Health Services Learning Hub

ACTION BRIEF

Delivering palliative care services amidst the COVID-19 pandemic at a rural hospice in Uganda

Country / Institution:

Uganda, Little Hospice Hoima- Hospice Africa Uganda

Uganda, African Palliative Care Association

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Key learning points

- Our experience shows the use of a mobile phone to reach patients instead of in-person visits and “boda boda” services for the delivery of medicines are simple cost-effective interventions that can be rapidly adopted in emergency situations like lockdowns, to ensure continuity of care.
- Palliative care services in Uganda heavily depend upon nongovernmental organizations. Integration of palliative care into the national health care system is vital for a more effective people-centred response to emergency situations and for achieving universal health coverage.

Background

Hospice Africa Uganda (HAU) provides palliative care to patients, as well as palliative care training for providers across Africa. Uganda is the clinical headquarters of operations for Africa, where HAU produces morphine, treats patients and runs education programmes in other African countries. HAU is located across three sites, comprising the headquarters in Kampala, and two smaller sites in Hoima and Mbarara.

HAU is a member of the African Palliative Care Association (APCA). APCA is a membership-based non-profit pan-African organization that works through partners to ensure that palliative care is available to all those who need it across Africa.

Similar to many countries around the world, Uganda’s health system was not prepared to appropriately respond to the unprecedented emergency situation caused by the COVID-19 pandemic. The pandemic increased inequities and the vulnerability of people who were already vulnerable, such as patients with chronic conditions such as cancer and HIV infection.

This action brief describes interventions adopted by Hospice Mbarara to cope with the shock caused by the COVID-19 pandemic and to ensure continued delivery of palliative care services to those in need in the South-Western part of Uganda, during the pandemic.

Impact of COVID-19 on essential health services

When the pandemic struck Uganda, like in many other countries, COVID-19 was given priority over essential health services such as palliative care, mental health and cancer care.

The nationwide lockdown instituted in Uganda to reduce community transmission of the COVID-19 infection sharply impacted access to palliative care services, with many patients missing their clinical appointments due to the restrictions imposed, and also increased transport fares. Health workers were also challenged by the movement restrictions.

Facing a very challenging financial situation, community service organizations were forced to downsize staff or reduce staff salaries to reduce costs. Additionally, the provision of personal protective equipment, and other equipment such as temperature guns, and the structural modifications to ensure physical distancing further increased the financial burden. This was made even worse due to dwindling donor funding, as priorities shifted to COVID-19.

Socioeconomic consequences of the pandemic on the population included anxiety due to financial problems, fear of contracting and dying from the infection, having limited social interactions, and conflicting or confusing messages about COVID-19.

What was the intervention or activity?

1. In compliance with COVID-19 preventive measures, Mbarara Hospice introduced work shifts for health workers to ensure physical distancing, i.e., four staff at a time (two clinicians, a receptionist, and a security guard) as opposed to 17 during the pre-pandemic era.
2. To overcome movement restrictions, clinicians and nurses used mobile phones to call the patients and gather information about their issues. Medicines were sent to patients via “boda boda” (bicycle and motorcycle taxis). Follow-up phone calls were made to check that each patient had received their medicines, and to assess their effect on relieving symptoms.
3. To face the unforeseen financial situation, the hospice applied for rescue grants and received some support in the form of money or supplies e.g., masks, temperature guns, tents. Mobile Hospice Mbarara won a GBP 5000 grant from the True Colours Trust run by the African Palliative Care Association, to ensure extension of palliative care services through home visits to patients outside the hospice’s catchment area (beyond a 40km radius), including the provision of information about COVID-19 prevention.
4. The Hospice’s Clinical Director formulated communication guidelines to reduce communication gaps and associated anxiety related to the pandemic.
5. Welfare support was provided in the form of food supplies for financially-stressed patients and their families. This was enabled through the hospice comfort fund, and also in-kind donations.
6. Daily home visits were modified to emergency home visits, conducted under strict observance of SOPs.

How did this intervention/ activity contribute to the maintenance of EHS?

Thanks to implementation of the above-mentioned interventions, Mbarara Hospice was able to ensure continuity of palliative care services for 1298 patients and 7146 patient contacts during the pandemic (March 2020 to December 2021).

What were the key challenges involved?
How were these challenges overcome?

Lack of access to mobile phones limited the delivery of care to some patients. Where possible, in-person visits were then opted for.

The available funding did not meet the increasing demand and the hospice had to cut down on some services, such as community outreaches, which were temporarily suspended.

Please list any areas of support you require in the maintenance of essential health services

- Transport. There is a dire need for new vehicles to ease the conduction of home visits and outreaches as the ones available are now old, making it difficult to navigate poor roads, common in many rural areas.
- Funding for training/education, medicines, research and human resource for palliative care.
- Capacity-building, for research, training and service provision.
- Advocacy. Need for a national functional palliative care policy to guide, support and sustain palliative care service delivery.
- Support for strengthened community volunteer workers, who form a vital link between health facilities and the community, in terms of the identification, referral and follow-up of patients.

- Human resources. Adequately trained human resources are needed, given that many health professionals lack the knowledge and skills to provide good palliative care.
- Education and training, to build the capacity of nurses and medical doctors in caring for seriously ill or palliative care patients.