (edirr) • Existence of Health extension workers	• Absence of schools and qualified professionals Lack of budget Staff turnover
Infrastructure, technology and medical products and medicines	• Pain management drugs are included in the essential drug list • Cost-effective availability • University infrastructures and the new cancer centres • Availability of mobile palliative care app	• Poor supply chain management • Lack of sustainable local production of essential PC medications • Mismatch in demand and supply of medications • Lack of accessibility for strong opioids and other essential PC medications • Lack of essential drugs and equipment for PC • Absence of local production of morphine	• Plan on local production of morphine	• Limited budget for Morphine purchase • Socioeconomic status of the country • Poor multi-sartorial collaboration • Less attention by Stakeholders • Lack of Hospital infrastructure for palliative care service provision

	Strength	Weakness	Opportunities	Threats
Information, data and Research	• Availability of Palliative care website • Availability of brochures, leaflets, and mass media	• Lack of strong evidence on palliative care practice • Limited number of research • No national, regional, and facility-based data collection tool, reporting format, and data management system. • No indicators were reported through nationalDHIS2. • Limitation of access to Palliative care information materials • No indicators for home-based palliative care services	• Presence of volunteers to conduct research • Presence of information technology facilities. • Presence of on line learning	• No allocated budget for research.
Service Delivery	• Presence of palliative care hubs • Service is given with limited resources • Presence of community-based Palliative care service • Mostly, the service provision is outpatient	• Very few inpatient service and community-based palliative care • No standard SOP and protocol • Limited multi-disciplinary team approach • Poor referral linkage • Poor quality of care • Absence of Tele-Palliative care service	• The presence of Family Medicine, tertiary care hospitals, and regional RHBs interest • The new cancer centers interest in providing palliative care service	• High staff turnover • The hospital Organogram does not include PC • No reinforcement plan for palliative care initiators and providers • Unsustainable supply of medicines and equipment • Weak Health insurance system
Palliative care financing	• Existence of HIS	• Absence of financing mechanism	• The existence of Community-based organization (Iddirs)	• No Specific funding for PC
Community involvement	• Palliative care day celebration for awareness creation	• Very few home-based care services • Limited awareness of Health extension workers • Limited community awareness	• Presence of Home-based care service by Hospice • Pilot project planned to include HEWs and volunteers for PC	• Financial problems

4. Stakeholder Analysis

Table 2: Palliative Care Stakeholder Analysis.

MOH	Interest/Thematic Area Description	Role/Trend Analysis	Level of Influence	Involvement Mechanism
Leadership	Palliative care is a major agenda of the Ministry	Regulations, policy, promote, directives, support	High	Indirect through reports and newsletters
Non-communicable disease prevention and control case team	Eager to achieve, it will have an interest in PC activities this is a cross-cutting agenda	support, policy, promotion	High	Direct, training and mentoring
HIV/AIDS prevention & control case team	The palliative care aspects of care will be well integrated into the program and this model would serve as a good demonstration site	support letter for licensing and fund mobilization process	High	Direct
Human resource and training directorate	Model demonstration site contributes to training of health providers in PC and also how to replicate this in other parts of the country	it will support in-service HCW training, facilitate endorsement of training materials and job aids designed by the center, and its dissemination and use by others throughout the country	High	Direct
Federal HAPCO	To promote care and support programs at the community level through the home-based care strategy	Potential source of funding	High	Direct
PFSA	Importingofmorphineand other essential medicines and their supply chain	Access to drugs &medical equipment	Moderate	Direct
MOH	**Interest/Thematic Area Description**	**Role/Trend Analysis**	**Level of Influence**	**Involvement Mechanism**
EPHARM share company	produce morphine in the country and roll out including other drugs for PC, market for its products	supply drugs needed for PC and may support research on Morphine use (safety& efficacy)	Moderate	Direct
EFDA	promotion of in-service training and CME, monitoring its Morphine utilization and consumption	Licensing the model center as a center for service delivery and	Moderate	Indirect, regulatory
Regional Health Bureau	model demonstration site contributes to training health providers in PC and also how to replicate this in other parts of the city	support for the licensing process, accreditation, and supervision of activities	Moderate	Direct
Communities based (Iddirs) organizations	support to the community in chronic illness area	support recruit volunteers and during fund raising activities	Moderate	Indirect

Kebele& sub-city administration (lowest level city government	support to the community	support recruit volunteers and during fund raising activities	High	direct, advocacy, and awareness creations
MOSHE	Developing Human resources for palliative care	Implement design and integration of PC curricula into relevant health worker training curricula	High	Indirect
HERQA	Developing Human resources for palliative care	Maintaining standard education for palliative care in Higher education institutions	High	Indirect
WHPCA	Universal access to palliative care	Technical support for Advocacy for PC development in Ethiopia	Moderate	Indirect
Hospice Uganda	Universal access to palliative care in Africa	Supporting home-based PC in Ethiopia Training PC nurses	Moderate	Indirect
MD Anderson	Quality and standard palliative care	Post-graduate training of pc specialists and research	Low-Medium	Indirect
MOH	**Interest/Thematic Area Description**	**Role/Trend Analysis**	**Level of Influence**	**Involvement Mechanism**
Five Radiotherapy centers in Ethiopia	They need good palliative care services to be established	Implement training and research	High	Direct
Mathewos Wondu	Advocacy for cancer care	More funding and community participation	High	Direct
Cancer society	Health promotion and prevention of cancer	Public education and BCC	Medium	Direct
Cancer care Home	Advocacy for cancer care	More funding and community participation	High	Direct
DC Ethiopia	Promoting PC for PLWHA	Potentially major funding	Very High	Monitoring and evaluation and reports
USG partners /ICAP	Promoting PC for PLWHA	Experience sharing and collaboration	Low	Monitoring and evaluation and reports
USAID	Promoting PC for PLWHA at the community level	Potentially major funding source	Very High	Review meetings, training
AAU, Health science faculty, Tikur Anbessa Hospital,	PC training site for its undergraduates and research site for its postgraduates in public health, this can serve also as outreach home-based care for cancer and other debilitated and terminally seriously ill patients	Referral center for radiotherapy and other specialty cares such as hematology, endocrinology, neurology, etc.	High	Direct
MOH	**Interest/Thematic Area Description**	**Role/Trend Analysis**	**Level of Influence**	**Involvement Mechanism**
Hospice Ethiopia	Promotion of home-based palliative care in the community, Advocacy for	Experience sharing, partnering in research and	High	Direct

	Palliative care, Training of health care providers, actively participating in national guideline and protocol development for PC, PC research	training, and other collaborations		
African PC association	Promotion of PC and Drug availability & access	Support in training, and research and also help in mobilizing funding	Medium	Direct
AHPC	Universal access to palliative care	Technical support for Advocacy for PC development in Ethiopia	Medium	Indirect
African PC association	Promotion of PC and Drug availability & access	Support in training, and research and also help in mobilizing funding	Medium	Direct
AHPC	Universal access to palliative care	Technical support for Advocacy for PC development in Ethiopia	Medium	Indirect
African PC association	Promotion of PC and Drug availability & access	Support in training, and research and also help in mobilizing funding	Medium	Direct
AHPC	Universal access to palliative care	Technical support for Advocacy for PC development in Ethiopia	Medium	Indirect

5. Vision, Goal, and Core Values for Palliative Care

Vision

To see evidence-based quality palliative care become available and accessible for all in need in Ethiopia by the year 2029 (2021 E.C.).

Mission

To provide support and quality palliative care service for patients and their families through integrated physical, psychological, and spiritual care and its delivery, so that people can reach their full living potential and quality of life

Goal

To scale up and implement a policy-based, Ethiopian-led model of palliative care service in collaboration with our partners, which delivers an accessible, evidence-based quality service through drug availability, education, and research.

Main Objective:

To expand access to standardized, patient-centered palliative care services in 80% of health facilities nationwide by the end of 2029.

Specific Objectives:

- To scale-up and ensure that PC is offered by multidisciplinary teams countrywide
- To enhance equity in access to services
- To establish an efficient PC service in various health institutions
- To consolidate a genuine culture of pain and symptom management

Core values

- Accountability
- Transparency
- Compassion
- Respect
- Care
- Patient and family-centered
- Quality-focused (Education & Research)
- Partnership

6. Strategic objectives and interventions

A high-level professional workshop was conducted to develop the strategic pillars and plan documents on the pillars of essential and emergency surgical care based on mapping the development and the existing capacity, commitment, and funding.

The palliative care initiative has identified key strategic objectives in line with the commitment of approaching the initiative through the health system building blocks. Accordingly, the following key strategic objectives were identified.

- Strategic Objective 1: Strengthen Leadership and Governance
- Strategic Objective 2: Enhance access and quality of palliative care services' provision
- Strategic Objective 3: Strengthen palliative care Information Systems
- Strategic Objective 4: Strengthen Human Resources Development and Management
- Strategic Objective 5: Improve Access to and Rational Use of morphine and other essential Palliative Care Medications.
- Strategic objective 6: Improve partnership and collaboration

7. Strategic Objectives and Interventions

Strategic Objective 1 – Strengthen Leadership and Governance

Introduction

Effective leadership is crucial in palliative care as it influences various groups such as patients, families, healthcare colleagues, healthcare systems, and communities. Palliative care leaders must advocate for palliative care, emphasize its impact on quality, and effectively utilize resources. They should demonstrate how it contributes to quality healthcare and act as a catalyst for change within the healthcare system. Effective leadership in palliative care promotes patient-centered care and policy changes to meet the growing demand for palliative care across populations, settings, and geographic areas.

The Ministry of Health (MOH) will lead the palliative care initiative at the national level and work to integrate it within the existing health system structure at all levels. The MOH will also work closely with partners, patient associations, professional associations, and societies to secure the necessary budget and resources.

Strategic Intervention 1: Establish effective leadership and governance structures and capabilities

Key Activities

- Ensure a dedicated palliative care coordinating body/units/focal with representatives from different institutions at all levels of the healthcare system
    - Incorporating palliative care into national, regional, district, and facility health plans, aligning with the national strategy
    - Set up a national and sub-national palliative care Advisory group and technical task force
- Revise national palliative care guidelines and support developing facility-level protocols and SOPs for palliative care service delivery.
    - Revise national palliative care guidelines
    - Developing facility-level protocols and SOPs for palliative care service delivery.
- Identify skill gaps in leadership and governance at all levels of palliative care
    - Conducting needs assessment
- Develop leadership training packages and conduct targeted leadership training programs for designated palliative care leaders at all levels
    - Provide training to leaders on palliative care
- Develop and implement monitoring and evaluation systems in palliative care
    - Conducting a mentorship program
    - Monitor service delivery processes to identify any bottlenecks, challenges, or areas for improvement.
    - conduct evaluation review meetings and recognize good-performing facilities every year

Strategic intervention 2: Implement a transparent resource allocation mechanism

Key Activities:

- Advocate for dedicated budget allocation for palliative care at all levels of the health care system
    - Support all regions to allocate the budget for palliative care
- Develop and implement a Resource Allocation and resource sharing guide
    - Develop Resource Allocation and resource sharing guide
    - Implement the Resource Allocation and resource sharing guide
    - Conduct an audit in palliative care

Strategic Intervention 3: Advocate for policy changes and regulatory support

Key Activities:

- Conduct policy analysis and research to identify gaps and develop evidence-based recommendations for policy changes in palliative care leadership and governance
    - Conduct a comprehensive assessment of existing policies and regulations relevant to the organization's objectives.
    - Identify Gaps and Challenges, Stakeholder Consultations, and briefings with policymakers to present policy recommendations, discuss implications, and address questions or concerns.
    - Policy Mapping between different policies, stakeholders, and regulatory frameworks.
    - Work towards the adoption of national policies that prioritize palliative care and ensure the inclusion of morphine in essential medicine lists.
- Collaborate with regulatory bodies to develop and enforce standards for leadership and governance in palliative care.
    - Collaboratively draft standards for leadership and governance in palliative care, incorporating best practices, evidence-based guidelines, and stakeholder input.
    - incorporate feedback from stakeholders, including healthcare institutions, professional associations, and patient advocacy groups, to refine and finalize the standards.
    - Collaborate with accrediting bodies to ensure compliance.

Strategic objective 2: Enhance access and quality of palliative care services' provision

Introduction

Access and utilization of palliative care service provision can be achieved through the integration of palliative care services with the existing health care system in Ethiopia and cascading the services to regional, zonal, and woreda levels to provide quality palliative care for patients with life time illness and to their families.

Besides, the critical point in palliative care services is to ensure the continuum of care and address patient needs as they pass through the referral pathways between community and facility-based palliative care services. Palliative care can be delivered through different models such as outpatient palliative care, inpatient palliative care, home-based palliative care, and hospice care.

The model of care that is most suitable for Ethiopia is a community-based program due to its large population and geography and the fact that the majority of people live in a rural setting. However, a community-based approach would require a center or 'hub' such as a local hospital to support the provision of morphine and provide specialized services and training. This is best achieved through the hospital hub with its associated health centers and community.
The palliative care service provision will also be expanded through the development of a volunteer network. Furthermore, throughout this period, good communication strategies will be developed between different health-care providers and clinical pathways. To enhance access to and quality of palliative care service the following two strategic interventions were proposed.

Figure 1: Hub and Spoke Approach of palliative care

Strategic intervention 1: Establish and strengthen palliative care services in the health care systems

Key Activities:

- Establish and Strengthen inpatient, outpatient, home-based palliative care service based on the WHO standard
- Provide education for patients and caregivers
- Create access to holistic palliative care services for patients and their families
- Avail standardized palliative care protocols, format, and guidelines
- To conduct annual palliative care conference (MOH)
- Mentorship and supervision using the WHO standardized tool

Strategic intervention 2: Integration of palliative care service into existing health care systems

Key Activities:

- Integrate palliative care services into existing national referral systems with emphasis given at the primary health care level.
- Integrate palliative care services with the existing health care system

Strategic Results

Improved palliative care service provision system, measured by the following components:

- The PC service is available and derived by trained health care professionals in the selected public hospitals
- Implement a palliative care service package.
- Multi-disciplinary teams are established
- Patients have access to essential PC medicines and services

Strategic Objective 3: Strengthen palliative care Information Systems

Introduction

Health management information systems in palliative care are important for evidence-based decision-making and enhancing the service. In Ethiopia, there are currently only a few healthcare facilities reporting palliative care activities through the DHIS2. Furthermore, there is no regular mechanism established to capture facility and home-based palliative care services. Also, the estimated need for palliative care is primarily linked with the burden of cancer and HIV/AIDS, although there are several other conditions associated with palliative care needs. This minimizes the actual burden on the country. Therefore, it is critical to strengthen the health management information system by standardizing palliative care indicators and through regular use of data to inform practice and policy.

Strategic intervention 1: Strengthen palliative care Information

Key activities

- Standardize palliative care indicators and integrate them into the DHIS2
- Standardize palliative care registry

Strategic intervention 2: Strengthen evidence generation and use

Key activities

- Conduct research in palliative care and disseminate findings
- Strengthen data use for evidence-based practice and policy

Strategic intervention 3: Establish palliative care information and knowledge management system

Key activities

- Develop electronic libraries with updated global and local evidence and make them available for free

Strategic Results

- Comprehensive information on palliative care need
- Strong systematic documentation of activities/services
- Accurate and complete data gathering
- Optimal use of evidence generated for timely decision-making
- Adequate triangulation of data collected separately
- Consistent and standardized data collection tool, reporting format, and data management system for regional and national documentation
- No redundancy in reporting
- Proper joint planning and monitoring of palliative and hospice care performance
- Palliative care providers who are equipped and able to conduct research
- Adequately supported research activities

Strategic Objective 4: Human Resource Development

Palliative care education, training, and center of excellence in health workforce development Ethiopia has only recently begun to establish a palliative care workforce. The nation's health system is undergoing ongoing adjustment to meet the demands of the shifting burden of disease. To this end, palliative care needs are rising, and in order to meet the need, service delivery must also rise proportionately. In order to achieve universal health coverage and as part of a developmental plan, it is imperative to build comprehensive palliative care services. In order to integrate palliative care into community health care, the WHO states that the best method to provide it in resource limited nations is to include it in the primary health care package. In order to meet the increasing need for palliative care services, at all levels, developing the health workforce is a responsibility with few options.

Strategic intervention 1: providing short-term training and ongoing professional development (CPD) to empower the current health personnel

Key activity

- Providing short-term training and ongoing professional development (CPD) to empower the current health personnel

Strategic intervention 2: To integrate Palliative Care curriculum into the undergraduate programs

Key activities

- Develop a national standard curriculum for relevant health care disciplines
- Implement a curriculum integration into the medical, nursing, social worker, pharmacy and clinical psychology/psychiatry programs
- Integrate palliative care into the health extension workers program

Strategic intervention 3: defining a career pathway for interested health professionals through education and research

Key activities

- Recognize palliative care education as a specialty/ discipline
- Organize postgraduate programs for interested staff in palliative care (master's, specialty and Higher diploma programs)

Strategic intervention 4: Facilitate Experience Sharing

Key activity

- Arrange local, regional and international experience sharing for the palliative care providers

Important components that have to be delivered in this strategic intervention is annexed (See Annex F).

Strategic Results

- Efficient health workforce and multidisciplinary team development
- Sustainable and self-revolving palliative care education program

Strategic Objective 5 –Improve Access to and Rational Use Of morphine and other essential Palliative Care Medications

Introduction

In the Ethiopian context, the strategic objective of improving access to and rational use of morphine and other palliative care drugs is particularly crucial for addressing the healthcare needs of individuals dealing with serious illnesses, such as advanced stages of cancer or terminal conditions. This initiative aims to overcome challenges related to pain management and ensure that these essential medications are available and utilized effectively throughout the country.

Improving access involves local production of morphine, and establishing distribution channels and healthcare infrastructure to reach remote areas and underserved communities. Additionally, it entails addressing regulatory barriers to streamline the procurement and distribution processes of palliative care drugs, including morphine.

Rational use focuses on appropriate prescription practices, dosage management, and potential side effects. Emphasizing the importance of multidisciplinary palliative care teams can also enhance the rational use of these drugs, ensuring a comprehensive and patient-centred approach.

By tailoring these strategies to the Ethiopian healthcare landscape, the goal is to enhance the overall quality of palliative care, providing relief to those in need and respecting cultural and contextual considerations. For this strategic objective, there are 2 strategic interventions proposed

Strategic intervention 1: Ensure the sustainable availability and access to morphine

Key activities

- Start local production of oral morphine
- Strengthening existing morphine Procurement and Supply Chain Management System:
- Regulatory Compliance and Quality Assurance

Strategic intervention 2: Ensure the availability and rational use of opioids and other palliative care medications

Key activities

- Perform comprehensive need assessment
- Medication Procurement and Supply Chain Management
- Infrastructure and Facility Upgrades
- Implementation of Prescription Monitoring Programs
- Quality Assurance and Performance Improvement

Strategic Result

- To equip and ensure the rational use of morphine and essential palliative care medication by 90% in all palliative care health facilities and home-based care with a strong supply chain management system

For the Essential palliative care medicines and equipment list see the *annex H.*

Strategic objective 6: Improve partnership and collaboration

Creating better links with other governmental and nongovernmental organizations with shared aims facilitates working together in order to increase effectiveness and provide better services. A collaborative approach can make better use of existing resources and attract new resources. Resources can be used more efficiently and effectively where they are used collaboratively. Collaboration for palliative care services is needed at all levels to address unmet palliative care needs and ensure well-coordinated and concerted action. In addition, developing collaborative working assists palliative care has sufficient partner engagement for implementation of the strategic plan alongside the MOH. Mapping and engaging the right organizations and developing communication strategies are important to engage partners and work in collaboration.

Strategic intervention 1: Enhance stakeholders and partners engagement and their contribution

Key activities:

- Advocacy for the PC strategic plan and PC as a public health issue
- Divide responsibilities across core partners to ensure appropriate support for each PC pillar
- Solicit and mobilize resources to fund PC programs
- Improve engagement of relevant state sectors; FDA, PFSA, Regional health bureau, and health facilities
- Mapping stakeholders, defining their roles, and planning how to engage them
- Organize workshops, panel discussions, and meetings

Strategic Result

- Increased awareness of the palliative care program and increased investment from partners to improve access and utilization of quality palliative care service across Ethiopia.

8. Implementation Plan for the strategic document

Table 3: Implementation Plan for five-year Palliative Care Strategy in Ethiopia

Strategic objective 1: Strengthen Leadership and Governance										
Strategic interventions (SI)	key Activities	Responsible body	Detail activities	Indicator	Expected result	Timeline and target				
						2025	2026	2027	2028	2029
SI 1: Establish effective leadership and governance structures and capabilities	Ensure a dedicated palliative care coordinating body/units/focal with representatives from different institutions at all levels of the healthcare system	MoH, RHBs	Incorporating palliative care into national, regional, district, and facility health plans aligning with the national strategy	% Of regions established palliative care coordinating bodies	100% of coordinating body established at the end of 2028	20%	30%	65%	85%	100%
		MoH	Set up a national and sub-national palliative care Advisory group and technical task force							
	Revise national palliative care guidelines and Support on developing facility-level protocols and SOPs for palliative care service delivery.	MoH	Revise national palliative care guidelines	Number of updated and approved guidelines	1		1			
		MoH, RHBs, WHOs, Health Facilities	Developing facility-level protocols and SOPs for palliative care service delivery.	parentage of facilities with standardized protocols and SOPs	100%	20%	20%	20%	20%	20%
	Identify skill gaps in leadership and governance at all levels of palliative care	MOH	Conducting need assessment	Percentage of Completed needs assessments conducted at all levels	100% at regions and facilities	100%	100%	_	_	_
	Develop leadership training packages and Conduct targeted leadership training programs for designated palliative care leaders at all levels	MOH and RHBs	Provide training to leaders on palliative care	percentage of leaders trained	100%	15%	40%	70%	100%	
	Develop and implement monitoring and evaluation system in palliative care	MOH, RHB	Conducting mentorship program	Number of supervision sessions and mentorship programs	Bi annually conducted supervisions and mentorship programs	2	2	2	2	2
		MOH,	Monitor service delivery processes to identify any bottlenecks, challenges, or areas for improvement.							

		MOH,	Conduct evaluation review meeting and recognize good performing facilities every year	number of review meeting conducted	Once per year	1	1	1	1	1
SI 2: implement transparent resource allocation mechanism	Advocate for dedicated budget allocation for palliative care at all level of the health care system	MoH, RHBs, ZHBs, WHOs, Health Facilities	Support all regions to allocate budget for palliative care	% of regions and facilities Allocate Budget for palliative care	100% of regions and facilities Allocate Budget for palliative care at the end of 2028	20%	40%	60%	80%	100%
	Develop and Implement Resource Allocation and resource sharing guide	MoH	Develop Resource Allocation and resource sharing guide	Guidelines developed	1		1			
		MoH, RHBs	Implement Resource Allocation and resource sharing guide	No of regions implement Resource Allocation and resource sharing guide	15 regions	_	_	5	10	15
		MoH, RHBs	Conduct audit in palliative care	Number of audits conducted	5 audits at all regions	1	1	1	1	1
SI 3: Advocate for policy changes and regulatory support	Conduct policy analysis and research to identify gaps and develop evidence based recommendations for policy changes in palliative care leadership and governance	MoH	Conduct a comprehensive assessment of existing policies and regulations relevant to the organization's objectives.	assessment conducted	2	1	1	_	_	_
		MoH	Identify Gaps and Challenges, Stakeholder Consultations and briefings with policymakers to present policy recommendations, discuss implications, and address questions or concerns.	Number of workshops conducted	3	1	1	1	_	_
		MoH	Policy Mapping between different policies, stakeholders, and regulatory frameworks.	Number of Policy Mapping Reports Developed and Shared	1			1		
		MoH	Work towards the adoption of national policies that prioritize palliative care and ensure the inclusion of morphine in essential medicine lists.	Inclusion of Morphine in Essential Medicine Lists	morphine included as essential list		1			
	Collaborate with regulatory bodies to develop and enforce standards for leadership	MoH	Collaboratively draft standards for leadership and governance in palliative care, incorporating best practices, evidence-based guidelines, and stakeholder input.	standard developed	developed standard		1			

	and governance in palliative care.	MoH	incorporate feedback from stakeholders, including healthcare institutions, professional associations, and patient advocacy groups, to refine and finalize the standards.							
		MoH	Collaborate with accrediting bodies to ensure compliance.	No of regions adhered to the standard	100 % of regions			30%	70%	100%
Strategic objective 2: Enhance access and quality of palliative care services' provision										
SI 1: Establish and strengthen palliative care services in the health care systems	Establish and Strengthen inpatient, outpatient, home-based palliative care service based on WHO standard	MOH	Avail standardized palliative care protocols, format, and guidelines	Number of palliative care hubs established	Increase the number of palliative care hubs by 50% every year in the health facilities	6	12	24	48	96
		RHB	Implement the palliative care network and referral pathways							
			Ensure and endorse the strategy at the regional level to establish a palliative care hub							
		ZHD	Ensure and coordinate the palliative care hub establishment at PHCU							
		University Hospital, PHC	Establish a multi-disciplinary team and assign a focal person							
			Establish a palliative care hub in PHCU							
		Patient /family	Actively involvment in palliative care service provision							
	Create access to a holistic palliative care service for patients and their families	MOH	Endorse the psychosocial support as part the holistic care	Number of patients who get holistic palliative care services	Increase the number of patients getting holistic palliative care by 10%	10%	20%	30%	40%	50%
		RHB	Ensure the provision of holistic palliative care services at the regional level							
		University Hospital	Provide tertiary and holistic palliative care for inpatient, outpatient, and home-based care							
		PHCU	Provide palliative care services and work with the hospital palliative care hub							
	Mentorship and supervision using WHO standardized tool	MOH	Conduct annual mentorship and supervision	number of mentorships and supervisions conducted	five mentorships and supervisions	1	1	1	1	1
		RHB	Conduct biannual mentorship and supervision		10 mentorships and supervisions	2	2	2	2	2

		ZHD	Conduct quarterly mentorship and supervision		20 mentorships and supervisions	4	4	4	4	4
		University Hospital	Conduct mentorship and supervision in their jurisdiction		20 mentorships and supervisions	4	4	4	4	4
	Provide education for Patients and caregivers	MOH	Provide materials for palliative care education	The number of facilities providing palliative care education for patients and caregivers	Increase the number of healthcare facilities providing health education on palliative care for patients and caregivers by 10%	10%	20%	30%	40%	50%
		RHB	cascade the health education materials to hospitals and health centers							
		ZHD	Ensure the availability of educational materials							
		University Hospital, PHCU	Provide education for the patient and caregiver							
SI 2: Integration of palliative care service into existing health care systems	Integrate palliative care services into existing national referral system	PHC	Actively involved in palliative care service provision and self-care	Number of facilities that have a palliative care referral network	70% facilities that have referral linkage	30%	40%	50%	60%	70%
		MOH	Developing strategies for the palliative care network and referral pathways							
		RHB	Facilitate palliative care network and referral pathways							
		ZHD	Coordinate the palliative care network and referral pathways							
		University Hospital	Providing palliative care services through a network and referral system							
		PHCU	Providing palliative care services through a network and referral system							
	Integration of inpatient, outpatient, and primary care services	MOH	Develop and provide palliative care policies, strategies, and guidelines for the integration							
		MoH	Standardize formats for palliative care service	Number of facilities that have integrated palliative care services	Integrated palliative care service in 50 % of facilities	10%	20%	30%	40%	50%
		RHB	Adopt standard guidelines and formats for palliative care service integration at the regional level							

		ZHD	Ensure and coordinate the integration of palliative in PHCU							
		University Hospital	Provide integrated palliative care services to patients							
		PHCU	Provide integrated palliative care services to patients at PHCU							
Strategic objective 3: Strengthen palliative care Information Systems										
SI 1: Strengthen palliative care Information	**Standardize palliative care indicators and integrate them in the DHIS2**	MOH	Identify key national palliative care indicators with all stakeholders	Number of healthcare facilities that routinely report using standardized palliative care indicators	100%		40%	60%	80%	100%
		MOH	Integrate key palliative care indicators in the DHIS2 platform	Number of indicators integrated into the DHIS2	2	2				
		MoH, RHB	Analyse the HSIG data to assess hospital-level performance	Percentage of hospital performance on PC based on HSIG	70%		40%	50%	60%	70%
		MoH, RHB	Establish a feedback mechanism	Quarterly review meeting	1		1			
	Standardize the palliative care registry									
		MOH	Develop a national palliative care registry	National registry developed	1		1			
		RHB	Adapt facility and home-based palliative care registry	Number of facilities which report by using the facility or home-based PC registry	70%		40%	50%	60%	70%
		MOH	Standardize palliative care assessment forms	Assessment forms prepared	1		1			
		MOH	Standardize monthly reporting form	Reporting tools prepared	1		1			
	Provide capacity building on PCIS	MOH	Organize TOT in palliative care information system(PCIS)	Number of palliative care providers who receive TOT in PCIS	Every year	1	1	1	1	1
		RHB	Organize basic training in palliative care information system	Number of palliative care providers who are trained in PCIS	60%			40%	50%	60%

SI 2: Strengthen evidence generation and use (move to HR)	**Conduct research in palliative care and disseminate findings**	University Hospitals and Health Training Institutions	Support a national research agenda for palliative care	Number of research priorities for palliative care						
		University Hospitals and Health Training Institutions	Facilitate a palliative care research group that promotes the research agenda, conducts research and disseminates findings	Number of palliative care research projects conducted	Every year	1	1	1	1	1
		University Hospitals and Health Training Institutions	Secure research funding from local and international research grant opportunities	Number of research grants for palliative care	Every year	1	1	1	1	1
	Strengthen data use for evidence-based practice and policy	MOH	Standardize data use for evidence-based practice and policy	Percentage of major actions taken based on the evidence generated	To be revised every year					
		RHB	Standardize data use for evidence-based practice and policy	Percentage of major actions taken based on the evidence generated						
SI 3: Establish palliative care information and knowledge management system	**Develop electronic libraries with updated global and local evidence and making it available for free**	MOH	Standardize e-learning platforms	e-learning platforms developed						
		University Hospitals and Health Training Institutions	Establish website-based electronic libraries	Website developed	1		1			
		University Hospitals and Health Training Institutions	website maintenance	uptime percentage	90%	90%	90%	90%	90%	90%
		University Hospitals and Health Training Institutions	Update e-learning platforms	Number of times the e-learning platform is updated	1			1		
Strategic objective 4: Human Resources										

SI 4.1: Empower the already existing health workforce through short-term training and continuous professional development	Capacity building for Primary palliative care providers	MOH, RHB, CPD centers, Health Institutions	Provision of short-term training for qualified staff assigned in the palliative care unit	% of trained professionals assigned in the palliative care unit	100% trained palliative care providers assigned in palliative care units by 2027	25%	50%	75%	100 %	
			Provision of continuous professional development for qualified staff	% of CPD centers provide palliative care continuous professional development program	80% of CPD centers with a palliative care CPD program by 2027	15%	40%	65%	80 %	
	Capcity building for other health care providers and palliative care supporters	MOH, RHB, CPD centers, Health institutions	Provision of orientation for health care providers at all level	% of oriented health care professionals (working in service units other than palliative care) working in facilities with palliative care service	85% of health professionals working in service units other than palliative care unit will be trained by 2028	10%	25%	45%	70 %	85%
			Short-term training for multi-disciplinary members in palliative care	Proportion of trained multidisciplinary members of palliative care	75% of palliative care members will be trained from palliative care centers by 2028		15%	40%	65 %	75%
SI 4.2: Integrate Palliative care Curriculum in to the undergraduate programs	Palliative care curriculum development and accreditation	MOH, MOE, University hospitals	Prepare a standardized curriculum for medical and allied health care professionals	Number of accredited curricula	5 curricula from 5 different disciplines will be developed by 2028		1	2	4	5
		MOH, HERQA	Accreditation of the curriculum		5 accredited curricula by 2028		1	2	4	5
	Implement pallaitive care education delivery for all health education	MOH, MOE, University Hospitals	Implement the Integration of curriculum into the undergraduate programs of medical, nursing, social work, pharmacy, clinical psychology/ psychiatry programs	Number of University hospitals implementing palliative care integrated curriculum	10 first generation university hospitals and other target university hospitals will start palliative care integrated education by 2028			3	6	10
Strategic Objective 4.3: Create a career pathway for interested health	Initiate Palliative care postgraduate programs	MOH, MOE, HERQA, FDA	Recognize palliative care education as a specialty/ discipline	Number of University hospitals implementing palliative care postgraduate programs	3 University hospitals with established palliative care postgraduate programs by 2028			1	2	3
			Organize postgraduate programs for interested staff in palliative care (master's, specialty, and Higher diploma programs)							

professionals through education and research	Arrange for abroad education on Palliative care	MOH, MOE, University Hospitals, partners	Arrange a postgraduate study for health care providers regionally and internationally	Number of postgraduate trainings arranged regionally and internationally	24 professionals trained on palliative care internationally by 2026	3	16	24		
	Generate evidence on palliative care application	MOH, MOE, University Hospitals	Incentivise and allocate resources for palliative care research in the undergraduate and postgraduate programs	Number of high-impact research publications made for policy inputs	16 supported publications on reputable journals by 2028		4	8	12	16
Strategic Objective 4.4: Facilitate Experience Sharing	Arrange experience sharing for palliative care providers	MOH, Health facilities	Identify potential experience-sharing sites	Number of experience-sharing sessions arranged	10 experience sharing sessions for academician and palliative care clinicians by 2027	1	3	7	10	
		MOH, RHB, Health facilities, partners	Arrange local, regional, and international experience sharing for the palliative care providers							
Strategic objective 5: Improve Access To and Rational Use Of morphine and other essential Palliative Care Medication										
SI 1: Ensure the sustainable availability of morphine	Local production of morphine	MOH	Develop a policy on the local production of morphine	a, number of facilities/companies who produce oral morphine	4 facilities/companies produce morphine		1	1	1	1
		MOH, RHB	Identify and support local initiatives addressing morphine production							
		University hospitals	produce quality morphine at an affordable price							
		pharmaceutical companies	produce quality morphine at an affordable price							
		FDA	Establish quality control mechanisms to safeguard the integrity and potency of morphine							
		Agricultural Minister	Cultivation of Opium Poppy: selecting suitable regions with optimal climatic and soil conditions							
			Harvesting and Extraction of Opium Gum							
		NGO	Provide technical support and funding.							
	Strengthening the existing morphine Procurement and Supply Chain Management System:	MOH	Set clear policy, develop a central SOP and TOR on availability and equitable distribution of morphine based on the demand	Consumption of morphine per capita (Consumption of morphine per year/ Total number of inhabitants)	Increase of morphine consumption by 10%	10%	20%	30%	40 %	50%
		EPSS	Purchase and distribute morphine based on demand							
		HOSPITALS	Implement timely and demand-based procurement							
		HEALTH workers	Prescribe appropriate palliative care medications based on the standards							

		Federal EPSS	Monitor and supervise the availability of morphine at the regional EPSS	Total number of facilities with morphine throughout the year.	50 facilities	10	20	30	40	50
		Regional EPSS	Timely distribute the requested morphine in the respective hospital							
		Hospitals	regular audit of the stock out of morphine							
	Regulatory Compliance and Quality Assurance:	MOH	Ensure compliance with international standards and guidelines for the production, distribution, and prescription of morphine.	Adherence to clinical guidelines for morphine use in pain management.	100%	100%	100%	100%	100 %	100%
		FDA	Establish quality control mechanisms to safeguard the integrity and potency of morphine products throughout the supply chain.	Percentage of morphine samples meeting pharmacopeial quality standards.	100%	100%	100%	100%	100 %	100%
			Prepare regulatory frameworks for the production, distribution, and use of morphine.	Check the presence of regulatory frameworks	existence of regulatory frameworks					
		MOH, EPSS, FDA	Collaborate with regulatory authorities to streamline approval processes for importing morphine and other essential medications.							
Strategic intervention 2: Ensure the availability and rational use of opioids and other palliative care medications	• Perform comprehensive need assessment :	MOH, RHB	Conduct annual comprehensive assessment of the current availability and utilization of palliative care medications in health facilities.	Number of assessments done /year	5 assessment	1	1	1	1	1
		hospitals	Conduct quarterly audits in medication stocks, storage facilities, and prescribing practices.	no of audits done/year	20 audit	4	4	4	4	4
	Pallative care Medication Procurement and Supply Chain Management:	MOH	Establish partnerships with pharmaceutical suppliers and wholesalers to ensure a reliable supply of medications at competitive prices	Total number of facilities with palliative care medications	50 facilities	10	20	30	40	50
			Develop clear policy on equitable distribution of pallative care medication across the country							

		Federal EPSS	Monitor and supervise the availability of pallative care medications at the regional EPSS	throughout the year.						
		Regional EPSS	Timely distribute the requested pallative care medications in the respective hospital							
		RHB	Monitor and supervise the availability of the required pallative care medications in the hospital							
		HOSPITALS	Develop a procurement plan to acquire standard palliative care medications							
			Implement inventory management systems to track medication stocks, monitor expiration dates, and prevent wastage.							
	Infrastructure and Facility Upgrades:	MOH,RHB	Assess the infrastructure and storage facilities of health facilities to ensure they meet the requirements for safe and secure storage of medications.	Percentage of health facilities equipped to handle palliative care medications.	70 % of health facility	10%	20%	30%	50 %	70%
			Invest in the renovation or construction of pharmacies and drug storage areas to comply with regulatory standards for medication storage and handling.							
		HOSPITALS	Equip health facilities with essential medical equipment and supplies necessary for palliative care							
	Implementation of Prescription Monitoring Programs:	MOH	set clear policy on implementation of prescription monitoring program	Number of health facility undergo prescription audit regularly	100%	100%	100%	100%	100 %	100%
		RHB	Adopt and endorse the prescription monitoring program policy to the hospitals and health facilities							
		HOSPITALS	Utilize electronic health records (EHRs) and prescription drug monitoring databases to monitor patient medication histories							
			Establish prescription monitoring programs to track the prescribing and dispensing of opioids and other palliative care drugs							
	Quality Assurance and Performance Improvement:	MOH, RHB, Hospitals	Implement quality assurance measures to evaluate the appropriateness and effectiveness of opioid prescribing practices and palliative care drug utilization.	Utilization of quality improvement measures for opioid and palliative care medication prescribing	The percentage of health facilities uses quality improvement measures for rational use of opioids and palliative care medications.	10%	20%	30%	40 %	50%
			Establish performance improvement initiatives in the rational use of opioids and other palliative care drugs							
		HOSPITALS	Incorporating feedback from patient outcomes and satisfaction surveys.							

Strategic objective 6: Improve partnership and collaboration										
SI 1: Enhance stakeholders' and partners' engagement and their contribution	Policy development and revision for PC service and opioids	MOH	Drafting national health policy on palliative care and morphine Drafting a strategic action plan	Policy review meeting conducted	Updated policy and regulations on opioids and PC are in place	1			1	
	Advocacy for PC as a public health issue	MOH	Organize events for public awareness Organize palliative care celebrations Design PC information dissemination strategies through fliers, posters, and media	-Public events organized -type and number of items distributed	Improved awareness on PC among the public, health facilities, healthcare professionals, and concerned key stakeholders	1	1	1	1	1
	Conduct bi-annual PC review meeting to supervise the overall activities	MOH	Organize a meeting Fund meetings Document the proceedings of meetings	No. of review meetings	2 review meetings	2	2	2	2	2
	Supervise and follow up on the implementation of PC programs	MOH	Organize supportive supervision trips Conduct supervision Document monitoring of activities Fund supportive supervision Document challenges and best practices and share in workshops	Number of supervisions conducted per year. Documentation of findings	To ensure plans are in practice	2	2	2	2	2
	Ensure PC is one of the priority areas of cancer control and NCD programs	MOH	TWG for PC Representations in the TWG for NCD and cancer Work closely with the disease prevention and control directorate	PC is included in the national NCD strategic plan	PC is available for patients with NCDs.		1			
	Include the palliative care agenda in the regional HSDP review meeting	RHB	Work closely with Policy and planning Present the PC strategic action plan and MEL plan to the policy and planning	Number of times orientation given on PC	5 review meetings	1	1	1	1	1
		RHB	Decentralization and task shifting			30%	40%	60%		100%

	Integrate palliative care into the secondary and primary healthcare levels		Training staff Disseminate guidelines and job aids Attach or link the PC service to the NCD and ART clinics Link PC to the family health team Link PC to the HIV counselling and testing unit.	% of health facilities providing PC services	Patients receive a continuum of PC services. Palliative care is coordinated across different levels				80 %	
	Organize the national annual PC day	MOH	See above	No. of PC day celebrated	To mobilize high officials' will and resources, to celebrate and reinforce achievements	1	1	1	1	1
	Raise awareness aimed at the general public through mass media, audio-visuals and other means	MOH		No. of TV/ Radio programs/promotion	Improved public awareness on what is PC and who needs it	3	3	3	3	2
	Solicit and mobilize resources to fund PC programs	MOH	Solicit grants from HIV, TB programs for treatment failure cases Solicit funds from NCD programs	No. of grant proposal submitted	5 grant proposal submitted to get finance or funding	1	1	1	1	1
	Collaborate with the Ministry of Education to integrate PC into the medical education	MOH		MoU created to work in collaboration	Palliative care is integrated into two medical schools in undergraduate curricula	1		1		
	Improve engagement of relevant state sectors; FDA, PFSA, Regional health bureau and health facilities	MOH		No. of workshops	Increase the relevant public sectors with PC implementation	2	2	2	2	2
	Mapping stakeholders for Palliative care	MOH	Prioritize on stakeholders in HIV, TB, NCDs, and cancer programs Patient associations from chronic diseases Define their roles Plan how to engage them Organize workshops, panel discussions, and meetings to enhance collaboration	Number of partner organizations engaged in the agreement	Increase the number of partners to achieve the strategy plan	5	8	10	10	
	Organize workshops, panel discussions and meetings	RHB		Number. of workshops, meetings, and messages in the mass media	Increased efficiency, involvement, innovation, and communication. Create better collaboration with stakeholders, partners, NGOs, and associations	3	3	3	3	3

	Community mobilization to raise awareness	Community leaders, CBOs like Iddirs			Improved awareness and increased community engagement	3	3	3	3	3
	Awareness raising, training and capacity building on PC	RHBs/NGOs			Improved awareness, increased trained HCWs	2	2	2	2	2

9. Implementation arrangement

Involving all pertinent stakeholders in the implementation plans is important for the effective execution of the strategic plan. The subsequent implementation of plans outlines the roles, duties, and authorities of all stakeholders involved, and the governance framework for palliative care.

Roles and Responsibilities in Palliative Care Implementation

Ministry of Health:

- Policy Development: Formulate policies to integrate palliative care into the healthcare system.
- Resource Allocation: Allocate funding for training, infrastructure, and service delivery.
- Monitoring and Evaluation: Oversee the implementation, track progress, and evaluate outcomes.

National Executive Committee

This team includes high-level representatives from key government ministries (such as the Ministry of Health), healthcare institutions, NGOs, donors, and patient advocacy groups.

Roles:

- **Strategic Direction:** Sets the overarching vision and priorities for palliative care development within the national health agenda.
- **Resource Allocation:** Approves funding and mobilizes resources necessary for plan implementation.
- **Oversight:** Monitors progress and ensures accountability across all levels of implementation.
- **Policy Support:** Advocates for policy reforms to institutionalize palliative care services nationally.

Advisory Team

This team includes subject matter experts, researchers, faith-based and civil society representatives, and community leaders.

Roles:

- **Strategic Advice:** Provides informed recommendations to enhance program design and implementation.
- **Advocacy and Awareness:** Supports advocacy efforts to raise the profile of palliative care among decision-makers and the public.
- **Stakeholder Engagement:** Strengthens partnerships and promotes collaboration across sectors, including education, social services, and community organizations.

Palliative Care Coordinating Team

Roles:

- **Technical Leadership:** Develops national clinical guidelines, training materials, and operational manuals for palliative care.
- **Program Coordination:** Ensures alignment of implementation activities with the strategic plan.
- **Capacity Building:** Oversees training programs for healthcare workers and supports integration into pre-service and in-service education.
- **Monitoring & Evaluation:** Tracks implementation progress and reports to the National Executive Committee.

Technical Working Groups (National and Regional Levels)

This team includes multidisciplinary experts from professional societies, healthcare providers, academic institutions, and partner organizations.

Roles:

- **Policy Development:** Contributes technical input for the formulation and review of national and regional palliative care policies.
- **Implementation Guidance:** Offers evidence-based recommendations to inform clinical practice and service delivery models.
- **Quality Improvement:** Drives initiatives to enhance the quality and consistency of care, including monitoring service standards and outcomes.
- **Localization:** Supports the adaptation of national strategies to regional contexts, ensuring relevance and feasibility.

Regional Health Bureaus:

- Coordination: Coordinate palliative care activities within the region.
- Support Health Facilities: Provide resources and guidance to health facilities for palliative care services.
- Data Collection: Collect data on palliative care services and outcomes within the region.

Hospitals:

- Service Delivery: Provide palliative care services to patients within the hospital setting.
- Staff Training: Train healthcare providers on palliative care principles and practices.
- Quality Assurance: Ensure quality care delivery and adherence to standards.

Health Centers:

- Patient Care: Deliver palliative care services to patients at the community level.
- Education and Awareness: Educate the community on palliative care and available services.
- Referral System: Establish clear referral pathways for patients needing specialized care.

Palliative Care Focal Person:

- Leadership: Serve as a focal point for palliative care activities within the organization.
- Coordination: Coordinate palliative care services and initiatives.
- Advocacy: Advocate for the needs of palliative care patients and services.

Facility Multi-Disciplinary Team: Comprised of diverse healthcare professionals at each facility.

- Collaboration: Work together to provide holistic care to palliative care patients.
- Expertise: Bring diverse skills and knowledge to address the complex needs of patients.
- Communication: Ensure effective communication and coordination of care.

NGO:

- Support Services: Provide additional support services for palliative care patients.
- Advocacy: Advocate for improved palliative care policies and resources.
- Community Engagement: Engage with communities to raise awareness and support for palliative care.

Community support groups:

- Education: Educate members of the community on palliative care and end-of-life issues.
- Support: Provide emotional and practical support to patients and families through Iddir and other social structures
- Advocacy: Advocate for improved access to palliative care services and resources.

10. COSTING AND FINANCING

The costing helps for identifying potential funding gaps or highlighting areas where additional resources might be needed, and prioritization of initiatives based on their cost-effectiveness. It also promotes accountability and transparency, allowing stakeholders to monitor developments and evaluate how well resources are being used throughout the implementation of the National Palliative Care Strategic Plan.

10.1. Costing Method

The method to estimate the cost of implementing the roadmap involves the use of program costing method. It mainly involves identifying and quantifying the specific activities to be costed, determining and quantifying the type of specific inputs for implementing the activities, and gathering unit costs from different sources. The activities under the strategic objectives and initiatives of the roadmap were used as costing units for the costing exercise. There were 162 activities identified under the NPCSP organized under the 6 strategic objectives. For the activities identified as costing units, the type and number of inputs required were then determined by the task force considering the realization of the strategic objectives through the execution of the activities. According to the nature of the inputs and methodological advantage, the inputs were categorized into the following groups: 1) Training and workshop; 2) Supervision; 3) Infrastructure, equipment and digitization; 4) Research and Development; 5) Consultation Service; and 6) Other cost elements. Unit costs for the different inputs were gathered from various sources, which include unit cost database available from the Strategic Affairs Executive Office (SAEO) where most of the unit costs were taken. In addition, standards and reports provided by the MOH and implementing partners were considered. If specific costs for items were not available, the costing data were drawn from an African regional or international source and noted as such in the costing tool. We have used a discounting rate of 3% and USD to ETB exchange rate of 135.35. Note that the cost does not include salary and benefits as well as pre-service training budget.

10.2. Costing summary of results

The total cost of implementing the National Palliative Care Strategic Plan in the five years is estimated to be about ETB 165.6 million which would be ETB 30 million investment every year. The investment needs for the strategic plan implementation years and under each strategic objective, are given in the table below.

Table 1: Total estimated cost under each strategic objective (Million ETB)

#	Strategic Objective	2025	2026	2027	2028	2029	Total
SO1	Strengthen Leadership and Governance	8.3	6.1	6.3	4.9	4.9	30.5
SO2	Enhance access and quality of palliative care services' provision	9.1	10.6	12.2	11.6	11.6	55.1
SO3	Strengthen palliative care Information Systems	2.4	2.5	2.6	2.6	2.6	12.8
SO4	Human Resource Development	3.2	3.7	3.6	3.4	3.4	17.2
SO5	Improve Access to and Rational Use of Morphine & other EPCM	4.0	4.1	4.3	4.5	4.5	21.5
SO6	Improve partnership and collaboration	5.2	5.3	8.3	4.8	4.8	28.5
	Total cost (Million ETB)	32.1	32.5	37.3	31.9	31.9	165.6

From the total cost, the strategic objective on 'Enhance access and quality of palliative care services', constitutes the majority share – 33.3% or about ETB 55.2 million while 'Strengthen Leadership and Governance' *requires 18.4% of the total investment or ETB 30.47 million.* The distribution of the cost by strategic objective is also shown in the Figure below.

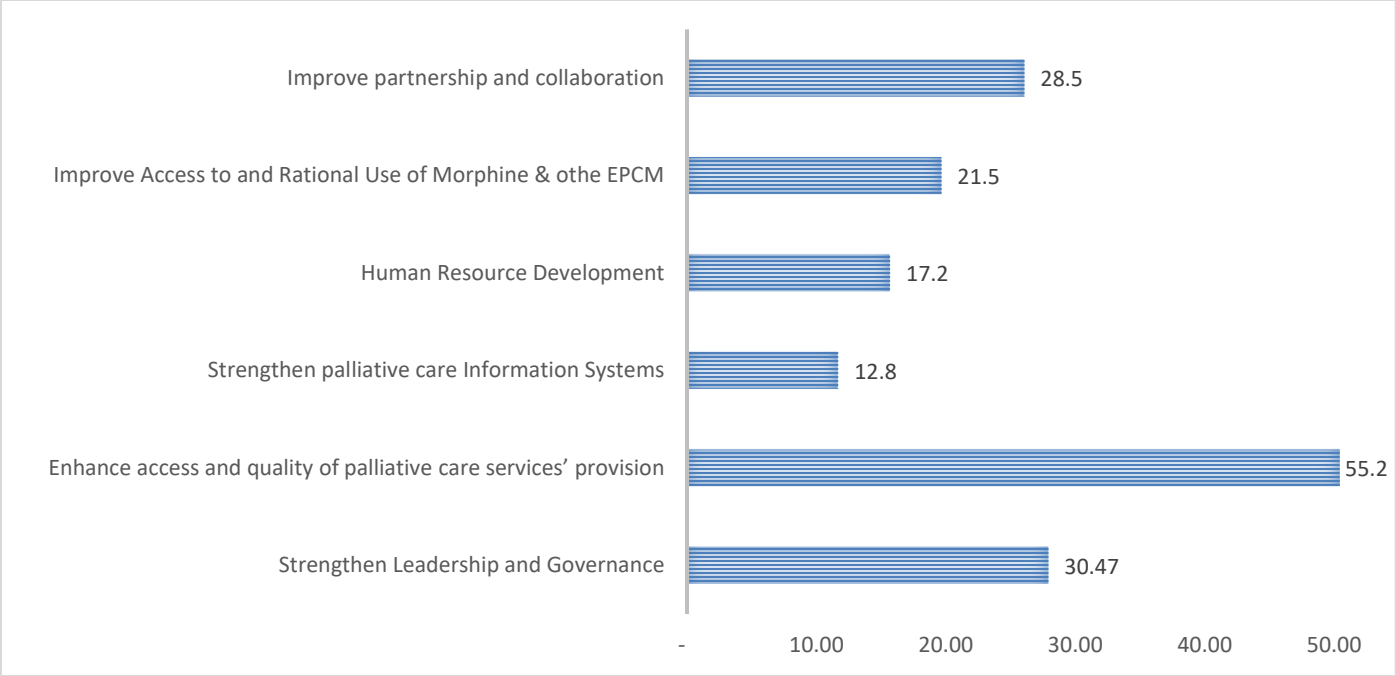

Figure 1: Distribution of total cost across strategic objectives of NPCSP (Million ETB)

The estimated costs under each type of cost-driver are also computed. Infrastructure, equipment and digitization takes the highest share (37.8%) followed by Training and Workshop (26.2%), and Supervision (19.917%). Each of the remaining cost drivers such research and Development require less than 5% of the total estimated cost. This shows that the bulk of the required resources for implementing the roadmap goes to highly capital-intensive investments.

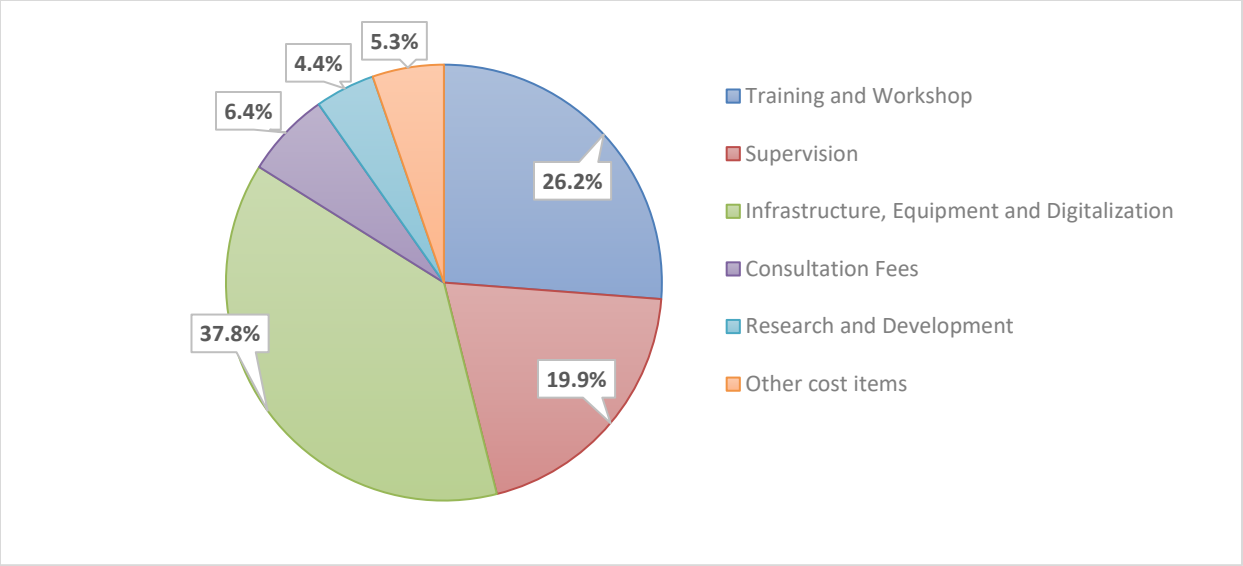

Figure 2: Total cost distribution across the different cost drivers

10.3. Proposed financing arrangement

It is planned to leverage resources from federal and regional governments, as well as development partners. The proposed share of finance from each of these sources is given in the table below, including the expected amount over the roadmap implementation period and annually. The federal and regional governments' option primarily targets budgetary allocations, while the development partner option would need to explore loans, grants, and concessional financing from donor agencies. The financing through community engagement shall be primarily led by the respective local administrative bodies through different modalities.

Table 2: Proposed financing arrangement

		Expected Budget (Million USD)						
Source of Finance	Share	2026	2027	2028	2029	2030	Total	Annual Average
Federal Government	45%	14.4	14.6	16.8	14.3	14.3	74.5	14.9
Regional Government	25%	8.0	8.1	9.3	8.0	8.0	41.4	8.3
Development Partners	30%	9.6	9.7	11.2	9.6	9.6	49.7	9.9
Total	**100%**	**32.1**	**32.5**	**37.3**	**31.9**	**31.9**	**165.6**	**15.1**

11. Monitoring and Evaluation

Aiming to achieve the national strategy objectives, hospital palliative care services should be monitored based on evidence synthesized using high-quality data, which will steer the implementation process in the appropriate direction. At the national, regional, zonal, and facility levels, information obtained through routine documentation, surveillance, and audits should be reported back to the appropriate authorities. Improvement requires prompt feedback on palliative care services provided to patients and their families, as well as coordinated efforts by staff members to operate as a team and manage the healthcare facility.

The World Health Organisation advises routine monitoring and assessment procedures to record program impact and progress. The standards and regulations that apply to various healthcare facility levels should be utilised to track advancements made toward the goals outlined in the strategic objectives. Health facilities should keep an eye on how well palliative care is being implemented and adhered to, as outlined in important national standards and manuals like HSTQ and EHSIG. In the end, this would effectively relieve the patient's and family's suffering. Every five years, the National Palliative Strategic Framework will be revised, and the strategy will be evaluated at the mid-term (third year) and end-of-term.

Monitoring of palliative care service

The major components of the monitoring mechanism for the national palliative care service are:

Indicators for Monitoring and Evaluation of the National Palliative Care Strategy

These indicators should be routinely collected to be used for decision-making and also should be reported to the concerned higher bodies.

Table 4: Key Performance Indicators for respective Strategic Objectives and Activities.

Key performance indicators	Base-line	Progress toward goal achievement in years					Data source	Reporting frequency /remark
Percentage of regions with an established palliative care coordinating team		2025	2026	2027	2028	2029	Letters / Minutes	Biannual
Number of review meetings conducted							Audit reports	Biannual
Number of palliative care hubs established							Audit reports / EHSIG	Biannual
Number of facilities that have integrated palliative care services							EHSIG	Monthly
Number of facilities that report PC services based on DHIS2							EHSIG	Monthly

Number of individuals who are trained in palliative care							Audit reports	Bian-nual
Number of institutions that integrate a palliative care curriculum							Audit reports	Annually
The proportion of facilities that produce oral morphine locally							Survey	Annually
Consumption of morphine per capita (Consumption of morphine per year/ Total number of inhabitants)							Audit reports	Annually
Total number of facilities with Morphine and other palliative care medications throughout the year (stock-out period)							Audit reports	Monthly
Number of public events to advocate for palliative care							Minutes	Annually

Conducting National and Regional Palliative Care Review Meetings

The national palliative care strategy recommends that healthcare facilities set up a stand-alone palliative care service with focal persons and multi-disciplinary teams, with the coordination of national and regional coordinating bodies. It is advised to have quarterly or less frequent national and regional level review meetings to exchange experiences and knowledge on the implementation of palliative care services across regions and healthcare facilities. Depending on the review meetings' level, the agendas could change. It might still concentrate on examining the best practice sharing in palliative care, hospital performance, and metrics unique to the country or region. Participants in the review meeting will include public and private healthcare facilities (hospitals, health centers), non-governmental organizations that work on palliative care, and concerned palliative care personnel from MOH, RHBs, and other stakeholders. The length of the review meeting could also be extended to two days if needed.

Supporting Supervision

A technical working group to support health facilities with current practices, recommendations, and technical guidance has been a practice in several programs at the national and regional levels. The technical and leadership experience of the team determines the efficiency of supportive supervision and mentorship activities; this experience should be strengthened by essential capacity building before visiting its facilities. The technical working group conducts quarterly supportive supervision based on the strategic plan.

Mid- and End-Term Evaluation

For strategy interventions like the national palliative care strategy, mid-term evaluation is advised to obtain early lessons and a peek at an implementation's results. The route that the implementation is taking in terms of efficacy and effectiveness may be determined by the mid-term evaluation. This can assist decision-makers and other pertinent parties in taking the necessary steps before the implementation fails. Therefore, after the conclusion of the third quarter, the plan will be evaluated. The primary purpose of the final review is to determine if the objectives and targets stated in the strategy document have been reached. An assessment team will be established by the implementing body, and instruments for an on-site assessment will be created.

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Tools for Assessment

Below are various indicators for palliative care, service provision, and quality that are helpful to assess current palliative care services.

Annex A. Palliative Care Indicators -National Level- adapted from APCA

1. Number of organizations provided with technical assistance (by type of technical assistance).
2. Number of health service providers, by type, providing palliative care.
3. Number, by type, of partners trained in palliative care.
4. National Palliative Care Association was formed.
5. Percentage of palliative care patients in targeted areas who receive quality palliative care.
6. Percentage of palliative care patients having access to essential palliative care drugs.
7. Number of target areas adopting palliative care standards, by type.
8. Number of organizations provided technical assistance for palliative care and HIV policy development.
9. Number of hospitals/health centers with palliative care in their service.
10. Number of palliative care provider organizations brought together to share lessons learned and best practices in palliative care

Annex B. Service levels upon which the standards are based – APCA standards

LEVEL(S)	DESCRIPTION	CAPABILITY REQUIREMENTS	RESOURCE REQUIREMENTS
Primary/ Basic level (1)	This level represents what is essential or the minimum package for palliative care. It provides basic clinical and supportive care services and relies heavily on the referral of patients and their families to level 2 and level 3 service providers for more advanced and specialist care. General and basic healthcare services, including primary services providing care to PLHIV and their families as well as those with other life-threatening conditions, are required to meet the criteria for level 1 for all standards. Examples • Community-based programs • Primary-level government health centers	• Uses a holistic approach to manage basic clinical and non-clinical problems of the patient, caregivers, and families. • Provides basic clinical services for Opportunistic Infections (OIs) and uses WHO analgesic ladder level 1 pain assessment and management guidelines. • Makes referrals to level 2 and 3 service providers for management beyond own capability. • Access to ART is by appropriate referral through a documented process. Follow-up on adherence is undertaken in partnership with the service provider for the drugs.	• Relies mainly on community care providers and a small team of general healthcare providers. • In general, relies heavily on community resources to provide services. • Clinical supervision is provided by qualified and experienced professionals.

LEVEL(S)	DESCRIPTION	CAPABILITY REQUIREMENTS	RESOURCE REQUIREMENTS
Secondary level/ Intermediary (2)	This represents intermediary service providers, which are providing a wide range of service components for HIV and AIDS and other life-threatening conditions. Have well-developed collaborations with community and other service providers. • All as in level 1, plus: • At least one team member has had a 1-2 week orientation course in palliative care • Ongoing availability of any Step 2 analgesics on-site • Availability of ART • OIs management • Receives referrals from, and makes referrals to, level 1 and level 3 service providers, via formal links. • There are limited specialised services Examples • Integrated Community Based Home Care Program (ICHC) • Community Home-based care program(CHBC) • Government regional and district level services, and other district level service providers such as mission hospitals	• Inter-disciplinary team or at least regular access to medical, nursing, and psycho-social and spiritual input on-site or through a functional and documented referral network. • Has formal and informal care providers. Formal care providers give training and support to informal care providers. • Access to ART and other medications on-site or through referral and a well-documented procedure for follow-up on adherence.	• An inter-disciplinary or multi-skilled team with some members of the team trained through specialist palliative care programs. • The actors include professional care providers. • A professional team working together with trained community care providers through a well-structured and documented process.

Annex C: APCA Standards for Providing Quality Palliative Care Across Africa

LEVEL(S)	DESCRIPTION	CAPABILITY REQUIREMENTS	RESOURCE REQUIREMENTS
Tertiary Level/ Specialist Level (3)	This level provides the full range of palliative care services: comprehensive care for the needs of patients, care providers and families with complex needs. It comprises all elements in levels 1 and 2 plus: • Access to ART on-site or through referral • Availability of Step 3 analgesics for use at the site and in the home (i.e. oral morphine, methadone) • Availability of palliative radiation and certain palliative chemotherapies at the site or a clear procedure of referral for access to such treatments. • Certificate or Degree-level training in palliative care represented in the team • All specialist palliative care services are required to meet the criteria for level 3 for all standards. <u>Examples of Services</u> • Specialist palliative care centers • Hospital-based palliative care units/teams • Palliative Care HBC programs e.g. ICHC*	Provides specialized palliative care for patients, care providers, and families, especially those with complex needs. Physical, social, psychological, and spiritual care are all accessed from the same point. Services have the capability to meet the most complex needs and provide a leadership role in palliative care service provision. Receives and manages referrals from levels 1 and 2, with clear documentation on the management of such referrals. Can also make referrals back to the level 1 and 2 for ongoing joint care. Has formal links with level 1 and level 2 service providers and provides them with consultant support, training, and mentorship. Ongoing availability of well-structured professional supervision for community care providers. There is a well-documented procedure for follow-up on adherence to medications	A multi-disciplinary team with specialist training, skills and experience in palliative care The actors include doctors, specialist nurses, allied health professionals, spiritual leaders, social care professionals, etc. A professional team working together with trained community care providers through a well-structured and documented process.

***** Some service providers such as ICHC can fit in more than one level depending on their capability and resources

Annex D: Palliative Care Indicators

Quality Indicators

A. African Palliative Care Outcome Scale- this can be used with patients and family members to determine the quality of service.

'The APCA African POS contains 10 items, addressing the physical and psychological symptoms, spiritual, practical and emotional concerns, and psychosocial needs of the patient and family. The answers to all questions are scored using Likert scales from 0 to 5, with numerical and descriptive labels. Questions 1-7 are directed at patients; questions 8-10 are directed at family informal caregivers and include a 'Not applicable' option for use when the patient does not have an informal carer. The African version of the POS is staff-completed, owing to varying levels of patient and family literacy. Respondents indicate their answers either verbally or using a hand scale (0 = closed fist, 5 = all fingers open). The responses use a combination of high score = best status and low score = best status as a mechanism to ensure that administration, and response formulation to the individual items, are conducted with due care and attention'.www.apca.org

APCA AFRICAN POS

ASK THE PATIENT Q1. Please rate your pain	(from 0 = no pain to 5 = worst/overwhelming pain) during the last 3 days 0 (no pain) - 5 (worst/overwhelming pain)
Q2. Have any other symptoms (e.g. nausea, coughing, or constipation) been affecting how you feel in the last 3 days?	0 (not at all) - 5 (overwhelmingly)
Q3. Have you been feeling worried about your illness in the past 3 days?	0 (not at all) - 5 (overwhelming worry)
Q4. Over the past 3 days, have you been able to share how you are feeling with your family or friends?	0 (not at all) - 5 (yes, I've talked freely)
Q5. Over the past 3 days have you felt that life was worthwhile?	0 (no, not at all) - 5 (Yes, all the time)
Q6. Over the past 3 days, have you felt at peace?	0 (no, not at all) - 5 (Yes, all the time)
Q7 .Have you had enough help and advice for your family to plan for the future?	0 (not at all) - 5 (as much as wanted)
ASK THE FAMILY CARER Q8. How much information have you and your family been given?	0 (none) - 5 (as much as wanted) N/A
Q9. How confident does the family feel in caring for ____?	0 (not at all) - 5 (very confident) N/A
Q10. Has the family been feeling worried about the Client over the last 3 days?	0 (not at all) - 5 (severe worry) N/A

B. **Further Quality Indicators:** WHO 2016-) P66 – Planning and Implementing Palliative Care Services: A Guide for Program Managers.

A number of palliative care domains can serve as a framework for measuring the quality of palliative care:

1. Structure and process of care (e.g. training and education for professionals; providing continuity of care).
2. Physical aspects of care (e.g. measuring and documenting pain and other symptoms; assessing and managing symptoms and side-effects).
3. Psychological and psychiatric aspects of care (e.g. measuring, documenting, and managing anxiety, depression, and other psychological symptoms; assessing and managing the psychological reactions of patients/families).
4. Social aspects of care (e.g. conducting regular patient/family care conferences to provide information, discuss goals of care, and offer support to the patient or family; developing and implementing comprehensive social care plans).
5. Spiritual, religious, and existential aspects of care (e.g. providing information about the availability of spiritual care services to the patient or family).
6. Cultural aspects of care (e.g. incorporating cultural assessments such as the locus of decision-making and preferences of patient or family regarding the disclosure of information and truth-telling, language, and rituals).
7. Care of the imminently dying patient (e.g. recognizing and documenting the transition to the active dying phase; ascertaining and documenting patient/family wishes about the place of death; implementing a bereavement care plan).
8. Ethical and legal aspects of care (e.g. documenting patient/surrogate preferences for care goals, treatment options, and the care setting; making advance directives; promoting advanced care planning).

Annex E: Level of training recommendation for palliative care from international recommendation (Adopted from WHO)

Level 1 = Foundations Courses (attitudes, perspectives, and understanding suitable for all); **Basic level training** for up to 10 days

Level 2 = Principles of palliative care for nurses and physicians **- level training** for 6 weeks

Level 3 = specific training for specialists in palliative care: **Advanced level training** as a Specialty/ sub-specialty program (Fellowship/ post graduate qualification in palliative care

Curriculum integration at all levels of education

An Integration of palliative care program as a measurable subject in all disciplines of health education and specifically in the undergraduate and post graduate programs of medical education, nursing, social work studies, pharmacy, and clinical psychology/psychiatry.

Masters/ Specialty programs

Initiating a specialty and post-graduate palliative care program is an option less task to accomplish. Initiating post graduate palliative care programs is mandatory as part of creating the future palliative care owners. This can be taken forward through establishing a post graduate master's program for all health care providers, Specialty programs, fellowships and higher diploma program. Since the palliative care education programs should be both theoretical and practical attachment centers with better developments of palliative care delivery could take the lead. These shall be university hospitals with cancer centers. Still, the limiting factor will be limited trained professionals who will deliver the program.

To overcome this, establishing sandwich programs where the training program will be based in the country and online learning sessions and experience-sharing sessions will be included with the best practicing partnering institution abroad though an affiliation program.

Sending health professionals to study abroad through the ministry's and the university's links to learn from the best experience and to bring back a standard care experience.

Annex G: WHO (2016) P66 – Planning and Implementing Palliative Care Services: A Guide for Program Managers

Policy indicators	• Existence of a current national palliative care plan/program (yes/no) • Palliative care is included in the basic package for universal health coverage • Laws and regulations in place for safe and effective opioid prescribing, in line with international drug conventions
Education indicators	• Proportion of medical schools which include palliative care education in undergraduate curricula (i.e. ratio of medical schools with palliative care at undergraduate level to total medical schools) • Proportion of nursing schools that include palliative care education in undergraduate curricula (i.e. ratio of nursing schools with palliative care at undergraduate level to total nursing schools) • Number of specialized palliative care educational programs for physicians, accredited by the national responsible authority (absolute number), with specialized palliative care education defined as specialty, sub-specialty, master, or diploma, as defined by the respective competent authority
Service provision indicators	• Inclusion of palliative care in the list of services provided at the primary care level • Number of palliative care services per million inhabitants • Number of accredited/specialized physicians working in palliative care per 1 million inhabitants • Number of communities that own and provide palliative care services
Medication indicators	• Consumption of strong opioids per cancer death (mg per number of deaths) • WHO essential medicines for palliative care are all included in the national list of essential medicines • Proportion of districts where oral morphine is available in primary health care
Outcomes	• Percentage of deaths with access to palliative care • Number of palliative care patients cared for per 100000 inhabitants

Annex H: EHSIG (Chapter 13) pain and palliative care management service

S/N	Operational Standard	Score	Verification Criteria	Scoring	
				Weight	Score
1.	The hospital has functional pain and palliative care service organization.	13	Designated area/office for Pain and palliative care	1	
			There is assigned full time pain and palliative care service coordinator (look assignment letter)	2	
			Full time Pain and palliative care unit staffs are assigned as per the hospital tier level	2	
			Service area pain focals are assigned in OPD, IPD, ER…(look assignment letter)	2	
			Look palliative care service as part in the hospital organogram as responsible for Medical director.	2	
			Look for Pain and palliative care plan with specific budget list	2	
			All clinical staffs are trained on pain management (look for training record or certificate)	2	
			Score	13	
2.	The hospital has multidisciplinary team for pain and palliative care service	10	There is a multidisciplinary pain and palliative care service committee (look assignment letter of committee members)	2	
			Look TOR for the multi- disciplinary committee	1	
			Regular monthly meeting (look meeting minutes)	2	
			Submit pain and palliative care service agenda for SMT decision and follow up schedule	1	
			Training and capacity building for multi-disciplinary team (look for training record or certificate)	2	
			Support other hospital or health centers in the hub specific in pain and palliative care	2	
			Score	10	
3.		6	Check Pain and palliative care guidelines in all service delivery areas (OPDs, IPDs, ER…)	1	

	The hospital has written standard Documents/tools for pain and palliative care services		Look the hospital Palliative care SOP & protocols approved by the hospital management	1	
			Look for availability of standard pain and palliative care patient reporting tool **(See annex 1)**	1	
			Adult and pediatric Pain Management protocol is available in the hospital in wards and clinical areas	1	
			Palliative patient assessment tools available for use	1	
			Patient satisfaction format available **(See annex 3)**	1	
			Score	6	
4.	The hospital has all the necessary medication equipment and supplies for pain and palliative care.	10	Pain medications are included in the vital list of hospital	2	
			Check availability of all the vital Pain and Palliative care Medications in store and dispensaries **(see annex 4)**	2	
			The hospital DTC has representative from pain and palliative care department (check DTC letter of assignment)	1	
			The hospital shall have a clear strategy for opioid consumption and reporting **(see annex 5)** for pain medication reporting form	1	
			The hospital pharmacy department promote Good Dispensing practice for pain medication	2	
			The hospital avail all the necessary palliative care equipment and supplies as per the tier system **(See annex 6)**	2	
			Score	10	
5	Hospital has implemented pain as a 5th vital sign	10	Have a written policy on pain is 5th vital sign and must be assessed and managed.	2	
			Pain score integrated with patient chart as fifth vital sign	2	
			Patients pain assessed and scored as per standard scale **(See annex 7)**	3	
			Holistic pain assessment and management approach is implemented	3	
			Score	10	

6	Pain is managed according to WHO analgesic ladder	6	Patients pain managed according to WHO analgesic Ladder (look 5 IPD Medical records in different wards)	3	
			All departments provide appropriate pain symptom control (Look for 5 IPD Medical records V/S progress in different wards)	3	
			Score	6	
7	The hospital has regular health education program on pain and palliative care.	8	Pain and palliative care service is integrated in health education program of the Hospital.	2	
			There is a system to check the patients awareness on proper utilization of pain medication.	2	
			The hospital Post information, lectures and pamphlet about how to report pain in a visible area and use of medication for patients and care givers.	2	
			Availability of short audio video for health education in pain and palliative care	2	
			Score	8	
8	The hospital has conducted regular pain assessment and management audit	6	There is quarterly Pain and Palliative care assessment and management audit. (see annex 8)	2	
			Pain and palliative care KPIs are regularly done	2	
			Clinical audits results analyzed and action plan/ QI projects developed	2	
			Score	6	

9	The Hospital Provides pain management service in outpatient, inpatient, emergency, MCH and other necessary area.	13	There is a practice of pain management in outpatient, inpatients and emergency service areas	2
			Look for self-developed adherence follow up system/checklist	2
			There is regular support for pain and palliative care focals of each service area	3
			Observe palliative care patient's referral in and referral out - registry in palliative care service area is available	3
			Registry for admitted patients, outpatients and other area patients linked for homecare are available	3
			Score	13
10	Pain and Palliative care unit/ department facilitates the delivery of home based care palliative care	18	Look for Home-based palliative care Guidelines, Protocol, Registration book, education materials etc.	3
			HBC Service plan (nursing care, Companionship etc.) and staff visiting schedule	3
			Look for the presence of MDT for HBC or trained team in facilities of the cluster/hub	3
			Look for reporting format, Activity Report or referral service linkage reports	4
			Check the presence of necessary HBC set Medical equipment's (vital sign monitoring set, suction catheters ,pulse oximetry etc)	5
			Score	18
Total Score				100

Annex E: Palliative Care Audit Tool

1	Does the hospital clinic have a functioning palliative care team?	Y/N Y=2 N=1	Comments
2	Do they have the minimum number of palliative care staff in the team? (According to WHO guidelines)	Y/N	
3	Have the palliative care team attended a one-week training course?	Y/N	
4	Do they have a room or office to meet and see patients?	Y/N	
5	Do they have a hospital palliative care policy with referral criteria?	Y/N	
6	Do they have palliative care notes which are stored appropriately for their patients? Check 6 Patient Records)	Y/N	
7	Do they have access to palliative care medicines including morphine - including liquid form?	Y/N	
8	Is there evidence of a palliative assessment including pain as the 5th vital sign Check 6 Patient Records)	Y/N	
9	Is there evidence of pain and symptom control assessment and appropriate treatment (Check 6 Patient Records)	Y/N	
10	Do they have palliative care equipment (according to list)	Y/N	
11	Do they have a linked home-care service?	Y/N	
12	Do they offer a bereavement service?	Y/N	
13	Have any of the team any post-graduate education in palliative care?	Y/N	
14	Does the palliative care hub have volunteers to support patients and family?	Y/N	
15	Does the hub have a clear referral pathway for patients from all appropriate departments?	Y/N	
16	Do the palliative care hub team provide basic updates/experience sharing with other health care professionals in the hospital	Y/N	

Annex F: Essential Palliative Care Medicines List

Drug Name	Properties	Clinical Uses	AlternativeDrugs
Paracetamol	Non opioid Analgesic Antipyretic	Fever Pain	
Aspirin	Non opioid Analgesic Antipyretic Anti- inflammatory	Pain Fever Sore mouth	
Ibuprofen	NSAID	Pain (esp. bone pain) Fever Anti-inflammatory	Diclofenac Indomethacin
Tramadol Codeine	Weak opioid Analgesic	Pain	Low dose morphine
Morphine liquid	Strong opioid Analgesic	Pain Introduction Breakthrough pain Difficulty swallowing children Breathlessness Severe Diarrhea	Morphine slow release tablets
Morphine (slow release tablets)	Strong opioid	Pain Severe diarrhea	Morphine Liquid
Dexamethasone	Corticosteroid Anti- inflammatory	Painful swelling and inflammation Poor appetite	Prednisolone
Amitriptyline	Tricyclic Antidepressant	Neuropathic pain (nerve pain)	Carbamazepine Phenytoin
Amitriptyline	Tricyclic Antidepressant	Depression	Imipramine
Hyoscine Butyl bromide (Buscopan)	Antimuscarinic Antispasmodic	Abdominal pain (Colic)	Propantheline
Diazepam	Benzodiazepine Anticonvulsant	Muscle spasm Seizure Anxiety, sedation	Lorazepam
Phenobarbitone	Anticonvulsant	Seizure	Diazepam
Metoclopramide	Antiemetic	Vomiting	Haloperidol Domperidone Promethazine
Metoclopramide	Pro-kinetic	Abdominal Fullness	

Chlorpromazine	Antipsychotic	Hiccups	Metoclopromide Nifedipine
MagnesiumTrislicate	Antacid	Indigestion Gastro-esophageal reflux Gastritis	
Loperamide	Antidiarrheal	Chronic diarrhea	
Bisacodyl	Stimulant laxative	Constipation	
ORS	Rehydration Salt	Diarrhea Rehydration	
Chlorpheniramine	Antihistamine	Drug reactions	
Flucloxacillin	Antibiotic	Chest infection Skin infection	
Cotrimoxazole	Broad Spectrum Antibiotic	PCP treatment & prophylaxis Infective diarrhea in HIV/AIDS Urinary Tract Infection	
Metronidazole	Antibacterial for anaerobic infections	Foul smelling wounds gingivitis dysentery Vaginal discharge	
Lumefantrine artemether (LA)	Anti- malarial	Malarial treatment	
Acyclovir	Antiviral	Herpes zoster	
Chloramphenicol eye ointment/drops	Antibacterial	Eye infections	
Fluconazole	Antifungal	Oral & esophageal candidiasis Cryptococcal meningitis	
Clotrimazole 1%Cream	Topical antifungal	Fungal Skin Infection	
Nystatin Suspension and pessaries	Antifungal	Oral & vaginal candidiasis Prophylaxis for patients on steroids	