REPUBLIC OF KENYA

MINISTRY OF HEALTH

KENYA PALLIATIVE CARE POLICY

2021-2030

“Towards attaining
the highest standards
of palliative care”

Kenya Palliative Care Policy 2021-2030

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Kenya Palliative Care Policy 2021–2030

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Table of Contents

LIST OF FIGURES

LIST OF TABLES

Foreword

Globally, approximately 56.8 million people are in need of palliative care services; 78% of them living in low and middle-income country yet only about 12% have their needs being met causing great suffering for many. The majority of adults in need of palliative care have non-communicable diseases accounting for about 69%. In Kenya, about 800,000 Kenyans are in need of palliative care every year. Unfortunately, only about 14,552 Kenyans are accessing these services. Access to palliative care is even more limited among children with less than 5% of pediatric patients having access.

Palliative care endeavors to improve the quality of life of patients with life-limiting diseases and their families, through the prevention and relief of suffering by means of early identification, correct assessment and treatment of pain as well as other problems, physical, psychosocial and spiritual. The Constitution of Kenya guarantees its citizens the right to the highest attainable standards of health.

Similar to other health services constituting Universal Health Coverage, provision of palliative care requires integration of a multi-disciplinary, multi-sectoral and inter-governmental approach into its implementation framework. It is therefore the responsibility of both the National and County governments to mobilize resources for the effective provision of quality palliative care in line with global and regional policies, Sustainable Development Goals (SDGs) and other relevant resolutions.

This policy is guided by several key principles, among them the protection of rights to health of specific vulnerable cohorts including children, persons with disabilities, marginalized communities, the youth and the elderly in accordance with the Constitution of Kenya.

It is my sincere hope that this policy will provide guidance to policy makers, healthcare providers, implementing and development partners and all other health stakeholders on the various diverse components necessary to ensure provision of holistic palliative care for all those in need of these important services.

Sen. Mutahi Kagwe, EGH
CABINET SECRETARY FOR HEALTH

Executive Summary

This policy has been anchored on the following seven pillars of the Health System - Leadership and Governance; Service delivery, Availability and Access to Essential medicines; Health workforce and education; Health Information Systems and Research; Financing; Advocacy & communication. The policy covers palliative care, end-of-life care and survivorship care as well as key considerations in palliative care.

The policy development process began in February 2018 through involvement of relevant stakeholders. The development was guided by the findings of a situational analysis undertaken targeting key informants, policy makers, healthcare providers, Persons Living with Palliative Care Need and training institutions with the aim of identifying gaps in palliative care in Kenya.

The policy consolidates and standardizes already existing initiatives on hospice and palliative care and provides a legal framework within which holistic and well-coordinated palliative care services are made available and accessible to everyone. It will facilitate the scale-up of palliative care provision that encompasses the relief of pain and other distressing symptoms, right from diagnosis, treatment, end-of-life care, and bereavement support for families, at all levels of the health system through the adoption of a primary health approach.

It elaborates the Government's goals and actions on palliative care and will facilitate scaling up of palliative services within the universal health coverage agenda.

Susan N. Mochache, CBS
PRINCIPAL SECRETARY

Acknowledgements

The Ministry of Health wishes to thank all those who contributed to the successful completion of this document. We appreciate the support from the Office of the Cabinet Secretary, Chief Administrative Secretaries, Principal Secretary, Director General, Directorate of Medical Services, Preventive & Promotive Health, Department of Non-Communicable Diseases, Division of National Cancer Control Program, the Kenya Hospices and Palliative Care Association (KEHPCA) and the Africa Palliative Care Association (APCA) for their support towards the development of this policy.

The policy development has been through a participatory process and engagements involving key stakeholders in health including government ministries, departments and agencies; persons living with palliative care needs (PLWPCNs), counties, constitutional bodies, development partners and implementing partners (hospices, faith-based, private sector, and civil society).

We are very grateful to the institutions represented in the National Palliative Care Technical Working Group under Pillar 3 of the National Cancer Control Strategy 2017-2022 who worked tirelessly to ensure completion of this policy. A special appreciation to the Kenya Hospices and Palliative Care Association(KEHPCA) led by Dr. Zipporah Ali and the Technical Working Group members- Dr. Joyce Nato, Dr. Eunice Gathitu, Dr. Esther Munyoro, Dr. Esther Muinga, Dr. Asaph Kinyanjui, David Musyoki, Miriam Igobwa, Dr. John Weru, Anne Mwangi, Mercy Kamau, Christine Ajulu, Dr. Mary Nyangasi, Dr. Joy Chepchumba, Ted Wandera and Daniel Morogo. We recognize the valuable inputs we received from our external reviewers- Katherine Pettus from the International Association for Hospice and Palliative Care; Dr. Stephen Connor, Executive Director of the Worldwide Hospice Palliative Care Alliance and Dr. Emmanuel Luyirika, Executive Director of the African Palliative Care Association

The policy development process was spearheaded by the Ministry of Health through the National Cancer Control Program in collaboration with KEHPCA. The launch of this document after years of discussions and deliberations is a major milestone in enhancing access to palliative care in Kenya and will ensure that palliative care is prioritized at all levels of healthcare in Kenya.

Dr. Patrick Amoth, EBS
Ag. DIRECTOR GENERAL FOR HEALTH

Abbreviations & Acronyms

AG- Attorney General

AD – Advanced Directives

ACP – Advanced Care Plan

AIDS - Acquired Immune Deficiency Syndrome

APCA - Africa Palliative Care Association

CHMT - County Health Management Team

CHA – Community Health Assistant

CSO - Civil Society Organization

CME - Continuous Medical Education

DNR – Do Not Resuscitate

DHIS - District Health Information Software

EM- Essential Medicines

HCP - Health Care Professional

HIV - Human Immunodeficiency Virus

HMT - Health Management Team

HSIP- Health Sector Investment Plan

HSSP - Health Sector Strategic Plan

INCB- International Narcotics Control Board

LMICs - Lower Middle-Income Countries

KHIS –Kenya Health Information System

KAFP – Kenya Association of Family Physicians

KPA - Kenya Pediatric association

KEHPCA - Kenya Hospices and Palliative Care Association

MOE - Ministry of Education

MOH - Ministry of Health

MER - Monitoring, Evaluation and Reporting

NACC - National AIDS Control Council

NASCOP - National AIDS and STI Control Program

NCCP - National Cancer Control Program

NCD - Non-Communicable Disease

NCI - National Cancer Institute

NHIF - National Hospital Insurance Fund

NCK – Nursing Council of Kenya

PC - Palliative Care

PHC – Primary Health care

PLWPCNs - Persons Living with Palliative Care Needs

PPB – Pharmacy and Poisons Board

SHS - Serious Health- Related Suffering

TOTs - Trainer of Trainers

TWG - Technical Working Group

UHC- Universal Health Coverage

WHA - World Health Assembly

WHO - World Health Organization

Definition of Terms

1. Adult Palliative Care

The World Health Organization (2002) defines Palliative care as; 'An approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness/SHS, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

2. Pediatric Palliative care

Palliative care for children is 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. Health providers must evaluate and alleviate a child's physical, psychological, spiritual and social distress.

3. Persons Living with Palliative Care Needs (PLWPCN)

This includes recipients of palliative care – patients (adults and children), family members and caregivers..

4. Hospice and Palliative Care Unit

In the Kenyan context, hospice is a community focused institution that provides care to PLWPCN at the community level including home-based care. Some hospices may have in-patient facilities. A palliative care unit may be housed within a health facility or maybe a stand-alone unit/clinic, which provides both inpatient and outpatient palliative care services. It is important to note that hospices and palliative care units provide care from the time of a diagnosis of a life-threatening illness and not just at the end-of-life.

5. Life threatening Illnesses/Serious Health Related Suffering

A state of distress associated with events that threaten the intactness of a person. It may be accompanied by a perceived lack of options for coping. The suffering cannot be relieved without professional intervention and comprises of physical, social, spiritual and emotional functioning.

6. Interdisciplinary Team

A palliative care team should be interdisciplinary and should share information and work interdependently. It includes both clinical and non-clinical professionals, patient as well as the family.

7. Quality of Life

WHO defines Quality of life as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, spirituality, personal beliefs, social relationships and their relationship to their environment.

8. Continuum of Care

Provision of palliative care should commence from diagnosis and throughout the trajectory of the illness including bereavement care.

9. Terminal Condition

A terminal condition is a progressive condition that has no cure and that can be reasonably expected to cause death of a person within a foreseeable future.

10. End of Life

End-of-life is the final common pathway of many progressive illnesses with irreversible decline in functional status before death; it may occur over days or weeks. End-of-life care therefore describes care provided during the period when death is imminent, and life expectancy is limited to a short number of hours or days. It includes physical, emotional, social, and spiritual support for patients and their families.

11. Do Not Resuscitate (DNR)

A medical order indicating a person does not consent to receive resuscitative measures in case of cardiopulmonary arrest. There should be a discussion between the Clinician, the patient and the caregivers on DNR.

Definition of Terms

12. Advanced directives

An advanced directive is a product of advance care planning, which is a voluntary discussion and a guide from a person who is competent and capacitated. The person gives directives on what elements of care that they would wish to receive or not in a situation they are unable to give guidance.

13. Doctrine of double effect

The doctrine of double effect states that actions with both good and bad effects are ethically legitimate only if the intent was the good effect but there is a like hood of the bad effect occurring. The good outcome must be achieved independently of the bad outcome.

14. Euthanasia

A physician (or other person) intentionally ending the life of a person by the administration of drugs, at that person's voluntary and competent request.
In Kenya, Euthanasia is illegal.

15. Physician assistance in dying

A person intentionally helping another person to terminate his or her life, at that person's voluntary and competent request. **This is illegal in Kenya.**

16. Physician-assisted suicide (PAS)

A physician intentionally helping a person to terminate his or her life by providing drugs for self-administration, at that person's voluntary and competent request. **This is illegal in Kenya.**

17. Non-treatment decisions

Withholding or withdrawing medical treatment from a person either because of medical futility or at that person's voluntary and competent request.

18. Palliative sedation

The monitored use of medications intended to induce a state of decreased or absent awareness (unconsciousness) to relieve the burden of otherwise intractable suffering in a manner that is ethically acceptable to the patient, family and healthcare providers.

19. Withholding treatment

Non institution of treatment which is a shared decision between provider and patient in line with goals of care.
It is not a decision to seek death or hasten death.

20. Withdrawing treatment

If there is an agreement that treatment is not in the best interest of the patient, the treatment can be withdrawn. The palliative care team continue the provision of care and support ensuring the patient is as comfortable as possible.

21. Bereavement

Bereavement is the state of having lost an important person via death. Bereavement support helps the bereaved to cope with the loss.

22. Survivorship

In cancer as with other life threatening illnesses, survivorship focuses on the health and life of a person from post treatment until the end-of-life. It covers the physical, psychosocial, and economic issues of disease, beyond the diagnosis and treatment phases. It includes issues related to the ability to get health care and follow-up treatment, late effects of treatment, possible recurrence/secondary disease and quality of life..

VISION, MISSION, GOALS AND GUIDING PRINCIPLES

Vision

A Kenyan population with access to quality palliative care services.

Mission

To ensure provision of timely, evidence-based, holistic palliative care services for the improvement of quality of life for persons living with palliative care needs.

Goals

To enhance palliative care services in Kenya by guaranteeing access to quality services at every point of demand.

Guiding Principles

The following principles will guide the implementation of the Kenya Palliative Care Policy:

1. Equity

Fair distribution of resources to guarantee accessibility to quality palliative services at every point of demand, especially for the vulnerable, marginalized and underserved in line with universal health coverage.

2.Ethics

The provision of palliative care must adhere to the principles of medical ethics, the codes of conduct of professional bodies, the constitutional and legal rules and, at all times respect the individual. Respect for human dignity, rights, confidentiality and cultural beliefs must be promoted.

3. Evidence-based

Implementation of this policy should be guided by adoption of practices proven by research.

4. Partnerships

Increasing community empowerment; active involvement of the private sector, county government authorities, civil society organizations (CSOs), effective public-private partnerships and co-ordination.

5. Interdisciplinary approach

Ensuring that all relevant professionals and non-professionals, including the PLWPCNs, work in collaboration and partnership to ensure holistic services. The recognition of each stakeholder's role and contribution is vital in ensuring accessibility and availability of palliative care to every person in need of these services.

6. Hospice and palliative care as a human right

Hospice and palliative care services should be provided in a manner that does not compromise or undermine the dignity of the patients and families, based on respect for the human rights of all the intended beneficiaries and providers.

7. Enacting of enabling legislation

Ensuring that legislation that affects provision of palliative care is reviewed to enable the provision of holistic services and where such legislation is not available, the same shall be developed to ensure services are available to all, relevant, understood, utilized and culturally appropriate.

8. Responsiveness

Aligning to the changes within the health environment and emerging needs of the patient.

9. Person/Family Centered

When palliative care is provided, the ill person and his/her family are treated as a unit. The person is actively engaged in all aspects of care which are provided in a manner that is sensitive to the person's and family's personal, cultural, and religious values, beliefs and practices, their developmental state and preparedness to deal with the dying process. There is a valuable distinction to be made between patient-centered and person-centered, with the former being focused on the illness role and the latter focusing on the whole person for whom illness is but one part of life.

10. Innovations and technology

Application of changing trends to promote delivery of quality palliative care services.

Rationale for a Palliative Care Policy

The WHO public health strategy for palliative care advocates for development of a palliative care policy by countries as one of its three key pillars, alongside its integration into existing health systems, availability of essential medicines, and education. This policy is meant to address structural challenges, the increasing burden of disease demands especially with a shifting focus on provision of palliative care services at the point of diagnosis and not only at the end-of-life, health system challenges and sociocultural determinants.

In most African countries, palliative care is a new discipline and service and access to palliative care in the region remains largely sparse despite the high disease burden and particularly diagnoses that can benefit from palliative care including human immunodeficiency virus (HIV), cancer, and other life-limiting illnesses. Access to palliative care is increasingly recognized as a component of human right to health, which is stipulated in the International Covenant on Economic, Social, and Cultural Rights (ICESCR) Article 12.1 (1996). According to the most recent World Health Organization Atlas, over 56.8 million people including 25.7 million in their last year of life are in need of palliative care with 78% of these living in low and middle income countries. 98% of children in need of palliative care live in low and middle income countries. Kenya faces a rising burden of Non-Communicable Diseases in addition to the infectious diseases burden and emerging pandemics such as COVID-19 and these diseases will often require palliative care.

A national policy, therefore, provides guidance to the palliative care development process entrenching sustainability of the service by enabling governments to set goals for ensuring its universal access. The lack of a policy framework is a limitation to government investment in the development of palliative care services, leading to limited access, poor coordination, and inequities in service provision.

The expansion of access to appropriate, standardized, holistic palliative care for adults and children in Kenya requires a policy to guide proper decision making, goal setting and resource allocation both at the national and county governments. It is expected that this policy will provide an overarching frame work for palliative care that will guide development of relevant national standards, strategies, clinical guidelines and regulations among others to effectively establish palliative care within the health system in Kenya.

CHAPTER ONE

> Palliative care aims to provide hope, enhance dignity and promote resilience for both the patients and their families

Introduction

Palliative care is an approach that improves the quality of life of patients (adults and children) and their families who are facing problems associated with life-threatening illness. It prevents and relieves suffering through the early identification, correct assessment and treatment of pain and other problems, whether physical, psychological, social or spiritual.

Palliative care commences from the point of diagnosis up to end-of-life care and should be accessible throughout the continuum of care at all levels of health service provision. End-of-life care helps those with advanced, progressive, incurable illness to live well as much as possible until they die. It entails identifying and meeting the supportive and palliative care needs of both the patients and their families throughout the last phase of life and into bereavement.

The majority of adults (69%) in need of palliative care have non-communicable diseases. In adults, the leading conditions that generate most serious suffering requiring palliative care interventions include cancer (28.2%), HIV (22.2%), cerebrovascular diseases (14.1%), dementia (12.2%) and lung diseases (5.1%). Other conditions that may require palliative care include organ failure, chronic liver disease, multiple sclerosis, Parkinson's disease, rheumatoid arthritis, neurological disease, dementia, congenital anomalies and drug-resistant tuberculosis. In children, HIV/AIDS (29.6%), premature birth and birth trauma (17%), congenital anomalies (16.2%) and injuries (16%) are the leading conditions requiring palliative care intervention with cancer contributing to 4.1% of the need. Most patients in need of palliative care will experience pain and difficulty in breathing as the two most frequent and serious symptoms. A number of validated screening and assessment tools are used to identify patients who have an increasing need for palliative care regardless of prognosis such as the Supportive and Palliative Care Indicators Tool (SPICT), the Gold Standards Framework Prognostic Indicator Guidance (GSF-PIG) and the UK-based Association for Children with life-threatening (ACT) classification of conditions requiring pediatric palliative care.

Table 1: Association for Children with life-threatening (ACT) classification of conditions requiring pediatric palliative care (Hains et al., 2013)

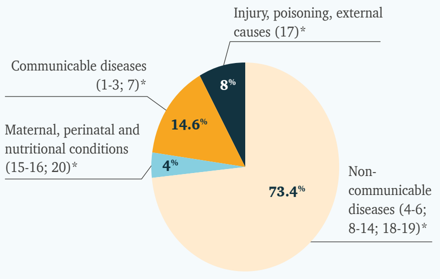
Category	Key characteristic	Description	Examples
1.	**Potential for cure** - life is threatened, not necessarily limited.	Conditions for which treatment may be feasible but can fail	Cancer Some cardiac anomalies
2.	**Period of normality** despite having fatal diagnosis.	Conditions where premature death is inevitable but where there may be long periods of participation in normal activities	Duchenne Muscular Dystrophy
3.	**Relentless deterioration** from, or before, time of diagnosis.	Progressive conditions without curative treatment options, where treatment is exclusively palliative and commonly extends over many years	Metabolic or neurodegenerative conditions
4.	**Unpredictable** course whose progression is not easily judged from natural history.	Irreversible but non-progressive conditions causing likelihood of premature death through complications	Severe cerebral palsy Traumatic brain injury Septic brain injury

Palliative care should focus on relieving the serious health or illness related suffering that is associated with serious health problem or the end of life. It aims to provide hope, enhance dignity and promote resilience for both the patients and the families/caregivers faced with a life-threatening illness which may or may not be curable. It also focuses on survivorship, aiming to empower the individual to be independent physically, psychosocially and economically post-treatment.

Global and Regional Status of Palliative Care

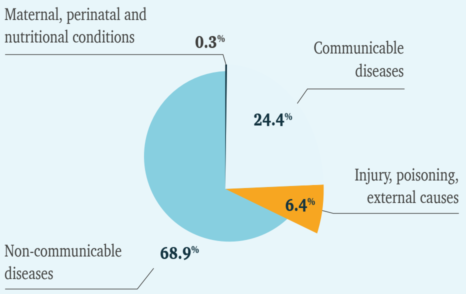
Globally, a large percentage of the population live and die with little or no palliative care or pain relief thus resulting in extreme suffering. Of the 53 million adults in need of palliative care, 76% live in low and middle-income countries. Almost 4 million children and adolescents (0-19yrs) are in need of palliative care with the majority (51.8%) living in the African Region. Out of the 55.9 million deaths reported worldwide in 2017, 73.4% were due to non-communicable diseases and 45.3% of all those who died needed palliative care.

Figure 1
Distribution of major causes of death worldwide for all ages, males and females (2017)*



*Based on data for 354 diseases and injuries and 3484 sequelae

Figure 2
Worldwide need for palliative care for adults, by major diagnostic group (20+ years, 2017)



N = 52,295,120 adults

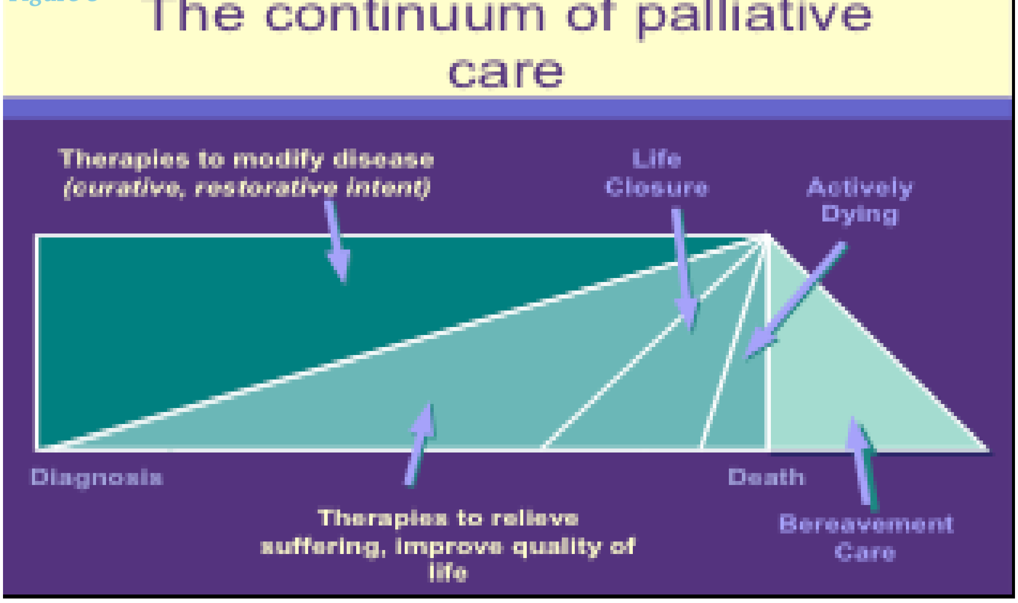
Suffering is health related when associated with illness or injury of any kind, and it is moderate to severe when it cannot be relieved without the intervention of a health care professional, and when it compromises physical, emotional or social well being.

In 2012, the African Union adopted a common position on controlled substances and access to pain medication having noted with concern that approximately 80% of the world's population has either no, or insufficient access to treatment for moderate to severe pain for which medications are not evenly distributed worldwide, disproportionately affecting low and middle income countries, even though they are home to about half of all cancer patients. Countries committed to ensuring well-functioning national and international systems for managing the availability of narcotic medications and psychotropic substances for the provision of relief from pain and suffering by ensuring safe delivery of the best affordable medications to patients who need them and ensuring correct education and training of health professionals in the rational use of these medicines for pain management.

The COVID-19 pandemic has revealed that current global supply chains for essential medicines, including generics needed for palliative care, are not fit for purpose and that local and regional manufacturing and pooled procurement of medications is a more sustainable alternative.

Continuum of Palliative Care

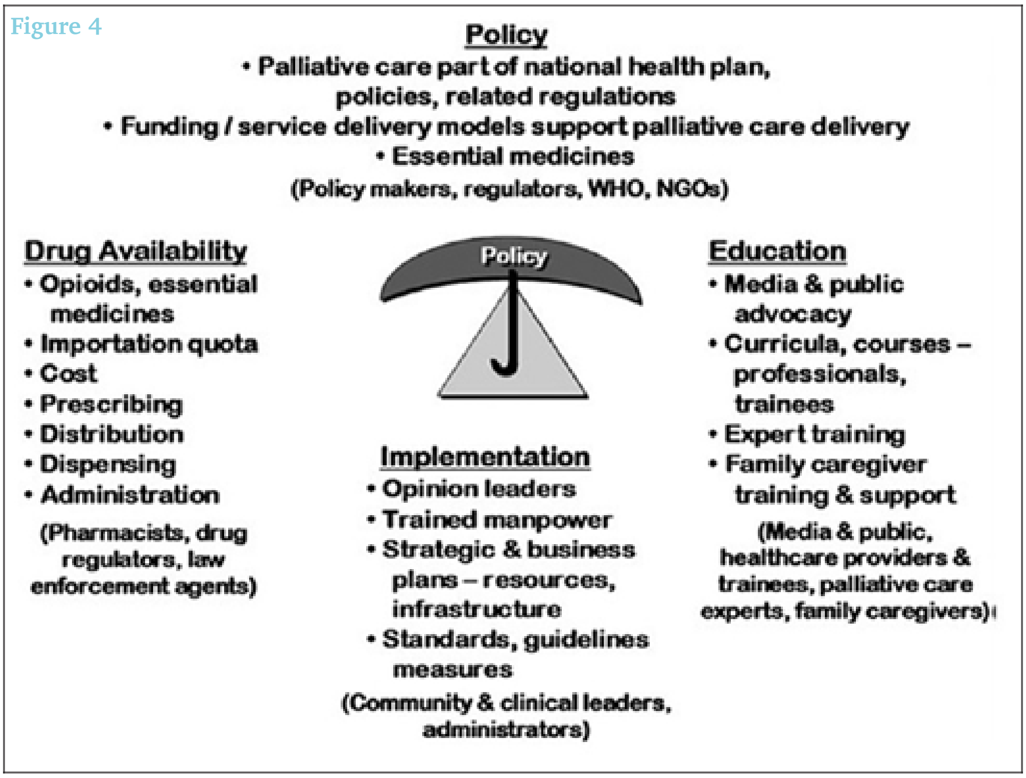
Figure 3



WHO Public Health Model Approach

Palliative care should be integrated into existing health care systems at all levels of care, from community level to tertiary level facilities, as guided by the WHO public health model approach for palliative care development as illustrated below:

Figure 4



Policy
- Palliative care part of national health plan, policies, related regulations
- Funding / service delivery models support palliative care delivery
- Essential medicines

(Policy makers, regulators, WHO, NGOs)

Drug Availability
- Opioids, essential medicines
- Importation quota
- Cost
- Prescribing
- Distribution
- Dispensing
- Administration

(Pharmacists, drug regulators, law enforcement agents)

Implementation
- Opinion leaders
- Trained manpower
- Strategic & business plans – resources, infrastructure
- Standards, guidelines measures

(Community & clinical leaders, administrators)

Education
- Media & public advocacy
- Curricula, courses – professionals, trainees
- Expert training
- Family caregiver training & support

(Media & public, healthcare providers & trainees, palliative care experts, family caregivers)

The main barriers to palliative care development are lack of policy, limited education on palliative care (basic and specialist) among health professional, challenges in availability of essential palliative care medicines as well as implementation challenges. Psychological, social factors and cultures that prohibit informing patients of their diagnosis and prognosis when life threatening also hinder palliative care development. A minimum package of palliative care services has been proposed by the Lancet Commission on Palliative Care and Pain relief that include human resources, medicine and equipment as below:

Figure 5

What is the Minimum Package of Palliative Care Services?

The Essential Package contains the inputs for safe and effective provision of essential palliative care and pain relief interventions to alleviate physical and psychological symptoms, including the medicines and equipment that can be safely prescribed or administered in a primary care setting. The list of essential medicines in the Essential Package is based on WHO's list of essential medicines,[11] and considers the medicines, doses, and administration routes for palliative care for both adults and children.

The Essential Package is designed to be lowest cost by including only off-patent formulations, frugal innovation for needed equipment, and a staffing model based on competencies rather than professions. Tasks often undertaken by specialised medical personnel in high-income countries can be performed by other specialised and general practitioners and nurses or by community health workers empowered with the necessary training and medical supervision to participate effectively in the delivery of palliative care and pain treatment at all levels of care, from the hospital to the home.[16,17]

With the key exception of morphine, the medicines in the Essential Package are available in most countries even if supply is limited. For morphine, an essential palliative care medicine, assuring safety and accessibility is complex. Ensuring a balance between appropriate medical access to controlled medicines and the prevention of their diversion and non-medical use is crucial, and the Commission not only designed appropriate human resource models but also the strategies to provide the complementary policy and stewardship to expand access to an Essential Package that includes morphine.[17]

The health services of the Essential Package must be complemented by interventions for the relief of social and spiritual suffering to preserve the dignity of patients, facilitate access to health interventions, and prevent financial hardship and impoverishment. Yet, these social supports are neither part of the remit of health ministries nor should they be financed from a health budget.

Antipoverty and social development policies, publicly funded safety nets, programmes, and ministries must give special attention to ensure that families do not sacrifice their basic needs in desperate attempts to care for loved ones. These persons with life-limiting or life-threatening health conditions and their families should be mainstreamed into existing social support and social welfare programmes, yet they are often ignored, excluded, or marginalised, preventing them from being effectively integrated into these programmes.

Medicines
- Amitriptyline
- Bisacodyl (Senna)
- Dexamethasone
- Diazepam
- Diphenhydramine (chlorpheniramine, cyclizine, or dimenhydrinate)
- Fluconazole
- Fluoxetine or other selective serotonin-reuptake inhibitors (sertraline and citalopram)
- Furosemide
- Hyoscine butylbromide
- Haloperidol
- Ibuprofen (naproxen, diclofenac, or meloxicam)
- Lactulose (sorbitol or polyethylene glycol)
- Loperamide
- Metaclopramide
- Metronidazole
- Morphine (oral immediate-release and injectable)
- Naloxone parenteral
- Omeprazole
- Ondansetron
- Paracetamol
- Petroleum jelly

Medical equipment
- Pressure-reducing mattress
- Nasogastric drainage or feeding tube
- Urinary catheters
- Opioid lock box
- Flashlight with rechargeable battery (if no access to electricity)
- Adult diapers (or cotton and plastic, if in extreme poverty)
- Oxygen

Human resources (varies by referral, provincial or district hospital, community health center, or home
- Doctors (specialty and general, depending on level of care)
- Nurses (specialty and general)
- Social workers and counsellors
- Psychiatrist, psychologist, or counsellor (depending on level of care)
- Physical therapist
- Pharmacist
- Community health workers
- Clinical support staff (diagnostic imaging, laboratory technician, nutritionist)
- Non-clinical support staff (administration, cleaning)

Additional detail is provided in the additional online material.

Kenya's Constitutional and Policy Commitments to Palliative Care

Kenya is a signatory to various international and regional treaties, declarations and resolutions that commit governments to integrate and ensure access to holistic palliative care services for children and adults at all levels of care. The World Health Assembly resolution 67.19 called for strengthening of integration of palliative care services into national health systems and defines palliative care as a basic human right. It advocates for a holistic service integrated throughout the continuum of care at all levels of the health system. The Global Action Plan for the Prevention and Control of Non-Communicable Diseases 2013 - 2020 provides for development and implementation of a Palliative Care Policy using cost-effective treatment modalities, including opioids, analgesics for pain relief and training health workers. The Sustainable Development Goal 3 was adopted in 2016 as a universal call to action to ensure healthy lives and promote wellbeing for all at all ages including palliative care.

Kenya's Constitution and legislative framework recognizes the right to health services and emergency medical treatment. As such, the state obligation to respect, protect and fulfill this right should be expressed. This is reinforced further in the Kenya Health Act 2017, Vision 2030 and Kenya Health Policy 2014-2030. The country is progressing towards Universal Health Coverage which aims to ensure that all Kenyans have access to quality promotive, preventive, curative, rehabilitative and palliative health services without suffering financial hardship.

Below are some of the legislative and policy articles touching on palliative care:

Constitution of Kenya	Article 43(1) Every person has the right to: the highest attainable standard of health, which includes the right to healthcare services such as palliative care.
Vision 2030	To improve the overall livelihood of Kenyans, the country aims to provide and efficient integrated and high-quality affordable health care system with the highest standards of care.
Kenya Health Policy	Aims to design and implement integrated health service provision tools, mechanisms, and processes, with a view to enhancing comprehensive control of diseases;
Kenya Health Act, 2017	Emphasizes on standard of health which shall include progressive access for provision of promotive, preventive, curative, palliative and rehabilitative services.
Narcotic Drugs and Psychotropic substances (control) Act of 1994 CAP.245. (Rev. 2012)	Makes provision for prescription of opioids by a medical practitioner, dentist for medical or dental treatment of the person. Other cadres are restricted from prescription. The Act in subsection 84 however makes provision for the Minister to make regulations for any of the following matters including (d) on regulating the issue of prescriptions containing narcotic or psychotropic substances.
Kenya Cancer Policy 2019-2030	Objective 5 outlines the need to promote access to optimal diagnostics, treatment, palliative care and survivorship care for cancer patients
Nurses and Midwifery Act Cap 257	Section 13 (a) outlines the conditions under which the Nursing Council of Kenya (NCK) may register a person, "has undergone a prescribed course of instruction and has passed the appropriate examination conducted or prescribed by the Council". Further section 2 recognizes palliative care nurses as a specialist discipline.

The **National Cancer Control Strategy 2017-2022** describes palliative care as the active total care of the body, mind and spirit of the patient, and involves giving support to the family from the time of diagnosis and throughout the continuum of care. It supports training of all healthcare workers on use of opioids for pain management, breaking bad news, end of life care, bereavement, palliative care, depression in cancer and sexual issues after treatment.

The **National Palliative Care Guidelines 2013** envision an effective and efficient national palliative care program in order to achieve the goal of providing holistic and quality palliative care services to patients and families faced with life threatening illnesses throughout the country.

Situational Analysis

Kenya is located in East Africa along the equator and has a population of 47,564,296 people. It covers an area of 580, 367 km2 and is bordered by Ethiopia and Sudan to the North, Somalia to the East, Uganda and Tanzania to the West. Kenya has a devolved system of governance with a total of 47 counties. With the new constitutional dispensation, emphasis has been placed on organization and management of health services including palliative care service delivery at the county level.

Much of the palliative care services in Kenya has been provided by Non-Governmental Organizations (NGOs). In 2005, a team of palliative care providers from 7 hospices joined hands to register the Kenya Hospices and Palliative Care Association (KEHPCA) as an NGO mandated to coordinate palliative care services in the country. By 2007, an active secretariat was in place whose role was to advocate for availability of palliative care services. Palliative care service provision was through mission hospitals, hospices and private facilities in 18 sites. Through partnership with the Ministry of health, it was agreed that the services need to be integrated into government health facilities. This also included integrating palliative care in undergraduate training curriculum in nursing and medical schools. Currently palliative care has been integrated in 78 health facilities in 42 out of the 47 counties.

The Kenya Health Facility Assessment conducted in 2018 revealed that mean availability of palliative care services in Kenya was low with only 3% of health facilities offering the services. It also showed that the mean availability of tracer items for palliative care like morphine was only 5% among facilities offering palliative services. Additionally, of the facilities that reported they offer palliative care services, only 7% had all the tracer items.

Persons living with palliative care needs currently access palliative care services from hospices, government facilities, faith-based facilities and through community organizations.

PALLIATIVE CARE IN KENYA : SITUATIONAL ANALYSIS		
LEADERSHIP AND GOVERNANCE	• National Cancer Plan, with PC Section	Yes
	• National HIV Plan with PC Section	Yes
	• National PC plan	No
	• PC Clinical Guidelines	Yes
	• MoH PC Focal Person	Yes
HEALTH FINANCING	• PC allocation in Health Budget	No
HUMAN RESOURCE	• Training Program for PC Workforce	Yes
	• Trained PC Nurses prescribing Morphine***	No
HEALTH PRODUCTS	• Availability of Morphine	Yes
HEALTH INFORMATION	• No of patients accessing PC Services in 2019	14,352
SERVICE DELIVERY	• Counties with PC Services	42/47
	• No of PC Patients served (2016)	3000
	• Hospitals with in- patients for PC	58/300
	• No of Home-Based care for PC	18/70
ADVOCACY	• National Association for PC	Yes
	• National Conference for PC	Yes

*** This issue needs legislative action to effect it.

Further, there has been a growing body of evidence and case studies on legal support in palliative care—from reflection on approaches to legal support to iterations of the rights of palliative care patients. Although each individual faces unique challenges, there are some globally recognized commonalities in the legal and rights issues specific to palliative care patients. Common legal issues include disposing of property, drafting wills, family law matters and planning for children, addressing discrimination -particularly for patients living with HIV and Cancer - or navigating obstacles in the justice system.

In Kenya, some hospices have developed partnerships with legal aid providers to expand access to legal services for palliative care patients via hospice referrals. In 2015, Nyeri Hospice and KEHPCA commenced a pilot project documenting patient legal issues via an electronic data management system it was hoped that the data collected during the project could be used as evidence to boost awareness of patients' legal needs and advocate for scale up of legal support in palliative care in Kenya and establish a new component in holistic palliative care.

A baseline assessment survey was conducted between August 2018 and January 2019 to identify gaps in palliative care service provision in Kenya. This survey targeted key informants, policy makers, healthcare providers, PLWPCNs and training institutions. The survey revealed the following gaps:

1. Palliative care is not adequately provided across the healthcare levels;

2. Lack of care for healthcare workers providing palliative care;

3. Inadequate access to palliative care services;

4. Inadequate care for caregivers of persons living with palliative care needs;

5. Lack of awareness in the community on the importance and need for palliative care;

6. Lack of dissemination of palliative policies and guidelines to policy makers;

7. Inadequate capacity for healthcare workers to adequately provide palliative care services;

8. Lack of recognition of palliative care and career progression by some professional regulatory bodies;

9. Inadequate palliative care student placement while in training.

It is hoped that this national policy framework will therefore provide guidance and a framework within which to plan for the strengthening and implementation of palliative care services in Kenya.

CHAPTER TWO

> To promote awareness and education among all stakeholders including the media, religious leaders, the general public and public servants.

Policy Pillars

This policy is anchored on the following pillars:

1. Advocacy and communication
2. Leadership and governance
3. Service delivery
4. Availability and access to essential medicines and commodities
5. Human resource and education
6. Health information systems and research
7. Healthcare financing

2.1 Advocacy and Communication.

Advocacy is critical in ensuring that palliative care services are accessible at all levels of care and should be applied at individual, community and systemic levels to address serious health related suffering. Communication is important to ensure that palliative care is understood at all levels by the public, policy makers, health care workers and all the other relevant stakeholders.

Challenges

1. Limited awareness on palliative care- a lack of understanding on what palliative care is and what it is not, that is, end of life.
2. Limited access to proper information on palliative care and service availability.
3. Inadequate information, education and communication materials on palliative and hospice care.
4. Limited integration and coverage of palliative care in health forums and activities.
5. Lack of funding for advocacy activities and training

Priority Actions

To promote access to information and awareness on palliative care, the following initiatives will be undertaken;

1. Strengthen advocacy and information management initiatives among all relevant stakeholders on holistic palliative care, concepts and practices
2. Develop and disseminate a communication strategy on palliative care to promote awareness and education among all stakeholders including the media, religious leaders, the general public and public servants.
3. Ensure annual recognition and celebration of national and global palliative care events at all levels of government.
4. Develop and disseminate information, education and communication materials on palliative care targeting various audiences at all levels of governance, from community to national level.
5. Promote the integration of palliative care information, education and communication in all relevant chronic disease areas and health forums at national and county level.

2.2 Leadership & Governance.

Leadership and governance involve ensuring structures and strategic policy frameworks exist and are combined with effective engagement, co-ordination, oversight, coalition-building, regulation, attention to system design and accountability. This policy will be aligned with the highlighted frameworks to ensure provision of holistic palliative care services to all stakeholders.

Challenges

1. There is a poorly defined structure for palliative care stakeholders' engagement and coordination,
2. An appropriate governance structure for palliative care at both the national and county levels is lacking.
3. There is limited knowledge and support for palliative care initiatives among decision makers both at national and county levels
4. There exist prohibitive laws limiting prescription and access to opioids for palliative care.

Priority Actions

To promote leadership and governance in palliative care at national and county levels, the following initiatives will be undertaken;

1. Establish a well-coordinated palliative care leadership and governance framework with clearly defined roles an responsibilities at the national, county and institution level.
2. Establish mechanisms to mainstream palliative care within the health sector and beyond.
3. Develop, regularly update and disseminate national guidelines to ensure standards for provision of quality palliative care services
4. Advocate for prioritization of palliative care resources by policy makers at all levels of governance
5. Inclusion of palliative care in all relevant government policies, strategies, guidelines and plans across all chronic disease conditions including within special populations.
6. Review of the Narcotic Drugs and Psychotropic substances (control) Act and development of appropriate regulations to improve access to opioids for legitimate use by all patients in need.

2.3 Service Delivery.

The Government is committed to ensuring access to holistic and culturally appropriate palliative care services to all those in need. Majority of palliative care patients will have needs that can be addressed at the community or within primary care settings.

Challenges

1. Lack of a well-defined standardized package for the provision of holistic palliative care services at all levels of the health system.
2. Poor implementation of existing palliative care guidelines
3. Inadequate access to palliative care services across all levels of care with poor community linkages
4. Lack of standards of care for holistic palliative care service provision
5. Lack of effective private/public partnerships for collaboration on palliative care service provision
6. Lack of integration of palliative care in various chronic and emerging disease care models
7. A general lack of awareness on patients' rights leading to violations against those with life-threatening illnesses
8. Lack of prioritization of legal and spiritual needs of patients with life-threatening and life limiting illness
9. Population aging, isolation of elders, and growing Non Communicable Disease burden among older persons

Priority Actions

To promote service delivery in palliative care at all levels of care, the following initiatives will be undertaken;

1. Define a holistic package of palliative care services for provision across all levels of the healthsystem for all ages, related to the patient's level of function.
2. Ensure utilization of palliative care guidelines for standardization and holistic palliative care provision
3. Establish structures for effective collaboration with relevant stakeholders including NGOs and private sector to strengthen palliative care service delivery
4. Establishment of palliative care services in health facilities at all levels of care with clearly defined linkages to community and home-based care systems.
5. Integrate palliative care in all relevant chronic and emerging disease care models at all levels of care including through an interdisciplinary team approach.
6. Advance the inclusion of legal and spiritual support as essential components of holistic palliative care services.
7. Promote increased access to palliative care for children.

2.4 Availability and Access to Essential Medicines and Commodities.

Access to medicines, equipment and commodities for palliative care should be as outlined in the WHO and the national essential lists. These medicines, equipment and commodities should be accessible and affordable at all levels of care for all patients who need them at the time and place where they are required.

Challenges

1. Limited incorporation of essential palliative care medicines, commodities and equipment in relevant essential lists

2. Limited funding for the procurement of essential palliative care medicines and commodities

3. Low prioritization of essential palliative care medicines and commodities

4. Unaffordable prices of essential medicines and commodities for palliative care

5. Low demand and negative attitudes towards opioids (prescription, dispensing, use)

6. Limited capacity of professionals on use of the essential palliative care medicines, equipment and commodities.

Priority Actions

To promote the accessibility of essential palliative medicines and commodities, the following will be undertaken;

1. Incorporate essential palliative care medicines, equipment and commodities in the Kenya Essential Medicines,Equipment and Commodities lists

2. Enhance funding for essential palliative care medicines and commodities

3. Subsidize the prices and review taxation for essential palliative care medicines and commodities

4. Include palliative care services in the Universal Health Coverage and insurance benefit packages

5. Improve the capacity, number and distribution of legal opioid prescribers for the effective management of moderate to severe pain

6. Strengthen the supply chain management and reporting systems for opioids and pain medicines at all levels of care including for the provision of locally reconstituted oral morphine solution.

2.5 Human Resource and Education.

A knowledgeable, skilled and motivated health workforce in adequate numbers is critical to the delivery of palliative care services; the provision of palliative care services is multidisciplinary. Health Care providers should be trained to offer differing levels of palliative care.

Challenges

1. Inadequate workforce to provide holistic palliative care services at different levels of care
2. Inadequate capacity of the workforce to provide holistic palliative care services at different levels of care
3. Lack of recognition, motivation and inadequate support for Palliative Care providers
4. Inadequate structures to promote career growth, remuneration and recognition of basic and specialist palliative care cadres.

Priority Actions

To promote human resource capacity in palliative care the following will be undertaken;

1. Deployment of adequate and dedicated trained workforce for the provision of holistic palliative care services at different levels of healthcare
2. Build the capacity of the existing workforce to provide holistic palliative care services through continued in service training
3. Develop and implement strategies and support systems to prevent burnout among palliative care providers
4. Develop structures to promote career growth and progression, remuneration and recognition including retention and development of appropriate schemes of service for palliative care providers
5. Promote task shifting and task sharing for human resources in provision of palliative care services including opioid prescription as per relevant scopes of practice through engagement with relevant regulatory bodies.
6. Integrate palliative care training into all curricula for health related courses at diploma,undergraduate and graduate level so that all health workers are trained on palliative care.
7. Liaise with Ministry of Education to develop curricula and roll out relevant palliative care training programs at diploma and postgraduate level.

2.6 Health Information Systems and Research.

Health information systems should provide timely, reliable and accessible quality health service information for evidence-based decision making to maximize utilization of scarce resources. Research in palliative care will generate innovative solutions to emerging challenges across the spectrum of care. Currently there exists a palliative care tool in the Kenya Health Information System whose reporting rate is low.

Challenges

1. Inadequate, inconsistent collection and reporting of data on hospice and palliative care

2. Inadequate research for palliative care and data system management.

3. Inadequate monitoring and evaluation framework for palliative care services.

4. Relatively low use and translation of data to influence decision making

Priority Actions

To strengthen health information systems and research in palliative care, the following will be done:

1. Review key indicators for monitoring palliative care services and incorporate in the Kenya Health Information System

2. Review and revise palliative care data collection tools and sensitize health workers on their use

3. Strengthen palliative care services and commodity management reporting (including International Narcotics Control Board (INCB) and integration in the Kenya Health Information System

4. Adopt digitalization of palliative care health record systems with linkages to relevant databases including disease specific registries, insurance and mortality databases.

5. Allocate adequate resources and build capacity for research in palliative care in collaboration with stakeholders

6. Strengthen use of data and research findings for policy and decision making in palliative care.

2.7 Health Care Financing.

All stakeholders will mobilize adequate financial resources to facilitate successful coordination, implementation, monitoring and sustainability of palliative care services.

Challenges

1. Low prioritization of palliative care planning and financing at both national and county governments

2. Inadequate financial coverage for palliative care services at all levels of care

3. Lack of dedicated budgetary allocations to support essential package for palliative care.

Priority Actions

1. Promote inclusion of essential palliative care services and commodities in annual work plans and integrated development plans both at the national and county governments to ensure its prioritization.

2. Promote allocation of dedicated budgets to support a minimum essential package of palliative care across the various levels of care.

3. Strengthen public-private partnerships with the goal of resource mobilization for palliative care services implementation

4. Encourage provision of appropriate palliative care packages in both private insurance and government social insurance scheme (NHIF).

5. Integrate palliative care benefit packages within the Universal Health Care plans and budgets.

CHAPTER THREE

> "Establish and implement guidelines on end-of-life care, advance directives and DNR requests"

Key Policy Considerations

Section 1: End of Life Care

End-of-life care is the term used to describe care provided during the period when death is imminent, and life expectancy is limited to a short time. Quality end-of-life care is realized when strong networks exist between multidisciplinary palliative care providers, caregivers and community. It includes physical, spiritual, psychosocial assessment, care and treatment delivered by healthcare workers and caregivers. End-of-life care acknowledges that the patients approaching death may magnify the intensity of physical, psychological, existential, spiritual and family issues. It also includes support of family and carers, and care of the patient's body after their death and the bereavement period. The policy requires that care and comfort is given to clients who are dying, their, death is handled with dignity and propriety, and their spiritual needs, rights and functions are observed. It also requires that institutions providing in-patient care should have in place policies and procedures for handling death and the dying and ensure that all staff observe these.

Each aspect of the end-of-life care should be handled sensitively with the aim of ensuring people can die in a dignified, respectful manner, as free from pain and distress as possible and in accordance with their own wishes.

Challenges

1. Limited capacity of the health care providers and community carers to provide end of life care
2. Limited guidelines on end of life care
3. Legal and ethical issues and dilemmas at end of life
4. Cultural and spiritual aspects at end of life

Priority Actions

To promote end of life care the following will be undertaken:

1. Build the capacity of the community and health care providers to provide end of life care
2. Establish and implement guidelines on end of life care
3. Promote enactment and enforcement of legislation to guide appropriate practice at the end of life
4. Define and establish a framework on ethical issues to address dilemmas at end of life
5. Address cultural and spiritual practices and beliefs at end of life and death

Section 2: Advance Directives (AD)

Directives given by a patient on the level of care they prefer or interventions that should or should not be instituted during their treatment when they are not in a capacity to make decisions for themselves. This directive is given in writing by a patient in discussion with their doctor or in some cases with their lawyer in the process of advance care planning (ACP). The health provider must document the mental assessment status of the patient.

Challenges

1. Legal and ethical challenges on the basis of Advance Directives
2. Reluctance of medical professionals to initiate these discussions

3. Reluctance of patients to hold these discussions

4. Low knowledge and skills in regard to the importance and role of Advanced Care Planning in meeting quality care. This is by patients, families, practitioners, policy makers and the community at large.

5. Socio-cultural norms affecting decision making processes

Priority Actions

1. Establish and implement guidelines on Advance Directives

2. Build capacity for health care providers to hold Advanced Care Planning discussions with their patients

3. Empower patients and caregivers on Advanced Care Planning

Section 3: Do Not Resuscitate (DNR)

The clinician of the PLWPCN writes the order only after having discussions with the patient (if possible), the proxy, or the patient's family. In the event that the patient is unable to state his /her wishes due to illness or injury, the following apply:

- The family may not override a clinician's order for DNR that was given by the patient
- A patient's legal guardian or health care agent (holder of medical power of attorney) can request for a DNR order from the clinician on behalf of the patient.

Challenges

1. Legal and ethical dilemmas during a Do Not Resuscitate request

2. Reluctance from medical personnel to issue a Do Not Resuscitate order

3. Inadequate information to allow patients to make informed decisions on Do Not Resuscitate

4. Delayed discussions on Do Not Resuscitate limiting the patient's participation in the Do Not Resuscitate decision

Priority Actions

1. Establish and implement guidelines on Do Not Resuscitate requests

2. Define and establish a framework on ethical issues to address dilemmas around Do Not Resuscitate requests

3. Build the capacity of healthcare workers to provide timely Do Not Resuscitate support when needed.

Section 4: Survivorship

An individual is considered a survivor from the time of diagnosis of a serious health related condition, during and immediately after treatment, and through the balance of his or her life. The disease also affects family members, friends, and caregivers.

SURVIVORSHIP

SOCIAL
FINANCIAL
SEXUAL

PSYCHOLOGICAL
INTELLECTUAL
SPIRITUAL

PHYSICAL

Challenges

1. Lack of a framework to guide survivorship care aspects
2. A fragmented and poorly coordinated multi-sectoral approach
3. Limited research to guide the implementation of survivorship programs
4. Inadequate resources for survivorship programs

Priority Actions

1. Develop a survivorship care framework that focuses on holistic approach including clinical care, financial empowerment,reintegration into society and rehabilitation among others.
2. Strengthen the existing health care system to ensure well-coordinated survivorship care
3. Promote research on survivorship and utilize evidence-based practices
4. Allocate adequate resources for the implementation of the survivorship framework (Financing, Human resources, Health products and technologies).

Section 5: Palliative Care Needs in Special Populations

As per the World Health Assembly resolution, this policy intends that palliative care services must be accessible to all. It is therefore important to highlight the needs of special populations (such as individuals with disabilities, children (including neonates and adolescents), older persons including those living in institutional care settings, asylum seekers and refugees, those experiencing homelessness including street children, persons in long term care facilities such as Tuberculosis and Psychiatric patients and inmates in correctional services) when planning for palliative care services so that their needs are identified and met. Palliative care services should be accessible to all persons with special needs, and should be tailored to address the needs of the special populations. Different local needs and situations will require different models of care. Internationally, different models of palliative care service delivery based on needs in a population have been developed and different counties may adopt a model or combination of models that best suit their needs.

Challenges

1. Lack of definition of palliative care package for special needs populations
2. Lack of integration of palliative care services for special populations
3. Inadequate capacity of healthcare workers to provide palliative care services to special population groups

Priority Actions

1. Allocate adequate resources for palliative care services among special populations
2. Integrate and institutionalize identification and provision of palliative care services in special populations
3. Avail adequately trained workforce for the provision of holistic palliative care services in special populations

CHAPTER
FOUR

> "The Ministry of Health will take lead in the implementation of this policy"

Section 1: Key Stakeholders

	Stakeholder	Role of Key Stakeholders in Palliative Care
1.	**National government**	
	a) Ministry of health	1. The MOH relevant programs will take lead in the dissemination and integration of this policy within relevant departments and divisions (Cancer, HIV, TB, Child health, Reproductive health, Mental health, nutrition) as well as other SAGAs: National Cancer Institute-Kenya, National Aids Control Council, National Referral Hospitals among others. 2. Take lead in developing strategic plans, standards and guidelines to operationalize the policy 3. Provide technical and logistical support to ensure that there is adequate capacity for implementation of this policy. 4. Conduct capacity building on palliative care among health care providers 5. Promote research on palliative care
	b) Ministry of Education	1. Ensure palliative care education is included in the school curriculum 2. Formulate and implement PC training curriculum for training institutions 3. Accredit palliative care training institutions 4. Support expansion of palliative care training programs including through provision of scholarships 5. Institutionalize palliative care in all health worker trainings to improve service delivery 6. Promote palliative care research
	c) Ministry of Finance	Provide adequate resources for the implementation of this policy
	d) Other government ministries and institutions	Collaborate with MOH in mainstreaming palliative care training, research, innovation, infrastructure development and seamless provision of technology and products
2.	**County governments**	1. Allocate adequate resources for the provision of palliative care services including through employment of relevant cadres trained in palliative care. 2. Provide access to palliative care services 3. Strengthen capacity for palliative care at the County level. 4. Forge appropriate multi-sectoral partnerships at the county level. 5. Implement national government policies and guidelines for Palliative Care 6. Provide quality and timely reports on Palliative Care
3.	**Civil society organizations including KEHPCA and survivor support groups**	1. Spearhead PC advocacy and integration of PC across counties 2. Participate in policy formulation, research, financing and implementation palliative care programs. 3. Promote awareness on palliative care and demand creation for palliative services at all levels of care. 4. Provide psycho-social support for survivors and PLWPCNs

4.	**Palliative care providers**	1. Ensure provision and coordination of quality PC services 2. Influence of skills and knowledge through on-job learning, mentorship and research 3. Liaison at all levels of care 4. Support implementation of the policy at all levels of care
5.	**Regulatory bodies (PPB, KMPDC, Nursing Council, Clinical Officers Council, NCI-K)**	1. Recognition and accreditation of PC 2. Definition of PC structures and organograms 3. Regulate and enforce aspects of the policy related to their respective body 4. Advocacy and provision of guidelines on PC matters 5. Provide direction on prescription and handling of opioids in palliative care.
6.	**Medical supply agencies (Including KEMSA, MEDS among others)**	1. Stock and supply essential PC medicines and commodities including oral morphine 2. Facilitate, procurement, storage and distribution of essential PC commodities 3. Recommend other stakeholders who can support procurement of PC commodities 4. Identify and recommend digital technologies applicable for the said supply and distribution of PC commodities
7.	**Training institutions**	1. Institutionalize palliative care in all health training programs 2. Promote establishment of Palliative Care education and training programs 3. Conduct Palliative Care research 4. Inform and guide policy review and development of PC guidelines 5. Support community awareness creation on PC
8.	**Insurance providers (Including NHIF and Private insurance)**	Provide timely and comprehensive medical insurance package for palliative care and survivorship in line with this policy
9.	**The public and persons living with palliative care needs**	1. Utilization of palliative care services 2. To participate in policy formulation, implementation and improvement of palliative care services 3. Participate in PC awareness creation and communication within their communities
10.	**Legal Practitioners**	Providing legal guidance for health workers, policy makers and PLWPCNs on palliative care
11.	**Development Partners**	To provide technical and financial resources for implementation of this policy.
12.	**Media houses**	1. Create awareness on Palliative Care 2. Advocate for quality reporting on Palliative Care 3. Dissemination of accurate Palliative Care information to create public awareness
13.	**Complementary and alternative services providers**	These services should be provided in a manner compatible with conventional treatment. They include herbalists and traditional healers.

Section 2: Monitoring, Evaluation and Reporting

The Ministry of Health will periodically review the implementation process and address gaps that hinder the realization of the policy goals and objectives. The Ministry will also document the lessons learnt and the outcomes of evaluation to guide the ongoing planning, and implementation of the various activities. To improve quality of care, the Ministry will prioritize digitization of reporting tools and linkage to databases such as the National Cancer Registry, insurance bodies, Pharmacy and Poisons' Board and Vital Statistics to enhance quality of data for proper decision making.

Management, monitoring and evaluation of implemented activities will be under the supervision of existing organs and structures in the Ministry of Health, County Governments, Kenya Hospices and Palliative Care Association (KEHPCA) and other stakeholders.

Policy Monitoring Framework

This policy document will have annual, mid-term and an end term reviews. The monitoring and evaluation of this policy should be aligned to the implementation framework in the Kenya Health Policy 2014-2030. The MOH and stakeholders may revise the policy depending on any emerging national or patient needs or changes that affect the provision of hospice and palliative care.

The table below outlines the indicators and targets for this policy

Pillar	Impact level indicators	2021 estimates	2030 target
Advocacy and communication	Number of patients (adults) and children in need of palliative care accessing services	14,552	400,000
Leadership and governance	Number of counties that have incorporated palliative care included in to their County Health Strategic Plan and Annual Work Plans	5	47
Health financing	Percentage of National and county budgets including UHC allocated to palliative care	0.1%	1%
Human resource	Number of personnel providing palliative care services	250	5000
	Number of nurses trained to prescribe opioids	100	1,000
Education	Number of core curricula that have integrated palliative care	7	14
Service delivery	Mean availability of palliative care services	3%	50%
Availability and access to essential commodities and supplies	Mean availability of tracer items for palliative care like morphine	5-7%	50%

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Annex 1: Health Care Provider expertise by Level of Care

Levels of Palliative Care Expertise	Skills of Health Care Workers	Level of Health Service Delivery
Palliative Care Approach (All health care Workers including Community Health Volunteers)	A Palliative care approach can be offered by any cadre of health care worker (HCW), Community Health Care Worker (CHW) and Community Health Volunteer (CHV) at all levels of the health system. The palliative care approach should be included in all pre-service and in-service trainings. The undergraduate curricula of health professionals should include the palliative care approach. Most patients will have needs that can be adequately met by HCWs, CHWs and CHVs with this level of skill.	Community Primary care clinics Community Health Centres Sub County hospitals County Hospitals Tertiary/ National Referral Hospitals (NonPalliative Care Specialists)
General Palliative Care (Nurses, doctors, Clinical Officers, Allied health)	General palliative care may be offered by HCWs who are not full time palliative care practitioners but have a higher level of training in palliative care (such as a postgraduate diploma or family physicians with appropriate training in palliative care).	Community Primary care clinics Community Health Centres Sub County hospitals County Hospitals Tertiary/ National Referral Hospitals (Non Palliative Care Specialists)
Specialist Palliative Care (Nurses, doctors, Pharmacist, Pharmaceutical technologist Clinical Officers, Allied health)	Specialist palliative care services are provided by fulltime palliative care specialists with relevant specialist postgraduate training in palliative care. These HCWs will care for patients with complex or high intensity needs.	Sub County hospitals County Hospitals Tertiary/ National Referral Hospitals

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In the end, it's not the years in your life that count. It's the life in your years.

Abraham Lincoln

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