Special Article

Uganda: Delivering Analgesia in Rural Africa: Opioid Availability and Nurse Prescribing

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Abstract
Hospice Africa Uganda introduced palliative medicine to Uganda in 1993 with enough funds to support a team of three clinicians for three months. Training in the medical and nursing schools was introduced in 1994. Since then, Uganda has achieved the three essential components of an effective public health strategy. It has also been the first country to have palliative care described as an essential clinical service and included in both the government's Strategic Health Plan and its HIV/AIDS National Strategic Framework (in 2000 and 2004), and to change the law to allow nurses and clinical officers who complete special training in palliative medicine at Hospice Uganda to prescribe morphine. Palliative care is spreading throughout the districts of Uganda, ensuring that morphine will be available to everyone who needs it. This is being done in collaboration with the Ministry of Health (MOH) and other organizations that collaborate in two umbrella organizations: the Palliative Care Association of Uganda and the Uganda Palliative Care Country Team. The former works "on the ground" in each district, establishing standards, collaborating, and carrying out continuing medical education in palliative care for all. The latter, chaired by the MOH, operates with the government to implement an integrated, coordinated, affordable, and culturally acceptable palliative care service throughout the country. J Pain Symptom Manage 2007;33:547–551.

Key Words
Policy, nurse and clinical officer prescribers, public health approach, affordable service, oral morphine, hospice, palliative care service and education

Introduction

Case Example

Mary is 28 years old. She is married to a subsistence farmer. She helps on the farm and raises her family. At 28, she has 7 children from 3 different men (the eldest 12 and the youngest 1 year old).

Mary first noticed that she was bleeding after intercourse. She woke up bleeding one morning and rushed to the traditional healer who gave her herbal medicine. Like 57% of Ugandans, she and her family do not see a health worker. Three months later, she was in severe pain. The herbs were no longer working and she was bleeding on and off on a daily basis. Although initially she experienced pain only

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during intercourse, it was now enveloping her pelvis, shooting down her legs, and making it difficult for her to get out of bed and to do her housework. Her 10-year-old daughter had to get the others up and into the fields or to school. The family was worried. Word got around the village that Mary was "down."

The volunteer health worker, John, also a village member, heard about Mary's plight and visited her. He realized that her pain was too severe and that she required help from the palliative care team, of which he had been a member for the last six months. He quickly made a mobile phone call and told the palliative care nurse of Mary's plight. He arranged to meet the team the next day at the health center to show them the way to Mary's house. A nurse from the palliative care team came to visit Mary. It took approximately one hour by car to reach Mary's house from the health center.

Mary's pain was controlled within 24 hours after a skilled examination, diagnosis, and treatment by Betty, the Certified Palliative Care Nurse Specialist. Betty also won the confidence of the family. When Mary was a little stronger, Betty was able to encourage her to see a doctor, who made a diagnosis of cancer with extensive spread and could refer her to the only radiotherapy unit in Uganda. For this, she would need money. Following assessment by her nurse, Mary received support from the Hospice "comfort fund," a fund to assist poor patients to acquire their basic needs and access to treatment. If needed, it ensures that transportation costs to hospital and the cost of food, blankets, and upkeep are covered.

This is a story ending in tragedy for a young family. When the diagnosis is finally confirmed, it is usually too late for curative treatment. Palliative radiotherapy, continued pain control, and support from the palliative care team will bring Mary some comfort and prolong her life. This will allow her time to make peace with her God, within her own beliefs, and peace with her family. Once she is free from pain, she can share time with her family and plan for the children's future. Visits from the palliative care team will also ensure support for her husband and provide honest explanations so that respect for her within the family is preserved when she weakens.

Mary died in peace at home surrounded by loving family and carers with the knowledge that through networking, the needs of the children have been discussed and action taken to ensure their future.

How was Mary able to access this care in Uganda? This paper explains the advances that have occurred using the three essential components for a public health strategy to integrate palliative care, recommended by World Health Organization (WHO): 1) political will (government support), 2) affordable medications, and 3) education of health professionals and advocacy in Uganda from the government to communities.

Initiation of Palliative Care and Palliative Medicine in Uganda

Palliative care in Uganda started in 1993, inspired by the vision of the founder, Dr. Anne Merriman, which arose from witnessing the suffering of cancer patients in Nairobi and HIV/AIDS patients in Uganda. Working with the Minister of Health, she insisted that palliative medicine required affordable oral morphine to be available. This was agreed to by government officials. Powdered morphine suitable for reconstitution in a pharmacy was imported, and the first palliative care started in 1993.

Prior to 1993, there was no specific care offered for those dying from cancer, HIV, or other terminal illnesses. The knowledge of the specialty, first described in 1967 and first confirmed as a specialty in the United Kingdom in 1987, was unknown in Uganda and most of the countries in Africa. Affordable medications were not available to control pain or other symptoms. These were introduced following training and the publication of "Principles of Pain Control" by Hospice in 1994.[1] These principles were later taken up by the Ministry of Health (MOH) and published in their own Uganda Clinical Guidelines in 2003.[2]

Policy Initiatives

After extensive advocacy to health officials, health planners, health care professionals, pharmacists, political leaders, and the community for a period of five years, a stakeholder's workshop was convened in 1998. At this workshop, a task force was established to draft a national policy for palliative care. At the same time, the government, through the MOH, was

discussing the First Health Service Strategic Plan (HSSP) for the years 2000–2005. The task force produced a Draft Policy for Palliative Care in Uganda. Through further advocacy and WHO support, the Palliative Care Draft Policy was incorporated into the HSSP 1, 2000–2005.

For the first time, palliative care was put into the package of Essential Clinical Services to be delivered in government health institutions.

In the current HSSP II, 2006–2011 palliative care is fully covered. It clearly states that all hospitals and Health Centers IV should be providing palliative care. It also states and confirms that adequate stocks of appropriate medication and supplies for palliative care will be available. The document goes into details of capacity building for palliative care in collaboration with stakeholders, strengthening partnership with community-based palliative care providers and strengthening referral systems and linkages with health services and home care. It emphasizes the need for community-based rehabilitation of the terminally ill, that outreach sites shall be established and strengthened, and most importantly, that palliative care shall be integrated into the curricula of health training institutions.

Education

Education and training were started in the two medical schools by delivering palliative care lectures to fourth-year medical students, from 1993 onward in Makerere, and from 1998 at Mbarara University of Science and Technology, the second medical school based in Mbarara (in the southwest of the country). Since then, sensitization and strategic action to dispel myths, fears, and misconceptions about addiction associated with the use of morphine have been ongoing. Teaching has emphasized the fact that addiction is rare when morphine is used for severe pain (in keeping with the WHO position[3]).

Implementation

Country Palliative Care Team at the MOH

To oversee countrywide palliative care, a national palliative care team was established. This team, chaired by the MOH Commissioner for Clinical Services and encompassing all networking organizations involved in support and palliative care, ensures that policy, personnel, essential drug supplies, etc. are available wherever they are needed. It is also concerned with the establishment of guidelines and standards within the national health policy. The "country team" consists of representatives from

- MOH: pharmacists and doctors
- Mildmay Centre
- Hospice Africa Uganda
- TASO
- Uganda Cancer Institute
- The Radiotherapy and Surgical Departments—Mulago Hospital
- Makerere University
- Kitovu Mobile Care Centre
- The AIDS Control Programme—ACP/MOH
- WHO Representative's Office
- Palliative Care Association of Uganda (PCAU, 2006)
- African Palliative Care Association (APCA, 2005)
- Uganda AIDS Commission (UAC)—not yet a member

Widening Opioid Prescribing

Since 1998, advocacy efforts focused on amending the section in the National Drug Policy and Authority Statute 1993 that only allowed registered medical practitioners, dentists, and veterinary surgeons to prescribe morphine. On April 23, 2004, an amendment was passed that allows specialized palliative care nurses and a special Ugandan cadre of health workers, known as clinical officers, to prescribe morphine. This was a great step in the efforts to increase accessibility and availability for pain relief right down to the level of rural homes, where 86% of Ugandans live. People, who were previously doomed to die in pain from cancer or HIV/AIDS and other painful conditions, could now be cared for in their homes, among their communities, where most Africans prefer to die.[4] As well as being more culturally acceptable, this approach is cheaper than hospitalization.

Clinical Palliative Care Course

The Clinical Palliative Care Course (CPCC) trains palliative care nurses and clinical

officers to prescribe morphine appropriately and effectively since the CPCC began in 2002. To date, 53 individuals have graduated. This nine-month course consists of eight weeks of theory, one 12-week residential period at Hospice Africa Uganda sites (a palliative care specialist experience), one 10-week palliative care/HIV placement (at specialist HIV care organizations and Mulago Hospital), and one 10-week session back in their own place of work, where they are expected to plan implementation of their palliative care service following completion of the course. The curriculum includes a public health approach to the needs in their own district. The CPCC graduate is expected to take a lead in coordinating palliative care through initiating or supporting a local branch of the PCAU, arrange case conferences and continuing medical education sessions for those working in palliative care, work with the District Health Commissioner in extension of services, and advocate to incorporate palliative care into district and community plans for finance and support.

To date, graduates are working in hospices, on palliative care teams in hospitals, and in districts under the MOH. Initially, a few graduates encountered constraints when they returned if palliative care had not been well defined at their place of work in advance. To address this, before a trainee is accepted in the program, course directors are now asking employers to guarantee that the trainee will work in palliative care for at least two years after graduation; graduates will lose skills if they are not used immediately and both they and the community lose out.

Community Volunteers

In the last three years, Hospice Africa Uganda has developed a community volunteer program. It began in Hoima, a poor rural area of Uganda, where reaching people scattered throughout the district was difficult and many patients were dying without palliative care. In 2006, 30 additional community volunteer workers were recruited at each of the hospice sites to strengthen the existing 34 community volunteer workers (across the three sites). These community volunteer workers, identified through their local community leaders, were given six days of training, followed by quarterly one-day refresher trainings. They receive monthly supervision and support visits by the Hospice Community Volunteer Worker Coordinators and day-to-day support by the Hospice palliative care team when they are in their areas. To help with transport and their work, these community volunteer workers were given bikes and were provided with a basic care kit to support them in provision of basic care (containing items such as gloves, mackintosh, soap, petroleum jelly and an antiseptic solution). Today, Hospice has a network of 122 active and dedicated community volunteer workers who identify and support patients in pain in the community. Those who are in need of our care due to pain, critical illness, or coming to the end of life are visited regularly and the community volunteer workers assist and serve as a liaison between the patient and the CPCC nurse in the team. When patients are encountered who are not in need of specialized palliative care but require other care, such as HIV testing or ARVs, they are referred to other relevant networking organizations after a full assessment and assured that if they need our help later in the disease, they will be cared for.

Conclusion

Using the three components for an effective public health strategy recommended by the WHO, Hospice Africa Uganda has been able to integrate palliative care into Ugandan health care by winning political support, ensuring the availability of opioid analgesics to the wider community of patients living in villages, and providing education and awareness about palliative care.

Today, palliative care is a reality for many patients and families in Uganda, and it is spreading rapidly throughout the county. By linking the palliative care strategy to the HIV/AIDS epidemic, it has been possible to accelerate the rapid development of palliative care. If palliative care had only been pegged to cancer, the story would have been very different.

References

1. Merriman A. Pain and symptom control in the cancer and/or AIDS patient in uganda and other

African countries, 1st, 2nd, 3rd, 4th, ed. Kampala, Uganda: Hospice Africa Uganda, 1994–2006.

2. Ministry of Health and National Drug Authority. Uganda clinical guidelines 2003. Kampala, Uganda: Ministry of Health and National Drug Authority, 2003: 341–349.

3. World Health Organization. Achieving balance in national opioids control policy—guidelines for assessment. Geneva: World Health Organization, 2000.

4. Sepulveda C, Habiyambere V, Amandua J, et al. Quality care at the end of life in Africa. Br Med J 2003;327:209–213.