

Rapid Appraisal of Palliative Care and Community and Home Based Care in Abidjan, Côte D'Ivoire

Summary Report

**For the Ministere d'Etat, Ministere de la Sante et
de la Population**

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Executive Summary

Rationale for Rapid Appraisal

As part of a three-pronged approach to strengthening support for people living with HIV and AIDS (PLHA) the Centers for Disease Control (CDC), Côte D'Ivoire requested technical assistance from Family Health International (FHI) in developing a strategy for home and community-based care and palliative care for the country. A lack of data on care in life-limiting illnesses, including AIDS and cancer, created the necessity for a rapid appraisal of existing services in community-based and palliative care. The appraisal also aimed to document the range of services provided and review enabling and constraining factors in the expansion of home and community-based care and palliative care.

In developing the appraisal it became evident that there were several and varying understandings of what community and home-based care and palliative care involved and definitions were not clear. It was against this background that the rapid appraisal was carried out. This report summarizes the findings and recommendations of the appraisal team.

Methodology

The appraisal consisted of a document review (see appendix 1) followed by site visits to those organizations deemed to be most representative of community and home-based care and palliative care. In-depth interviews with program staff and managers of services at tertiary and community level and were complemented by interviews with representatives of government departments involved in supervision, regulation or provision of aspects of care.

Main Findings

Palliative Care is Understood by Many, Practiced by Few

The term *soins palliatifs* is commonly heard on visiting programs caring for people with AIDS or cancer. It is generally understood, in lay terms, in a narrow context of “being with” the dying person, but in many of the services visited there was a clear understanding that palliative care embraces physical, emotional, social, psychological and spiritual care. How to provide the physical aspects of palliative care to the satisfaction of the client and the caregiver was a source of concern for many program staff. For many programs in the community the staff realized there needed to be more and better or different care but felt they were not equipped with the skills, knowledge, resources or drugs to achieve it.

For community programs home-based care often referred in reality to all the other aspects of care which they provided in the home, aside from the physical care which they did not feel skilled to perform; and included social visits, food and clothing distribution,

engagement with clients to join support groups, carrying prevention messages and encouraging attendance for counseling and testing, education for hygiene and for care of children. Thus, while there was in many programs an understanding of the need for comprehensive care including physical care and including addressing physical needs such as pain and symptom management, it was only in a few community programs that efforts were made to address all these needs; within the limits of the resources available.

At tertiary level, in some of the teaching hospitals there were individuals and specialist programs which had developed systems of palliative care originally in response to the need to address acute and chronic pain for their patients. The staff in these services had access to opioids for their clients, though this access was not always easy, and had for the most part taught themselves and their colleagues the principles and practice of palliative care. They were aware that most of their focus was on pain and symptom management as these were urgent needs and acknowledged the lack of being able to address other aspects of palliative care such as social emotional and bereavement care needs, due to lack of human resources.

Together, though they currently worked in isolation, the community and home-based care approaches and the tertiary level palliative care provision effectively combined to provide a comprehensive understanding of all that is needed for palliative care to develop effectively in a community and home-based care setting. The obvious next step is integration of all these existing skills, knowledge and experiences into one unified national palliative care strategy which would enable effective and comprehensive palliative care at all levels of health care including in the home.

Recommendations

The government of Côte D'Ivoire has a unique opportunity to expand on existing care and support services to develop an integrated model of community-based palliative care which could deliver palliative care wherever it was needed.

To achieve this goal it will need to address the three key elements of palliative care provision – government commitment, education and access to essential drugs.

This requires raising awareness of the need for palliative care at a national level and the development of a strategy for systematic expansion of existing palliative care approaches. It is best undertaken by a carefully selected palliative care task force which would act both as an advisory body in strategy development and implementation and carry out the steps in implementation of the palliative care strategy which would enable access to palliative care at all levels.

This undertaking requires funds and resources including technical assistance, and it behoves international donors to support such an initiative which would stand as a model for palliative care in resource-poor settings.

Background

Country Background

Côte d'Ivoire is a small West African country located on the coastline of the North Atlantic Ocean. It is bordered by Ghana to the east, Burkina Faso and Mali to the north, and Guinea and Liberia to the west and covers 322,460 square kilometers. The current population is estimated at 16.8 million, of which about 45% are below the age of 14¹. The population of Côte D'Ivoire's capital, Abidjan, is estimated as at least over 2 million, with some estimates as high as five million.

A combination of social, political and economic factors have combined in the last five years to change Côte D'Ivoire's status as one of the most prosperous of tropical African states into a country with fragile economic and social stability and with deteriorating United Nations Human Development Index (HDI) and per capita income rank². Currently, the infant mortality rate is 113 deaths per 1,000 live births and the under- 5 mortality rate is 167 deaths per 1,000 live deaths. The average life expectancy is just over 45 years³.

A military coup occurred in 1999; this was followed in 2002 by a political and military crisis as a result of an armed rebellion against the regular army of the country which had the effect of dividing the country into rebel-held North and government- controlled South. Although a power-sharing agreement was reached in July 2004, the years of unrest, together with considerable immigration from neighboring countries, including a marked increase in refugees from the civil war in its neighbor, Liberia, have resulted in severe and continuing economic, humanitarian, and social consequences, including massive population displacement, impoverishment, large-scale military deployment, and disrupted health and other essential services in the North³.

Most recently, in November 2004, fighting erupted again for a short time with further short-term disruption to health and other sector services.

Health Care and Service Provision

There are three levels within the health system in Côte D'Ivoire – the central level which is responsible for policy development, resource mobilization, coordination of management and performance evaluation, the regional level, responsible for oversight and coordination of districts, and the district level which is responsible for operations.

In June 1994 district health systems were created within each region of the country as part of the process of government decentralization in Côte D'Ivoire. There are currently 19 regions with at least 3 districts in each; more in some regions. These district health systems were to be responsible for all major activities in health including operational planning, health information systems, integration of vertical programs, health service provision, personnel training, capacity-building in management and ensuring local participation. Following the creation of the district health systems, in 1996, the national

¹ UNAIDS. Epidemiological fact sheet. 2004 Update.

² World Bank. Cote D'Ivoire HIV/AIDS Multi - Sector Response Project Vol. 1

³ World Health Organization. 2004. World Health Report.

government developed a National Health Development Plan (*Plan National de Développement Sanitaire (PNDS)*) for 1996 - 2005 with three specific objectives :- to reduce mortality and morbidity caused by the major health problems in the country; to improve the efficiency and efficacy of the health system and to improve the quality of service provision.

However, resource constraints and a lack of administrative and political capacity and accountability, have made these goals difficult to achieve. Data in the Côte D'Ivoire National Health Report for the years 1999-2000 show 1 primary health care centre per 12672 people, 1 hospital per 233,867 people and 1 hospital laboratory facility for every 324,551 people. There were at that time 1 doctor per 9908, 1 nurse per 2416 and 1 midwife per 2118 of the population⁴. Prevalence of malnutrition in children 0-5 years was 21% and health expenditure (private and public) per person was \$US 45⁵.

The socio-political effects of military and political upheaval and the ensuing economic crisis have combined to severely limit the ability of districts in the north to achieve the objectives of the plan and to meet the needs of local populations. State-run medical systems have been largely replaced by fee-for-service systems. Coordination between services, both public and private is fragmented, characterized by a lack of coordinated health information systems; difficulties with follow-up and case-finding; lack of transport, or the ability to pay for transport for clients to reach services⁶.

As a result of the political, economic and social instability, poverty has increased and services such as HIV prevention interventions, blood screening services, treatment for sexually transmitted infections (STI), tuberculosis (TB), referral for care and treatment for cancer and other health services have been significantly disrupted in areas outside the south of the country, creating new population-level risk factors for HIV and health needs in general. While public health interventions have been able to continue, political instability, population displacement and a weakened economy continue to pose a significant challenge to implementing health programs.

HIV/AIDS and Cancer in Côte D'Ivoire

HIV/AIDS

Côte d'Ivoire has the highest HIV prevalence rate in the West African region, currently estimated at between 7%-10% for the adult population. Both HIV-1 and HIV-2 are present, with HIV-1 more common. It is estimated that up to 770,000 adults and children are currently living with HIV or AIDS, with between 40,000 to 84,000 of these being children under the age of 14^{1,7}. HIV/AIDS has been the leading cause of adult mortality (15-49 years) since 1998 and TB is the most common opportunistic infection for people

⁴ Ministère Délégué auprès du Ministre de la Solidarité Charge de la Santé. Cote D'Ivoire. Rapport sur la Situation Sanitaire des Annees 1999 et 2000.

⁵ CIA World Fact Book. <http://cia.gov/cia/publications/factbook>

⁶ Echimane, A., Ahnoux, A., Adoubi, I., Hien, S., M'Bra, K., D'Horpock, A., Diomnade, M., Anongba, D., Mnesah-Adoh, I. and Parkin, D. 2000. Cancer Incidence in Abidjan, Ivory Coast. First results from the Cancer registry, 1995-1997. *Cancer*. Vol. 89. No. 3:653-662

with HIV/AIDS in Côte D'Ivoire. Cumulative deaths from AIDS are at least 420, 000 (1999 estimate) and the annual death rate from AIDS is over 70,000. More than 400, 000 children have lost one or both parents due to AIDS. Recent estimates that 53% (400,000) of HIV-positive persons are female compared to 330,000 males, and that AIDS among girls aged 15 - 19 years is up to 6.7 times that of boys in the same age group highlight the vulnerability of girls and women⁷.

The World Bank reported in 2004 that “the rapid expansion of the epidemic has already imposed a serious economic cost which adversely affects the production of wealth, labor and physical capital.” A decline in productivity, as a result of both the epidemic and civil unrest, has affected the government’s ability effectively to address needs for prevention, care and treatment, without support from outside donors. At the individual household level, since AIDS is now the leading cause of death, scarce funds that might have been used to provide for improving the well-being of families affected by AIDS are used to pay for funeral costs⁸.

In 2003, RIP+, the National Organization of People Living with HIV/AIDS, estimated that 25% of youth, 15% of private sector workers and 25% of the security and defense forces are infected, and that 1 teacher at secondary school level and 2 teachers at primary level die every day from AIDS⁹. In 1990, military medical records note that mortality rates, which were 3 deaths per 1,000 before 1990, surpassed 10 per 1,000 after 1990 and that the morbidity rate is estimated at about 30 per 1,000 when analyzing the various temporary permissions of convalescence. A mortality rate of 10 per 100 signifies that the number of military who die every year is equal to an entire battalion (approximately 150 military personnel). Over the last 8 years, the insurance benefits system created by the military has had a deficit of around 500,000,000 Francs CFA. In analyzing the preceding facts, even in the absence of an epidemiological study formally establishing the relationship between the above-mentioned facts and the epidemic of HIV/AIDS, it can be said without error that the military pays a grave tribute to HIV infection¹⁰.

Within the health system, every facility has seen the effects of HIV and AIDS. In 1997 it was estimated that 40% of hospital beds were occupied by people with AIDS. Risks for health workers are both real and perceived - 14% of health workers in specialist HIV/AIDS facilities have reported needle stick injury during performance of procedures with HIV-positive clients. The fear of needle stick injury contributes to a level of anxiety that often results in unwarranted health care worker referrals of clients presumed to be HIV-positive to specialist facilities, overloading those facilities and continuing a cycle of stigma and discrimination¹¹.

Efforts to address HIV/AIDS

⁷ World Bank. Cote D'Ivoire HIV/AIDS Multi - Sector Response Project Vol. 1

⁸ Ibid.

⁹ RIP+ 2003. Petition for Drugs for every Person in Cote D'Ivoire. planeta.online.fr/rip+/PETITION-rip_english.pdf

¹⁰ Ministry of Defense of Cote D'Ivoire. 2004. Sectoral Plan for HIV/AIDS.

¹¹ Ibid.

HIV was first diagnosed in Côte D'Ivoire in 1985. Although a national program for HIV/AIDS was created within the Ministry of Public Health in 1989¹², it was essentially directed towards prevention and policy development in treatment of opportunistic infections. Acknowledgement by government of the magnitude of the epidemic was limited until 2001 when HIV and AIDS were recognized as a national priority and a multi-sectoral, comprehensive approach was developed. This included the establishment of a National Ministry in charge of coordinating efforts to respond to HIV and AIDS (*the Ministère de la Lutte Contre le SIDA*), and the creation of a national strategic plan for 2002-2004 through extensive participatory consultation with all relevant stakeholders, and represented a significant shift in approach to the epidemic¹³. As part of this coordinated approach, and in collaboration with UNAIDS, *Le Fonds de Solidarite Therapeutique Internationale* (FSTI) (a French government initiative) – and Projet RETRO-CI (established in 1988 as a collaboration on research and epidemiology in HIV/AIDS between Centre for Disease Control, the Ministry of Health of Côte D'Ivoire and The Institute of Tropical Medicine in Antwerp (ITM)), a program was put in place in 1998 with a focus on access to antiretroviral drugs and treatment¹⁴.

This first strategic plan for HIV/AIDS has been reviewed and revised and a new national action plan for 2004-2006 has been developed with three main national objectives: to involve all sectors in a coordinated response to HIV/AIDS; to decentralize activities within the plan; and to adapt the national action plan to regional needs and priorities specific to departments and sectors¹⁵.

Priority areas for intervention have been articulated as access to care, treatment and referral services; prevention; reduction of socioeconomic impact; research and monitoring and evaluation¹⁶. Within the Ministry of Health an extensive structure of *directions* and *sous-directions* exists which clearly delineates the responsibilities of each department, and this includes those departments responsible for HIV/AIDS. This structure is replicated at regional level.

International support to Côte D'Ivoire, although disrupted during the period after the 1999 military coup, includes involvement of many of the United Nations organizations, the World Health Organization (WHO) and several partnerships with European and American organizations, with a considerable emphasis on prevention, and capacity-building in health services, for example in the areas of research and epidemiology, reproductive health, behavior change communication interventions and recently, treatment. Until now there have been only a very few international agencies working in care and support, specifically home based care (HBC) and palliative care approaches, namely Hope Worldwide, International HIV/AIDS Alliance, Care international and FHI.

¹² World Health Organization. 2004. World Health Report.

¹³ Ibid.

¹⁴ Ministère D'Etat, Ministère de la Santé et de la Population. Cote D'Ivoire. *Plan D'Action de Lutte contre le VIH/SIDA dans le Secteur de la Santé 2004-2006*

¹⁵ Ibid.

¹⁶ Ibid.

The national organization of people living with HIV/AIDS (PLHA), RIP+, has 22 non-government member organizations and is active in advocacy, in national and international campaigns, conferences and awareness-raising and in care and support, including organized supportive counseling as a part of the service provided by volunteer PLHA.

Until now, although the role of the community is recognized as an essential element in provision of care and incorporation of prevention within that care, and has been articulated thus within each National Plan, community involvement in care and support has been limited. For the most part, community care is carried out by small NGOs and this has tended to be confined to prevention activities and home-visiting for psycho-social support and distribution of resources, with very basic physical care, as a result of limited funds and limited human resources, with regard both to numbers and to skills and knowledge.

With regard to the NGO sector, although one *sous-direction* was confident that many NGOs existed outside of Abidjan, it was understood that the capacity of these NGOs needed considerable development and it was not clear how much involvement in direct care and support currently existed.

As part of the response to HIV and AIDS the *Guide National de Prise en Charge Communautaire des Personnes vivant avec le VIH/SIDA* was developed in 2002 by the Ministry of Health, Solidarity and Social Security with assistance from the USAID-funded Family Health and HIV/AIDS Project (*Santé Familiale et Prévention du SIDA*). The booklet combines basic guideline and training manual elements and is currently still in use by some programs.

Most of the programs visited as part of the rapid appraisal knew of and had used the booklet but since this appraisal was limited to Abidjan it was not possible to determine whether the booklet is in standard use by any groups involved in community care in other parts of Côte D'Ivoire.

Cancer

Until the last decade very little information was systematically gathered on the incidence of cancer in many countries in Africa, including Côte D'Ivoire. In 1994, however, under the auspices of the Ministry of Public Health, a Cancer Registry was established in Abidjan, to record all cases of cancer diagnosed within the city's population. The first published data from the registry, from the period 1995-1997 showed a total of 2815 cases of cancer registered, of which 1871 people were residents of Abidjan, corresponding to age-standardized incidence rates of 83.7 per 100000 in men and 98.6 per 100000 in women. The most common cancers were cancer of the liver (15%) and cancer of the prostate (15.8%) for men and breast cancer (25.7%) and cervical cancer (24%) for women⁶, all cancers with a significant symptom burden, including pain.

The registry currently registers about 1000 new people with cancer annually (disaggregated numbers for children and adults were not available), and the vast majority

of people present with advanced incurable disease. It is suggested that these figures may well under-represent the true incidence of people with cancer for several reasons; there is the possibility of under-estimation of the population at risk since cancer incidence estimates are based on available census data which may be several years old; hospital information systems, or even centralized indexes are rarely found; record-keeping is poor; there are inadequate diagnostic facilities; and, in common with many other resource-limited countries, it is likely that people with cancer do not always present for treatment since they cannot afford medical treatment in a fee-for-service system. Furthermore there is no one system for recording cause of death, so that case –finding becomes a slow and labor-intensive undertaking involving numerous follow-ups with individual hospital systems¹⁷.

The World Health Organization (WHO) estimates that there may be as many as 10,000 to 15,000 new cases of cancer per year in Côte D'Ivoire.

Efforts to address cancer

The establishment of a cancer registry is a significant step in addressing need for recognition and appropriate care and treatment of cancer as it is an essential part of comprehensive planning to address cancer in a systematic way - it enables documentation of cancer patterns, measurement of cancer burden, study of survival and evaluation of trends over time in the incidence of cancer. Côte D'Ivoire also has recently developed a National Action Plan for Cancer Control for 2005. There is evidence of a high level of commitment and enthusiasm from members of the Ministry of Health and from other key stakeholders, such as the National Cancer Centre (*Services de Cancerologie*) in Treichville Hospital, where the Cancer Registry is based, and the National Pain Society (*Societe Contre La Douleur – SILUD*, established before the political and military crisis), to address the needs of people with cancer.

Currently however there exist very few services; the *Services de Cancerologie* is the sole unit in Côte D'Ivoire specializing only in cancer; resources and personnel are extremely limited and there is an urgent need for a national strategy and framework for addressing the needs of people with cancer.

Objectives and Methodology of Rapid Appraisal

This appraisal was undertaken as part of a project to assist the government of Côte D'Ivoire to establish a comprehensive HBC and palliative care plan which will enable collaboration between partners: PLHA, health and other sectors, local and international NGOs, to provide an effective response to community needs. It was conducted with two local consultants – one chosen for palliative care-specific site visits and one chosen for HBC-specific site visits.

¹⁷ Echimane, A., Ahnoux, A., Adoubi, I., Hien, S., M'Bra, K., D'Horpock, A., Diomnade, M., Anongba, D., Mnesah-Adoh, I. and Parkin, D. 2000. Cancer Incidence in Abidjan, Ivory Coast. First results from the Cancer registry, 1995-1997. *Cancer*. Vol. 89. No. 3:653-662

The objectives of the appraisal were:-

- Rapid assessment of current provision of home based care
- Rapid assessment of current provision of palliative care
- Identification of strengths in the current provision of home based care and of palliative care
- Identification of issues and gaps in the current provision of palliative care and of home based care
- Appraisal of current supporting structural mechanisms, including current provision of training for home based care and palliative care and current policy and legislation relevant to HBC and palliative care
- Provide recommendations on strengthening HBC and palliative care in Côte D'Ivoire, specifically in developing a policy and practice framework for comprehensive palliative and home based care

Due to the brief period of time available for the appraisal – six days, it was only possible to visit a select number of programs and individuals, and these only within Abidjan. NGOs (local and international), clinicians and health services were chosen for their representativeness of the most comprehensive of current provision of care and support in HBC and in palliative care. The appraisal also included visits to government departments and officials whose role had relevance to the provision of HBC and palliative care.

Methods included a review of all relevant and available policies, guidelines, plans, journal publications and regulatory documents, observation field visits to sites, one-to-one interviews with key informants and group discussions. A total of 16 individuals or programs were interviewed – these comprised seven NGOs, (local and international), four government departments, two health service programs and three individual clinicians.

Current Status of Palliative Care and Community and Home Based Care

Overview of national approach to Palliative Care and Community and Home Based Care

Definitions

To enable consensus on the aims of the appraisal and on a common understanding of both palliative care and HBC a meeting with government stakeholders, representatives of NGOs and of the national group of people living with HIV/AIDS, RIP+, took place before the commencement of the appraisal. The World Health Organization definitions of palliative care for adults and children which were used to inform this appraisal were presented as part of the discussion :

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and

impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. (see appendix 2 for complete definitions)

The Ministry of Health of Côte D'Ivoire defines home based care as "comprising all those activities: medical, psychological, social, spiritual and legal, which are provided in the community for people living with HIV/AIDS and their significant others"¹⁰.

For the purposes of this appraisal the term "palliative care" is used to describe those services which have access to a full range of drugs for symptom management and have staff that have a level of knowledge and skills in palliative care in line with the WHO definition.

The terms "community and home –based care" and "community-based services" are used to describe those services (usually independent community-based care services, providing home care, outpatient or inpatient care, or a combination of these three) which provide the best level of service of which they are capable, using their understanding of palliative care approaches, in an environment of limited access to essential palliative care drugs and with limited opportunity to gain further knowledge and skills in palliative care even though there is a desire to do so.

Stakeholders

Within the *Ministere de la Lutte Contre le SIDA*, the *Program National de Prise en Charge Medicale des Personnes vivant avec le VIH/SIDA (PIVVH)*, created in 2001, has as its mission to reinforce and coordinate all activities in care for PLHA both in public and private sectors and is the main HBC and palliative care stakeholder. However given the policy, regulatory, legislative and educational implications of expanding and developing a comprehensive system of palliative care which would include HBC, there exist several other government stakeholders, including, but not limited to, the *Direction de la Population et de la Sante Communautaire*, responsible for developing and promoting policy and strategies in primary health, the *Direction des Etablissements et des Professions de Sante*, responsible for regulation and oversight of all health professions except pharmacists, *La Direction de la Pharmacie et du Medicament*, responsible for all regulatory matters regarding medications, the *Direction de L'Information, de la Planification et de la Evaluation* and several of the *Organes Consultatifs*, a series of consultative bodies with specific briefs, such as registration of medications, set by the *Ministre d'Etat, Ministre de la Sante et de la Population*.

Equally important stakeholders are those programs, both national and international, which are currently involved in provision of care and members of the medical, nursing, social work and pharmacist professions.

National Policy – Home Based Care

One of the main priorities in the draft National Action Plan for HIV/AIDS in the Health Sector 2004 -2006 (*Plan D'Action de Lutte Contre le VIH/SIDA Dans le Secteur de la*

Sante) is increased access to care, treatment and support services and a specific objective relating to provision of care in the community is articulated within this priority, namely, by 2006, to reinforce the capacity of 50% of the community actors involved in community care, but limited resources means that the provisional budget for this objective is only a little over 2% of the overall budget for this priority area.

Currently there is no HBC-specific policy or strategy; the *Guide National de Prise en Charge Communautaire des Personnes vivant avec le VIH/SIDA* (mentioned previously) is the only guideline directly addressed to HBC- this document combines aspects of clinical guidelines and training manual.

There is also no regular supplier of HBC kits, although the *Guide National de Prise en Charge Communautaire des Personnes vivant avec le VIH/SIDA* provides a basic list of kit contents. The list does not contain any medications other than antiseptic lotions and oral re-hydration solution. Commitment to the need to provide adequate care, especially in the community, is evident within the *Program National de Prise en Charge Medicale des Personnes vivant avec le VIH/SIDA (PIVVH)*, but the means and systems to provide that care are currently lacking .

National Approach to Home Based Care Education

There have as yet been no national training curriculum, trainer/facilitator manual or teaching materials developed for home based care to support the national HBC guide.

NGOs train their own staff and since there is no other, more comprehensive, standard national training rely on the *Guide National de Prise en Charge Communautaire des Personnes vivant avec le VIH/SIDA* and on transfer of their own skills and knowledge.

National Policy - Palliative Care

Comprehensive palliative care is a relatively new concept in Côte D'Ivoire. There are currently no palliative care policies, strategy, guidelines or available formal training in the country. There is no specific articulation of a national approach to palliative care in the national health plans. Until now description of palliative care (les soins palliatifs) has been confined to the HBC guidelines, which essentially provides basic information on care for terminally ill people in a setting with limited resources.

Again there is a high level of government commitment to the need for provision of effective care, at least in those government departments visited during the appraisal; although specific systems development and regulatory issues which need to be addressed are not always clearly understood .

National Approach to Palliative Care Education

There is no national approach to palliative care in undergraduate or postgraduate education for medical, nursing and allied health staff (pharmacists, social workers), or an equivalent community focus on palliative care education (apart from the relevant section

in the *Guide National de Prise en Charge Communautaire des Personnes vivant avec le VIH/SIDA* mentioned above).

The current undergraduate training of nurses, doctors and all allied health staff (except pharmacists) is overseen by one government department and the curricula are set and changed (if change is indicated) by university faculties; the training contains very little education on palliative care issues; there is no discrete module. One interviewee stated that there are usually two hours of training provided for medical students in the final stages of their training, at the end of which they have learned not to encourage the use of morphine. It was suggested at the government regulatory body for undergraduate level training that development of an additional palliative care module would be very difficult to achieve and that inclusion of elements of palliative care within the existing undergraduate curriculum would be a more achievable goal. It was further suggested, that this process would require all members of each faculty who had any part in developing and ratifying medical, nursing, pharmacist and social worker undergraduate curricula to be invited to join in a consultative process from the beginning if change were to be feasible, since these members must support and authorize the changes.

Issues identified with regard to post-graduate training included a lack of motivation on the part of qualified practitioners – it was felt that participants often attend formal post-graduate training because they are expected to do so but do not necessarily see any personal or professional benefit.

Unmet Need for Palliative Care

The lack of focus on HBC and on palliative care as priority areas is both a reflection of past years' concentration on prevention measures and also a result of the years of disrupted health infrastructure and severely limited resources. The current focus for Côte D'Ivoire, like many countries in Africa, on access to anti-retroviral treatment has a significant impact on allocation of funds and of priorities in care. While access to antiretroviral drugs is obviously a priority, the urgent need to provide comprehensive care, as well as treatment, is a parallel priority. This priority can be demonstrated by identifying the unmet need for comprehensive palliative care. From available data on morbidity and mortality and prevalence of illnesses in Côte D'Ivoire we can draw some conclusions regarding the potential need for palliative care. There is little information, other than anecdotal, on symptoms in the last year of life, as there is no system of routine collection of data on symptoms; even within the cancer registry variables for data collection on cancers are confined to site, type of tumor etc. Nevertheless an estimate of need for palliative care can be made from mortality data.

Mortality data for AIDS estimates that there is an annual death rate of about 70000. From Western research it is known that between 60-80% of people with advanced AIDS experience pain and/or other distressing symptoms, especially at the end of life. Taking a conservative estimate of possible prevalence of symptoms at a rate of 60% in people at end of life in Côte D'Ivoire needing some form of pain and/or symptom (including mental health symptoms) management gives a figure of 42000 people who could potentially

directly benefit from palliative care. Added to this are at least the same number of family members or informal caregivers who would also benefit – potentially 84000 people annually could benefit from palliative care.

For cancer if only the number of people registered on the Abidjan cancer registry are counted – 1000 per year, out of which, according to the cancer unit, the majority, perhaps 80%, present with advanced cancer. Again, from Western data it is known that between 60-80 % of people with advanced cancer have pain and/or other distressing symptoms, this gives a figure on the conservative end of the percentage range of potentially 480 people who could directly benefit from palliative care. Added to this again is at least an equal number of family members or informal care givers who would also benefit, so potentially at least 960 people annually in Abidjan alone could benefit from palliative care provision for cancer.

Availability of Services

Palliative Care

There are very few providers of comprehensive palliative care in Abidjan. Of those services that exist, four have been developed by medical specialists (in neurology, anesthesiology, and cancer), based in different tertiary hospitals, and one is provided by a faith-based organization. It was not possible to determine the comprehensiveness of the palliative care provided by this faith-based organization as they were unable to accommodate a visit by the appraisal team. There is also a professor of pediatrics based in one of the main teaching hospitals who has a strong interest in palliative care for children, and there is development of a system of palliative care for children, including a team specializing in children's palliative care, but a site visit was not possible to this program since he was out of Abidjan during the time of the appraisal.

The National Pain Society, SILUD, has been in existence since 2001.

Various initiatives have also been undertaken in the recent past; in 2003 a mental health nurse currently working in a children's care NGO was supported to attend a month-long palliative care training course in France and in June 2004; at the invitation of CDC Côte D'Ivoire, one of the specialists working in development of palliative care at Cocody Hospital attended, with the Care and Treatment Coordinator for CDC, the inaugural conference of the African Palliative Care Association (APCA) in Arusha, Tanzania. This visit was followed by a study visit to palliative care sites in Uganda. There is also currently a doctor from Côte D'Ivoire who has been supported to study at a cancer centre in France and who will be returning at the beginning of 2005.

Community and Home-Based Care

There are several models of community-based and home care in Abidjan. Many services have grown from an independent community-based or non-government organization (NGO) in response to the perceived need to provide care and most are based in the poorer

areas of Abidjan where little access to work or health or social services has existed previously and where populations include refugees and persons displaced by the war, street children and other marginalized groups. Most services provide support exclusively for PLHA and/or orphans and children affected by HIV and AIDS. Many of the organizations are funded by donors, some with international donor funding in addition to local fundraising.

Models of services include stand-alone NGOs which provide inpatient, outpatient and residential care for adults and children, a government –supported ambulatory care service for PLHA which refers on for inpatient services and which is based at CHU, a service which addresses needs of women living with HIV and AIDS and their children in a residential setting with an aim to rehabilitate them into their home communities, a service dedicated solely to the needs of children orphaned by AIDS and children and adolescents living with HIV and AIDS, and several community-based services which aim to provide for comprehensive medical, social and emotional and welfare needs through a variety of activities from diagnosis through treatment to end-of-life care, including care in the home. The majority of community-based services are not apparently involved in home visiting or in providing care. The services visited as part of the appraisal were selected specifically because of their involvement in provision of care.

All of the services visited during the appraisal (see appendix 3 for program descriptions) provide a varying and in several instances a substantial range and quality of services, most often in environments where human and material resources are limited, and with a consistently high level of commitment from the staff.

There were conflicting opinions as to the availability of care and support services outside of Abidjan in community and home-based care – some agencies felt that there were few given the lack of existing infrastructure; the government sub-directorate for psychosocial care was more optimistic and is currently developing a strategic framework engaging NGOs in other regions of Côte D'Ivoire in capacity-building for a wide range of services, not only including health. It was not possible to ascertain the current status of these other organizations, or their amount of involvement in care since the appraisal was confined to Abidjan.

Development of palliative care

All of the important initiatives in palliative care that have been undertaken in Abidjan have developed because individuals or organizations have recognized the critical need to address palliative care needs. A recurring comment was that these undertakings were a response to a situation to fill an identifiable gap in a situation where a systematic approach to raising awareness of palliative care and development of national policy and practice has not yet been addressed. This impetus came for most of the practitioners from an original recognition of *acute* pain needs and a desire to create a seamless response to pain and other symptoms including acute, chronic and palliative pain needs.

For each of the specialists interviewed, interest in palliative care grew out of the recognition that treatment of pain and other distressing symptoms was an essential part of their approach to care and treatment but was not an area in which they felt sufficiently well-equipped in skills and knowledge. Whereas often interest in palliative care has stemmed from a recognition of the need for pain and symptom management at the end of life, for these specialists palliative care provided the natural response to pain and symptom management needs across the spectrum of health and illnesses and so they had reached an understanding of palliative care, within an environment of few resources, which many others working in end of life or hospice care have struggled with over recent years.

Interviews with each of the medical specialists elicited similar themes concerning the development of their interest in palliative care: the need for palliative care for their clients, the need for training and access to drugs, and priorities for palliative care including awareness-raising and a national approach to palliative care provision to enable coverage.

Since palliative care is such a new concept in Côte D'Ivoire issues such as licensing services to provide palliative care, with all the legal implications which that might entail including access to trained staff and essential drugs, have not yet arisen, but will need addressing as the specialty develops.

Within the community-based organizations there was almost a universal understanding of the need for further development of skills and knowledge in order to provide comprehensive palliative care. Many of the program staff interviewed had had the benefit of using the *Guide National de Prise en Charge Communautaire des Personnes vivant avec le VIH/SIDA* and felt they had a clear understanding of what palliative care means, although often the understanding of pain relief was confined to massage, perhaps an unintentional effect of the inclusion in the manual under the heading of 'soins palliatifs' of massage as a valuable form of pain relief in the home. Since many of the services were perforce having to manage pain in the home as best as they could and since many of the clients would not be able to afford the prescribed pain relief also mentioned in the manual many of the services had come to see massage as the sole pain relief available (which currently, realistically, it is).

Access to Palliative Care

Access to comprehensive palliative care is restricted in the sense that those services able to provide a full range of care services (the tertiary services as mentioned above) are all based in Abidjan. Most clients come to the services from Abidjan and its surrounds – this itself involves considerable travel for many, as the city is spread out. Some clients however may also come from considerable distances for treatment at the tertiary hospitals in Abidjan, for cancer and for AIDS, but to be able to stay in Abidjan to gain access to services these clients need accommodation (where possible staying with extended family) money for transport, money for diagnostics, treatment and medication, and for those well

enough to be discharged home, there is no system of palliative care follow-up in areas outside Abidjan.

For clients of some of the community-based services for HIV and AIDS in Abidjan referral for 'soins palliatifs' involves referral to the faith –based organization; other community services endeavor to provide their own follow-up in the home, using palliative care approaches. Some are aware that they are not able to fulfill all the client's needs, due to a need for access to resources including drugs for pain and symptom management; others see their role as 'being with' the person and that this accompanying of the person until death is more important than pain and symptom management. Others desire both. Within the community-based organizations there was also a consistent awareness of the need to extend learning and skills to provide for more effective palliative care throughout the course of illness of the clients as well as at end-of-life and most of the services were very clear that they urgently needed sufficient training and expansion of skills of their staff in more effective approaches in palliative care, especially physical care. Many were also aware of the difficulties of providing comprehensive palliative care in the community because of regulatory constraints on access to essential drugs.

Advocacy for Palliative Care

Until now advocacy for comprehensive palliative care has essentially been the domain of the National Pain Society (SILUD), the Cancer Unit at Treichville Hospital (Service de Cancerologie Centre Hospitalier Universitaire [CHU] de Treichville, and by those individuals mentioned above. One of the aims of the Pain Society is to enable the creation of a palliative care team in each hospital, comprising nurse, surgeons, physicians, pharmacist and specialists in anesthesia which would serve as a consulting and teaching service. The members of the Society believe that the first step to developing coverage of palliative care is to teach your colleagues, enable them to teach others and so spread the expertise and knowledge . Before the political and military crisis following after the military coup of 1999, two initial meetings at CHU had demonstrated a significant lack of understanding of pain needs in surgery and a keen interest by surgeons, nurses and anesthetists in developing pain management skills. Members of the Society had commenced on a plan of monthly visits to cities in Côte D'Ivoire to raise awareness and share skills through teaching sessions and presentations at meetings; however the unrest had made travel very difficult and at the time of the appraisal the society was aiming to review this plan.

The Cancer Unit at Treichville Hospital has clear aims to meet the needs for clients, including a properly –equipped 25 bed ward in the hospital, with related outreach service, regulation change for easier access to opioids, medication subsidy, and a standardized system of palliative care training, has been involved in mass media sensitization activities and the development of the National Cancer Plan, and there are plans under way to develop pediatric palliative care.

Each of the individuals involved in palliative care are advocates in their own field, educating and raising awareness with their colleagues, clients, families of clients and other services. Resources and time are limited however and there is no one body which is able to concentrate on advocacy for palliative care as its work. Similarly for the community-based organizations the desire to develop an organized approach to advocacy for palliative care is obvious but time and resources are concentrated on managing the day-to-day needs of the clients.

There are also no international agencies involved directly in advocacy for palliative care in Côte D'Ivoire, although the newly formed African Palliative Care Association, which now has some members in Côte D'Ivoire, has indicated its support.

Range of Services included in Palliative Care

Currently those services endeavoring to provide comprehensive palliative care – the tertiary services - are focused mainly on pain and symptom management as they acknowledge this is an area which requires considerable advocacy and sensitization for professionals, clients and informal caregivers. At the same time they recognize that the need to address social, emotional, psychological and spiritual care is urgent but resources are scarce: there are no psychologists or psychiatrists available to provide psychological or mental health support; allied health staff that exist, such as social workers, are overstretched and unable to provide fulltime service to palliative care. The developing palliative care services are unable to employ a multi-disciplinary team; at present the teams that exist in tertiary settings comprise mainly nurse and doctors aiming to fill multiple roles.

Another aspect of palliative care in the Côte D'Ivoire context is that, in common with palliative care in other resource-poor countries, poverty is the biggest priority for many. Financial support is needed for food, travel for work or to get health care, support for children to attend school (money for uniforms and scholastic materials) and fees for health care. Provision for these needs is recognized as essential within the tertiary palliative care programs but within hospital services there is little to offer to address these needs. The need for bereavement care is likewise recognized but currently tertiary palliative care services are unable to offer this service. Follow-up for those clients who go home is dependent on the level of commitment of local doctors in the area to which the client returns – referral is one-way and knowledge about palliative care and pain and symptom management is scant outside of the reach of the palliative care or community-based services.

As is universally the case in palliative care provision in resource-poor settings, community-based organizations accept that the range of services that they need to provide include social, emotional, financial and welfare services which would not usually be taken up by palliative care services in resource –rich settings. Consequently, food distribution, providing meals for clients on attending clinics or meetings, support groups for PLHA, provision of clothing, cooking vessels, shoes for children, education in hygiene and assistance with forms of social welfare, all are part of the community –

based services, in addition to medical care including referral for counseling and testing, counseling follow-up, provision of drugs for treatment and prophylaxis of opportunistic infections and antiretroviral drugs. Most of the community-based organizations had a stronger component of social and psychological support for clients than the tertiary services, reflecting not only the priority of medical issues in hospitals, but also the direct response of community services to their community's needs. Most community-based organizations included people living with HIV and AIDS as staff and held regular collaborative decision-making meetings with staff and clients.

As has already been mentioned, many programs were unable to provide much in the way of physical care in the home, confining their visits to social care and emotional support, although two aimed (and succeeded within the limits of their resources) at providing a complete spectrum of care. As a result there was no system of consistent provision of home-based care kits to provide for physical care – most programs distributed goods as described above according to perceived need and according to resources available.

Access to Drugs and other Resources

Drugs Policy Relevant to Palliative Care and Community and Home – Based Care

The National Essential Drugs List (EDL) covers all drugs recommended as essential and availability of those drugs are at five levels of health care facility-

- level A pertains to Central (tertiary/reference) and University Hospitals,
- level B pertains to general hospitals ,
- level C pertains to Urban Specialist Health Centers,
- level D pertains to rural health centers and
- level E pertains to village pharmacies.

While a comprehensive selection of drugs essential to palliative care can be found within the Essential Drugs List, most of these are only made available at levels A and B; only weak opioids (e.g. dextropropoxyphene and paracetamol, are listed at level C and only aspirin or paracetamol are listed for use in levels D and E. Oral morphine tablets, buprenorphine and morphine injections (10mg and 30mg) are listed only at levels A and B.

Only one tricyclic antidepressant (useful in both depression and neuropathic pain) was on the EDL and this was only available at level A. In the benzodiazepine group (useful for breathlessness and anxiety) only one drug (with a very long duration of action) was listed, although this was included in levels ABC and D.

This has significant ramifications for those services wishing to expand provision of care services to include comprehensive palliative care – even with education, and increased human and material resources, services classified as at rural or village level, or not classified as urban specialist health centre, will be unable to gain direct access to many of the essential drugs required for effective symptom management, under the current regulations.

Côte D'Ivoire is a signatory to the Single Convention on Narcotic Drugs of 1961. This means that the national government has signed to agree to the International Narcotics Control Board's (INCB) main aim which is to promote member governments' compliance with the international drug control treaties (international law) of 1961, 1972 and 1988 to limit the use of drugs classified as narcotics (and psychotropic) to medical and scientific purposes only.

These treaties require a signatory country to provide details on countrywide past year's use of opioids and estimates of the future year's use, and to voluntarily provide the same data for psychotropic drugs. Côte D'Ivoire furnishes this information each year to the INCB, through collecting data on drugs used and estimates of future use from the national government departments which both regulate and supply all opioid drugs for the country. Future estimates are based on past year's usage.

There is considerable data to demonstrate a chronic under-use of opioids in resource-poor settings, where emphasis is placed on constraining use of opioids to avoid diversion of drugs into illicit use. One of the departments visited during the appraisal stated that "there is too much illicit trafficking of drugs in Côte D'Ivoire ", although there were no available data to support this statement and no evidence that whatever drug trafficking does occur is diversion of *licit* drugs (i.e. drugs manufactured for medical use, as opposed to drugs made illicitly).

The National system for prescription and storage of drugs is based on French regulations as outlined in the French Public Health Code for Pharmaceuticals. Prescription of drugs is restricted to doctors. In theory all qualifying doctors are allowed to prescribe all drugs, including opioids.

Accessibility of Drugs

There are two main issues with regard to drugs for use in palliative care in resource-poor settings. Firstly the drugs may not be obtainable in a country; secondly they may be obtainable but are inaccessible due to many forms of barriers. There are several categories of drugs which are essential to comprehensive palliative care and barriers to their access may be cost, lack of knowledge of their palliative use (e.g. use of benzodiazepines for breathlessness, use of anticonvulsants for neuropathic pain) unavailability due to the licensing system of a particular country.

Of these categories of drugs, opioid drugs are a central, essential component of comprehensive palliative care but are also often the most difficult drugs to which to gain access because of the regulatory and bureaucratic processes applied to narcotic drugs.

As already stated, opioid drugs – morphine, buprenorphine and tramadol and some weak compounds, are on the country's essential drugs list. In theory, in Côte D'Ivoire, access to opioids is possible even if only in tertiary hospitals. In practice there are several barriers to the pain management that effective access to opioids could achieve.

Prescription of opioids

Only doctors are allowed to prescribe opioids. All interviewees thought this was the best way to ensure appropriate prescription of opioids; most interviewees stated that even if training were provided nurses should not be allowed to prescribe opioids, even though, according to statistics, there are almost four times as many nurses as there are doctors and even when it is known that there is only one doctor per over 9000 people.

In theory all qualifying doctors are qualified to prescribe opioids; in practice the doctor must use a specific prescription form for ordering opioids which he/she should receive from the Medical Council on qualifying. Many doctors apparently simply do not receive this prescription form on qualifying and there are considerable bureaucratic steps to obtain one later, hence many doctors are in a real, practical way, not able to prescribe opioids, thereby reducing the pool of prescribers.

Prescription of opioids is bound to a seven-day limit; clients who are able to be discharged home and who live at some distance must either travel back each week to renew their script, or try to find a local doctor where they live who will prescribe for them; even with a referral letter from the tertiary hospital requesting this, local doctors are often reluctant to prescribe.

Palliative care service providers stated that effective pain management with opioids was difficult for several reasons: codeine as a mild opioid was not available, morphine syrup for oral use was also not available; imported slow release formulations of morphine were most often used but these were prohibitively expensive and so were not affordable for many of the clients; the immediate release morphine tablets and morphine injection included on the essential drugs list were often in short supply or not available from the government central pharmaceutical department, and many other service providers simply did not use opioids through fear and/or lack of training.

Regulatory processes

On a bureaucratic level the government department responsible for regulating all pharmaceuticals (DPM) states that opioids are available at the central pharmaceutical department. Hospitals must estimate the amount of opioids they will use in the coming year, tablets and injection. Considerable regulatory processes are involved if there is a request for increase of the estimates at other times of the year. There is little incentive to increase the estimate of the forthcoming year's opioid use, for example in the hypothetical instance where several doctors have undergone palliative care training and are using opioids regularly, because of the general feeling that the drugs would not be made available or there would be too many bureaucratic discussions on why the estimates needed to be increased.

The central pharmaceutical department (PSP) is responsible for receiving all prescriptions for opioids written by the hospital doctors and collated by the hospital pharmacies, for filling the prescriptions and dispensing back to the hospital pharmacies. The central department does not make up oral morphine.

Private pharmacies are able to make up oral morphine if they choose although they are not able to import narcotics. Presumably it is not to the advantage of the private pharmacies to make up oral morphine syrup from cheap powder when they can sell expensive slow-release formulations instead.

The responsibility of the pharmaceutical department is to stock the drugs the doctors in the tertiary or private hospitals order; the department stated that if the doctors do not order drugs the PSP does not stock them. Whether the barrier to availability of the cheap opioids contained in the essential drugs list is due to doctors not ordering in sufficient quantities or often enough; or due to the central department not carrying enough stocks, there is an evident rupture in the supply and demand system which effectively means clients do not have access to the drugs they need.

Clients in the home, unless they have been fortunate to have first attended one of the tertiary services providing palliative care *and* can afford the more expensive formulations which seem to be in more regular supply *and* live close enough to that tertiary service to be able to obtain weekly prescriptions, have no access to strong analgesia when needed.

Assessment of pain

On an individual client level assessment of need for pain relief is not made on a standardized basis, need for pain relief is often judged by the practitioner – two services stated that they knew their clients had pain because they were usually in an advanced stage of AIDS or cancer when they were admitted and both services made concerted efforts to provide pain relief, through educating themselves and colleagues about pain assessment and need to address psychosocial needs in conjunction with pain relief. Both however suggested that between only 20-30% of clients needed pain relief. Western research demonstrates from between 60-80% of hospitalized clients with cancer or AIDS have pain, so these estimates seem low – there is however, no body of evidence from developing countries to address this. This lack of systematic assessment of pain need can also act as a barrier to access to effective pain relief as practitioner assessment of pain may well underestimate level of pain and overestimate level of pain relief.

Access to other Resources

One tertiary level service identified the need for designated palliative care inpatient units to treat complex symptoms – the Cancer Unit suggested a ward equipped for 25 – 30 inpatient beds as an urgent priority, including facilities to provide radiotherapy for pain relief. The head of the Pain Society identified the need for development of palliative care consultancy teams which would play the dual roles of educating their colleagues while providing hospital-wide consultancy on palliative care issues for patients.

First priority for the community-based organizations was to address poverty and food needs for the clients in a sustainable way. Many identified the need to develop greater capacity within their own staff and in expansion of their services. The need for training in specific care skills including palliative care, in program management and supervision skills were acutely-felt needs for several of the services. Other resources identified as

lacking were a system of support for legal and financial needs of clients and a need for a focus on income-generation and rehabilitation needs for those clients on antiretroviral drugs.

Care for Children

While palliative care is at such an early stage of development, nevertheless the need for effective palliative care for children is already being addressed through the work of the pediatrician at CHU in collaboration with the Cancer Unit. There are plans for development of a pediatric palliative care service staffed by doctors and nurses for the hospital. It was not possible to visit the initiator of this program.

In community care for children elements of comprehensive palliative care are currently being provided through some of the initiatives of NGOs. One centre has expanded what was initially a long-term research project on children with HIV to incorporate provision of care, and now provides medical treatment including treatment for opportunistic infections (currently children are referred to a tertiary hospital for antiretroviral drugs but when the government begins procurement of these drugs this will be one of two centers providing ARV drugs for children in Côte D'Ivoire), day care for treatment and observation of sick children, referral to one of the tertiary hospitals for complex needs. Further, a second service at the same centre has grown out of the recognition that the children's emotional social and developmental needs must be met. This second service provides staff (social worker and nurse) who follow up children in their homes and address their multiple needs, including malnutrition, need for schooling, remedial teaching to get back into schools, sensitization of parents and guardians about the needs of the children, teaching parents and guardians how to care for the children, the effects of peer pressure on adolescents and the difficulties of maintaining adherence to ARV drugs. Again the need to provide care at end of life and the need to learn the skills to be able to provide it effectively were recognized – "many people are dying at home and people are reticent to provide care – we need the means to be able to do it well".

Another centre focusing on women and children aims to reintegrate clients into their own society and family if possible. For those who are sick the emphasis is on trying to teach the person's parents how to give care. For some of their clients for whom it is difficult to find family there is a possibility to stay for up to six months, although in reality some clients may stay until they die. There is a recognition that loss of control, being powerless over their situation, is one of the most frightening experiences for someone who is dying. Care of the dying person for this NGO is very clear – " it is very hard to die alone; people have a need to be accompanied".

Yet another centre provided food and support for scholastic materials, social events and education about HIV for children of their members and children referred from other NGOs, not in isolation, but rather as a part of their comprehensive approach to care and support.

Education in Palliative Care and Community and Home Based care

It was universally identified during the appraisal visits to tertiary and community-based services that education for palliative care was essential at all levels of health and other sectors, that a national policy and guidelines was a much-needed first step towards coverage of palliative care. Tertiary level services advocated provision for palliative care at undergraduate and post-graduate education, and most services suggested that in addition, and while this system were being developed, awareness-raising meetings (of the type described by the Pain Society), short courses in palliative care principles and practice, particularly in using opioids, and training in working in partnership with clients in management of their illness were urgently needed. In lieu of a national effort to focus on these educational efforts many of the tertiary services visited have held meetings and workshops to educate themselves and their colleagues in principles and practice of palliative care.

The community-based services have also endeavored to train their staff and colleagues in extending their skills in palliative care but are acutely aware of the need for expert assistance in this area. As one NGO stated in referring to their home visits " We understand that we want to do more- there is much fear, people think if they help someone, if they give them medications, they will hurt them. If there were training for this care in the home our staff's capacity would be greatly increased".

One major obstacle in the endeavor to provide education in palliative care is the significant lack of educational materials on palliative care in French available for resource- poor settings. While many resource-poor settings have suffered from a lack of appropriate educational materials up until the recent past, countries with at least one language in English now have access to several comprehensive training curricula and manuals and materials, thanks to the hard work of individuals and groups in other parts of Africa and Asia. Francophone countries urgently need a similar body of knowledge.

Supervision and Support for Caregivers

All those services visited (tertiary and community-based) demonstrated a high level of commitment by staff to the pioneering work which they were doing. Managers acknowledged that they were unable to provide the type of emotional support for workers that they would have wished and recognized the need for a psychologist or social worker for support of care givers as well as clients. This need was a priority for most of the services. In tertiary settings, professional support and supervision was provided through close mentoring of staff, regular meetings and mutual exchange in learning-by-doing situations such as ward rounds.

There was an unexpectedly and refreshingly high level of understanding on the part of the managers of the services of the value of the team approach in palliative care and of nurses' contribution in particular, unexpected in the sense that the services have essentially developed in response to perceived need, practitioners have been self-taught, and might have developed a narrower view of the essential elements of palliative care, in the absence of other palliative care influences.

In the community-based organizations support was mainly provided through the participatory group meetings which many of the services held regularly. In those services whose staff was also HIV-positive emphasis was placed on the support which comes from being a member of the organization; support groups which provided mutual sharing and focused on positive living were of central importance to most of the services.

While most of the community services recognized they had no recourse to a system of professional supervision to enable staff to gain professional and emotional support they attempted to address this need through the mechanism of their meetings and social events.

Recruitment and Retention of Staff

For the tertiary level services filling available positions was not currently an issue in the sense that there were a limited number of positions within the services which were able to be funded and these were filled. Needing more staff was certainly an issue. There was an impression that staff do not tend to move around from one job to another. The emotional and physical toll of the work may well affect retention of staff but as the services were still fairly new this had not yet made itself apparent.

For the community-based services recruitment of volunteer staff seemed to be a difficulty, with several of the organizations stating that it was very difficult to recruit volunteers. Various reasons were offered to explain this, two of the most common being firstly the fragmentation of societies - whereas in the villages people would help each other, in the poorer areas of the city, where many people are refugees or displaced or are simply too poor and underserved, they have lost a sense of community; and secondly the fear of disclosure – that merely by being associated with an organization providing services for PLHA the volunteer would themselves be stigmatized. As one community program manager stated – "fear of disclosure affects the health of the community because when people are too afraid to disclose, even if people want to help, help is refused". PLHA who had originally joined as beneficiary members of organizations often became more actively involved in the work of the organization and remained as volunteers.

Retention of staff in the community-based services did not currently seem to present problems – a combination of the strong feeling of solidarity generated by many of the community services and the real need for active engagement in work to provide purpose and support a positive approach to life may both be contributing factors.

Stigma and Discrimination

One of the reasons given for the late presentations of both people with AIDS and people with cancer was stigma and discrimination. AIDS-related stigma is well-known and has been mentioned above; cancer as well can be highly-stigmatized in resource-poor settings, and beliefs that cancer is contagious, that it is a punishment, that it is taboo to speak of cancer (especially cancer related to reproductive organs) are all believed to contribute to the lack of early presentation.

Given that in Côte D'Ivoire there are more women than men with HIV, that the prevalence of HIV in girls is far higher than in boys and that the two most common cancers in women are breast cancer and cancer of the uterus (two of the most stigmatized cancers in many resource-poor countries) there is the possibility that gender-based stigma will play a larger part in late presentation for care on the part of women. Data on how stigma of cancer, of AIDS and other chronic illnesses affects client presentation for treatment and care in Côte D'Ivoire is not available but would make a significant contribution to both planning for palliative care services and for enabling development of behavior change communication interventions related to palliative care.

Cost and Sustainability

An approach to assessing costs and benefits such as a systematic analysis of the economic, material and human costs of providing palliative care services across all levels of health care is beyond the scope of the newly developing services and there is no planned cost analysis for the future. Were there no provision of funds, human resources and technical expertise, the palliative care services would undoubtedly continue to grow in response to perceived need, and to the credit of those involved in its development. A far better option, however would be that there were a sustained funding mechanism for development of palliative care within a strategic framework.

The question of sustainability in an environment of fractured infrastructure, an uncertain future for peace and stability on which to base new developments, a health service which is based on fee-for-service due to structural adjustment demands and a desperate lack of funds is difficult to address. It is certain from the visits carried out during the appraisal that those involved in developing palliative care will continue to do the work that they feel is essential but this may well be done in an environment where access to outside assistance, whether that be technical/programmatic assistance or donor funding, may be limited or delayed, due currently to the political and economic instability of the country.

Partnerships between Services and Sectors

It is testimony to the endeavors of all those involved in developing approaches to palliative care that many of the services visited have also made efforts to collaborate, for example, in sharing ideas and expertise as in the case of the Pain Society, or in developing and maintaining strong links for referral and follow up, for example between some of the NGOs and the ambulatory care service based at CHU. There is also a network of NGOs in which many of the community-based services are very active.

Not all services had involved themselves in partnerships; one of the NGOs providing inpatient, outpatient, orphan care and end-of-life care was not aware of other services or organizations which might be able to assist their clients; and the faith-based NGO, while accepting referrals from the ambulatory care centre, and obviously highly-regarded within the community, did not seem to play a significant role in sharing of expertise.

Many NGOs stated the need for much greater government involvement in supporting their work - in relation to funding, but also for accreditation of services to enable them to provide more medical care and for development of training in palliative care which would benefit all levels of services.

In the limited time available for the appraisal it was not possible to gain a clear picture of how other government sectors and non-government organizations, including international donors and agencies, can contribute to strengthening a national approach to palliative care provision.

Monitoring and Evaluation

There are very little data available for tertiary services and for community-based programs that can be used to monitor the services themselves. Most services have no data collection instruments for care and support and rely on caregiver or practitioner written reports to assess quality of care, monitor progress and provide progress reports to donors.

Challenges to Expansion of Palliative Care

Government Commitment

It is clear that there are palliative care champions within the Ministry of Health. However for the development and implementation of an effective national approach to palliative care there needs to be consensus and commitment from all relevant national government departments on the key issues, namely access to essential drugs, including opioids, education and national policy. This requires sensitive and collaborative engagement with all government stakeholders and academic faculty to come to a clear understanding of what palliative care is and includes addressing delicate issues such as regulation of and access to opioids, roles and responsibilities of different disciplines involved in care, including the extended role of the nurse, incorporation of palliative care education into existing undergraduate training programs, and assuming responsibility for ensuring implementation of a national palliative care policy.

Competing Priorities

In the current era when provision of antiretroviral drugs and the need to develop the infrastructure required to provide them effectively are an urgent priority for Côte D'Ivoire there is a danger that palliative care is seen as something less urgent, a luxury to be added when the time and resources allow, whereas in fact palliative care provided at all levels and across the continuum of care is an *integral* part of that very supporting infrastructure needed to ensure effective delivery of antiretroviral drugs and treatments in other illnesses. As well as demonstrating an effective multidisciplinary management approach to integrating treatment and care needs, (for example, providing a role model for the partnership model of care between client, family and provider essential to sustained HIV management), palliative care also provides care for those who experience side-effects of antiretroviral drugs, for those who are unable to gain access or are too sick to benefit

from ARV drugs and enables access to people within households who can benefit from counseling and testing for HIV, treatment and prevention interventions for cancer and assessment of other illnesses. In particular with regard to HIV, provision of palliative care within a household can provide access to other vulnerable members of that household.

"Home-based palliative care allows access to the family members who are not infected with HIV or terminally ill with AIDS. The provision of tangibly effective care, especially pain relief, helps to break down barriers of mistrust between these communities and "outsiders". Cheap, effective, and culturally appropriate palliative-care programs are therefore a powerful tool for reaching vulnerable populations and so ideally should be locked into prevention and treatment programs."¹⁸

Limited Resources

With few resources and substantial reliance on donor support, the development of palliative care needs to be strategic, cost-effective and provide maximum coverage. Reliance on Western models of freestanding hospices will not achieve these goals – a community-based palliative care approach which integrates existing community and home –based care approaches with the skills, knowledge and access to drugs already found at tertiary levels in Côte D'Ivoire provides the best model for expansion of palliative in an environment of limited resources.

Health Infrastructure

With a history of economic and political instability Côte D'Ivoire's health infrastructure is fragile. The political and economic crises have undoubtedly adversely affected the government's ability to provide care and support services throughout the country and to expand those that exist.

Furthermore an emphasis on surveillance and prevention has meant that care and support services are not well-developed and are limited in coverage. There has, until now, been only a limited government response to leading regulation, institutionalization and provision of care in the community. The decentralization of government departments to district level exists on paper but in many areas is unable to function well, due to lack of resources and fragmentation during the years of political and military unrest.

The expansion of palliative care needs to be seen as a source of strengthening the ability of districts to reach those people in need of care and not an added burden on already fragile systems. A multi-sectoral approach to development of palliative care in districts would both share the responsibility for its provision and ensure palliative care would be recognized as a multidisciplinary approach from the outset rather than a purely medical approach. This would need skilful management and effective collaboration of a team drawn from the relevant sectors and stakeholders so that the responsibilities for

¹⁸ Lancet. Editorial • Vol 362 • November 29, 2003 • www.thelancet.com

implementation of a palliative care strategy are maintained and carried through in practice.

Need for National Consensus and Strategy on Palliative Care

Currently palliative care (les soins palliatifs) in Côte D'Ivoire is understood in several ways – for some it has the meaning of end-of-life care as described in the *Guide National de Prise en Charge Communautaire des Personnes vivant avec le VIH/SIDA* with the accompanying understanding that the skills involved comprise only massage and "being with" the person (both of which are indeed essential components of palliative care) . For others there is an understanding of "accompanying" the person who is dying, i.e. that palliative care is solely care of the dying person.

For many of the members of the NGOs involved in community care and for the palliative care specialists at tertiary level, however, there is a clear understanding that there is more to palliative care than care of the dying person, essential though that is. The challenge then is to develop a national consensus on palliative care for Côte D'Ivoire, drawing on the expertise of those already involved in its establishment and those groups already engaged in community-based support and addressing the three key areas of policy, access to drugs and education.

Successes and Opportunities

The development of the Cancer Registry at CHU is a significant step in creating a framework for a national approach to cancer and to palliative care. Research and publication of findings in peer-reviewed journals in an environment of very limited resources demonstrates a considerable commitment to improvement in quality of services.

Similarly the development of the Pain Society and its support throughout many of the leading health establishments in Côte D'Ivoire is testimony to the commitment and energy of its leading members.

Pediatric palliative care is in its infancy in most countries in the world; Côte D'Ivoire is already taking steps to address this urgent need and has, in its various programs the foundations of a comprehensive approach to palliative care for children, extending from community to tertiary level and back which could serve as a model for other resource-poor settings.

Collaboration with existing international palliative care organizations and associations can provide much-needed support in the expansion of palliative care. The newly-formed African Palliative Care Association is one such organization. Making links and collaborations with practitioners in other Francophone countries could also prove valuable in sharing expertise and experience.

In severely constrained circumstances Côte D'Ivoire has developed creative ways of addressing the need to provide palliative care. In the absence of much in the way of external influences individuals and community groups have defined for themselves, out of necessity, broader approaches to palliative care than might be seen in countries which have a longer history of palliative and hospice care and are struggling to expand their services.

The understanding of care across the continuum in the community which has arisen out of the urgent need to provide care and support and the approach to palliative care at tertiary level which has developed out of the need to address acute and chronic pain and pain in palliative care provides a broad base on which to build an integrated and community-focused palliative care framework for the country. While there yet needs to be consensus at national level on enabling the key elements required for national provision of palliative care, nevertheless in these early stages of development of palliative care this is a golden opportunity for the government of Côte D'Ivoire to create a strategic framework that ensures palliative care provision at all levels.

Limitations to the Appraisal

The greatest limitation to the appraisal was the brief amount of time in which to carry out site visits. As a result it was not possible to visit any services outside of Abidjan, and even in Abidjan, some services were not visited because of unavailability of personnel at those services during the ten-day period in which the appraisal took place.

In-depth interviewing of the service representatives consumed most of the time on the site visits. It was not possible to attend home visits with any of the services, and therefore not possible to interview clients in their own homes.

While it was possible to meet briefly with clients and family members on some of the site visits, it was not possible to undertake in-depth interviews with clients or family caregivers; the appraisal concentrated on aspects of service provision.

It was not possible to meet with representatives from medical and nursing associations due to time constraints. These bodies can be strong advocates of palliative care and their views and support are extremely important in any discussion of developments in health care – current understandings of palliative care by these bodies would have added to a broader understanding of the issues involved in expansion of palliative care and provided an opportunity to engage their support.

Recommendations

The overall recommendation of the appraisal is that the government of Côte D'Ivoire should take this current opportunity to expand palliative care into one integrated system, through integrating the comprehensive palliative care being implemented in tertiary settings with the palliative care approaches demonstrated in community settings; thereby

providing one unified national approach to palliative care which enables clients to gain access to palliative care at each level of services, and most importantly, in the home.

The following recommendations follow on from this overall recommendation and provide a series of steps and interventions to support the expansion of palliative care into one integrated system. They are based on direct recommendations of some of the staff of the programs visited, document analysis and observations of the appraisal team. It is acknowledged that many of these recommendations will be dependent on funding and other resources, not least human resources in the form of technical assistance. Cost-effective ways to achieve these steps need to form part of the future discussions and planning for a national palliative care strategy.

Immediate Recommendations

1. **Establishment of a national working group** with representation from tertiary level palliative care services, members of the NGOs currently involved in care provision, and government to develop an introductory workshop to engage stakeholders in discussion about palliative care expansion in Côte D'Ivoire.
2. **A workshop involving key stakeholders** from government departments, including drug regulators, legislators, policy makers, non-government organizations, academic faculty, medical nursing pharmacy and other professional associations, to raise awareness about palliative care – to discuss what palliative care is, the need for palliative care in Côte D'Ivoire, identify opportunities and barriers to its expansion, and reach consensus on development of a palliative care task force to lead the process of expansion of palliative care.
3. **The Palliative Care Task Force** should comprise broad representation from government departments, non-government organizations, clinicians, pharmacists, academic faculty staff, and professional associations.
4. The Task Force should have opportunity to engage in **intensive palliative care training of its members** to enable all members to share common elements of palliative care
5. **Technical assistance should be provided to the task force** in the short to midterm (one- two years) by a palliative care specialist/s experienced in development and expansion of palliative care in resource-poor settings.
6. **The Palliative Care Task Force** should develop an agenda of tasks as a result of the recommendations of the workshop, but which should essentially work towards development of a national palliative care strategy which integrates community-based care with tertiary palliative care skills, knowledge and access to essential drugs, to include :
 - national palliative care policy
 - palliative care clinical guidelines for each level of services,

- palliative care training strategy, including learning needs assessment for undergraduate, qualified clinicians, and NGO staff to inform discussion with academic faculty and NGOs on inclusion of palliative care training in existing training courses and curricula
 - palliative care training curriculum – can be adapted from existing and relevant international curricula
 - strategies to address access to essential drugs
 - strategies to disseminate and ensure implementation of the national palliative care strategy
 - palliative care monitoring and evaluation guidelines including quality assurance measures
7. To support the Task force in accomplishing these tasks the task force should have the ability to **co-opt representatives** to work on specific tasks, for example curriculum design, monitoring and evaluation framework.
 8. To support the above steps **resource development** needs to be addressed – international donors and other potential sources of assistance, technical, material and financial should be sought – a summary proposal of intended aims and activities should be developed by the initial working group to aid solicitation of funds from donors. However it is also incumbent on international donors to recognize and respond to the urgent need for sustained funding and sustained technical resources for Côte D'Ivoire to achieve its potential of expanding palliative care into a successful integrated national model.
 9. **Translation** of available and contextually-appropriate palliative care information into French should be supported as a short-term project to provide the task force with basic materials for distribution at meetings , workshops etc.

Midterm Recommendations

Implementation of Policy

- **Regional positions** should be created for representatives of palliative care who would assist in coordinating the implementation of national palliative care policy and practice at regional level.
- Government should identify and partner with selected NGOs currently involved in palliative care approaches in the community to **develop pilot community-based models** of palliative care, in collaboration with tertiary level facilities for access to essential drugs, to become demonstration models of palliative care for the country.

Advocacy

- International agencies and donors involved in prevention, health promotion, care and support activities should form **a network to share expertise and experiences**, collaborate on keeping up to date with expansion of palliative care, and most importantly to act as an advocacy body nationally and internationally.
- Regional coordinators (see above) should act as representatives of palliative care in the role of **local advocate for palliative care** within the region
- **Support should be provided for the Pain Society** to continue its advocacy and awareness-raising work in addition to its representation on the National Task Force
- Community organizations which have been less active in sharing experiences and expertise should be actively **encouraged to join the network of organizations** and regularly contribute to information-sharing

Education

- **A system of training in palliative care** should be developed according to the training strategy developed by the task force and should include – inclusion of palliative care training within existing undergraduate courses for medical, nursing, social work and pharmacy training, development of short course for post-graduate professionals, development of standard palliative care training for care workers in NGOs, development of introductory and advanced courses for practitioners at multiple levels and from multiple sectors
- Ways to **provide scholarships or bursaries** for NGO care workers to support attendance at palliative care courses should be explored.
- **mentoring, supervision and communication skills training** should be developed for palliative care practitioners at all levels to support and further train colleagues in these skills

Research and Quality Assurance

- **Research into pain and symptom prevalence** in different groups of clients, in hospital and at home, will provide solid data for support for increased access to essential drugs
- **Development/adaptation and consistent use of a pain assessment instrument** will provide a data collection instrument for research purposes and provide a quality assurance instrument by which practitioners can better address client needs, improve their own practice and the practice of others.

- **Research on stigma in cancer and AIDS** will provide data to inform education of practitioners in palliative care and support a behavior change communication interventions to address stigma on a broader scale.
- **Operations research** on development of the pilot community-based models of palliative care

Regulatory Mechanisms

- **Decisions on the licensing and accreditation of services designated as palliative care services**, that is, regulation of their status with respect to level of service which can be provided, access to essential drugs and accountability, should be included early on in the process of policy development
- **A follow –up workshop to engage government departments and other relevant stakeholders** in self-assessment on opioid availability, review constraints to access to essential drugs, to review current policy, e.g. seven -day prescription regulation, should be held within six months of the first awareness-raising workshop.

Appendix 1

Documents Reviewed.

Echimane, A., Ahnoux, A., Adoubi, I., Hien, S., M'Bra, K., D'Horpock, A., Diomnade, M., Anongba, D., Mnesah-Adoh, I. and Parkin, D. 2000. Cancer Incidence in Abidjan, Ivory Coast. First results form the Cancer registry, 1995-1997. *Cancer*. Vol. 89. No. 3:653-662

International Narcotics Board. *Narcotic Drugs. Estimated World Requirements for 2004. Statistics for 2002*

Ministere Delegue aupres du Ministre de la Solidarite Charge de la Sante. Côte D'Ivoire. *Rapport sur la Situation Sanitaire des Annees 1999 et 2000.*

Ministere Delegue aupres du Premier Ministre, Charge de la Lutte contre le SIDA. Côte D'Ivoire. *Plan National de Lutte contre le VIH/SIDA 2002-2004*

Ministere D'Etat, Ministere de la Sante et de la Population. Côte D'Ivoire. *Decret No. 2003-194 du Juillet 2003 Organization du Ministere D'Etat, Ministere de la Sante et de la Population.*

Ministere D'Etat, Ministere de la Sante et de la Population. Côte D'Ivoire. *Plan D'Action de Lutte contre le VIH/SIDA dans le Secteur de la Sante 2004-2006*

Ministere de la Sante, de la Solidarite et de la Securite Sociale. *Guide Nationale de Prise en Charge Communautaire des Personnes Vivant avec le VIH/SIDA*

Ministre de la Solidarite, Charge de la Sante. 2003. *Liste Nationale de Medicaments Essentiels et de Materiel Bio-medical.*

Program National de Lutte contre le Cancer. *Plan D'Action 2005*

Sante Familiale et Prevention du SIDA. Family Health International. *Analyse Situationnelle des Soins et Prise en Charge du VIH/SIDA et des Infections Sexuellemnet transmissibles. Burkina Faso, Cameroun, Côte D'Ivoire, Togo.*

Appendix 2.

Definitions of Palliative Care - World Health Organization

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

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

WHO Definition of Palliative Care for Children

Palliative care for children represents a special, albeit closely related field to adult palliative care. WHO's definition of palliative care appropriate for children and their families is as follows; the principles apply to other pediatric chronic disorders (WHO; 1998a):

- 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, and social distress.
- Effective palliative care requires a broad multidisciplinary approach that includes the family and makes use of available community resources; it can be successfully implemented even if resources are limited.
- It can be provided in tertiary care facilities, in community health centers and even in children's homes.

Appendix 3. People and Programs Visited

Day	Sept	Program	Program focus/activity	
Saturday	11 th	Centre l'Espoir and Centre L'Espoir D'eux Adjoufou	Community-based NGO providing clinical care and a wide range of care and support services for adults and children – outpatient, inpatient, end-of-life care, residential care for orphans	M. PERTON Yvon Acting Coordinator Mme. LHOMME Marie Odile Volunteer Nurse
Monday	13 th	Centre Plus. Ruban Rouge Yopougou	Community-based NGO providing Comprehensive care for PLHA including VCT, referral for ARVs, support for ARV maintenance including funding, support groups, Home Based Care	M. Cyprien N'Gouolele Mafoula Coordinator
Monday	13 th	Sous – Direction de la Prise en Charge psychosociale Ministere de la Sante	Ministry of Health sub Directorate - working in partnership with NGOs throughout the country in developing a decentralized system of care and support , through regional and local committees	Mme. Souberou. Sous-Directrice M. Bilou Raymond
Monday	13 th	Pharmacie de la Sante Publique (PSP)	Procurement and Distribution of Pharmaceuticals	Dr. Menson, Josette
Tuesday	14 th	ACONDA Program enfant Yopougou CHIGATA	NGO providing a range of services for adults, including clinical care, social and emotional support, outpatient and functional referral system for inpatient care Research program on children living with HIV and AIDS NGO providing a range of services for	M. Kouassi, Clement Mental Health and HIV Nurse, Dr Kouakoussui Alain Program Enfant As above

			children and adolescents, including social and emotional support, education of families in care for children and in supervision of ARVs and other treatment, counseling for adolescents, home visits	
Tuesday	14 th	CASM Hope Worldwide	International NGO providing a wide range of home- based care and support services including end- of life care, food clothing and home goods distribution, support children's scholastic needs	Dr. Isabelle Kouame Technical Director
Wednesday	15 th	National Cancer Service	Only specialist cancer unit, Inpatient unit and site of cancer registry, also cancer research unit	Dr Adoubi Service de Cancerologie Centre Hospitalier Universitaire de Treichville, Abidjan
Wednesday	15 th	Unite de Soins Ambulatoires et de Conseils	Ambulatory Care Unit for people with HIV/AIDS providing full range of services in outpatient setting, referral on to NGO for inpatient needs	Dr. Kangar , Constance
Wednesday	15 th	AMEPOUH	Women's and childrens' respite, residential and advocacy service, focusing on rehabilitation inot family and community, but also providing residential services and end-of-life care	Mme. Ouso, Christine President Mme Agnes Kouassi Secretary –general
Thursday	16 th	DPM Direction de la Pharmacie et du Medicament	Section of the National Ministry of Health responsible for drug regulation and reporting.	Dr. Assi Gbonon, Rosalie Directeur
Thursday	16 th	Palliative Care Service, Cocody Hospital	Head of Neurology department	Professor Beugre Head of Department
Thursday	16 th	Lumiere Action	Community-based PLHA NGO - a wide range of services including counseling and testing, counseling and emotional support,	Confidential

			minor outpatient treatments, referral for more complex needs to ambulatory care service, support groups, home visits for social support	
Friday	17th	Direction des Etablissements et Professions Sanitaires	Government Department in charge of health profession regulation	M. Natibale Benjamin
Friday	17th	Societe contre la Douleur – SILUD (Pain Society of Côte D'Ivoire)	PISAM Tertiary Hospital Abidjan	Dr. Kane Mbaye. Head Department of Anaesthesiology PISAM private hospital . Head of SILUD Dr. Kouadio Simplicie Anaesthetist Head of Dept ICU PISAM private hospital and SILUD executive member
Friday	17th	Dr. Die Kacou	PISAM Tertiary Hospital Abidjan	Professor of Pharmacology Faculty of Medicine University of Abidjan