



4th Uganda Conference on Cancer and Palliative Care

Hosted by

The **Uganda Cancer Institute (UCI)** and
The **Palliative Care Association of Uganda (PCAU)**



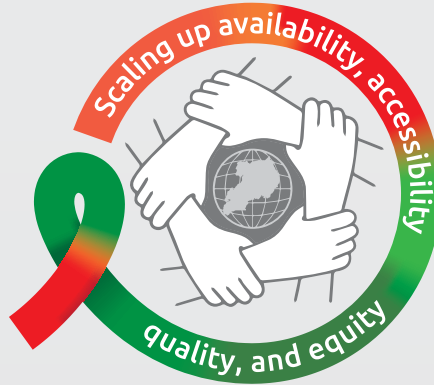
Uganda Cancer Institute



Conference Abstract Book and Programme



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Acknowledgment

Thank you
our sponsors!





Message from the Minister of Health

Dear Conference delegates and invited guests,

I extend a warm welcome to all of you to the Pearl of Africa. It is with immense pleasure that I address you today.

Over the past 8 years, the Ministry of Health has wholeheartedly supported the biennial Uganda conference on cancer and palliative care. This event has garnered international recognition, drawing professionals from East Africa, the rest of Africa, the USA, Europe, and around the globe.

Uganda's government has taken proactive steps to confront the escalating cancer burden and the associated challenges. In 2016, we enacted the Uganda Cancer Institute Act. Moreover, we have prioritized access to cancer services within the framework of National Development Plan III. In an effort to bring these services closer to communities, we are establishing regional cancer centers. Our commitment to improving cancer services is also reflected in the progressive increase in budgetary allocations within our resource constraints. These strategic initiatives aim to raise our country's cancer patient survival rates, which currently lag behind those of developed nations. I encourage you to focus your discussions during this conference on scientific interventions and recommendations that will bolster the government's efforts in this regard.

Turning to palliative care, Uganda stands as a model in the region, thanks to the Ministry of Health's concerted efforts, particularly in

providing access to oral liquid morphine for pain management. To enhance coordination and oversight, we have established a Division of Palliative Care in the Ministry of Health. This year, the government has integrated palliative care positions into staffing structures, spanning from the National Specialized Hospital to Health Centre III. Since 1993 when Prof. Anne Merriman Founded Hospice

Africa Uganda, private hospitals, hospices, and other civil society institutions under their umbrella organisation the Palliative Care Association of Uganda (PCAU) have been instrumental in the provision of this service. I applaud their 30 years of dedication and service.

I reiterate our government's unwavering commitment, as well as that of my ministry, to expanding cancer and palliative care services in alignment with Universal Health Coverage principles. Our ministry fully embraces the conference theme, "Scaling up availability, accessibility, quality, and equity." We eagerly anticipate the conference's outcome report and recommendations.

I extend my gratitude to the leadership of the Uganda Cancer Institute (UCI), the Palliative Care Association of Uganda (PCAU), and all individuals involved in organizing this pivotal event. I wish you all a productive and enriching experience.

Wishing you a successful conference period.

Dr. Aceng Jane Ruth Ocero
Minister of Health



Message from the Executive Director Uganda Cancer Institute

Dear participants, colleagues, and esteemed guests,

On behalf of the Uganda Cancer Institute, it is my great pleasure to welcome you all to the 4th Uganda Conference on Cancer and Palliative Care. This important event, held on the 14th and 15th of September 2023, brings together experts, researchers, and stakeholders to discuss and address the critical issues surrounding cancer care and palliative care in our country.

The theme of this year's conference, "Scaling up availability, accessibility, and equity," reflects our commitment to ensuring that cancer prevention, treatment, and palliative care services are accessible to all individuals, regardless of their geographical location or socioeconomic background. By focusing on scalability and equity, we aim to bridge the gap between urban and rural areas, and to empower healthcare providers to deliver high-quality cancer care and palliative services to every patient in need.

This conference provides a unique platform for sharing knowledge, experiences, and best practices in cancer prevention, early detection, treatment, and palliative care. Through insightful presentations, interactive workshops, and engaging discussions, we will explore innovative approaches and strategies to improve cancer outcomes and enhance the quality of life for

patients and their families.

I would like to express my gratitude to the organizing committee for their tireless efforts in putting together this remarkable event. Their dedication and hard work have ensured a robust program and a diverse range of topics, encompassing the multidisciplinary nature of cancer care and palliative care.

I am confident that this conference will not only enhance our understanding of the challenges we face but also inspire collaboration, foster networking, and generate innovative ideas to transform cancer and palliative care in Uganda. Together, we can make a significant impact on the lives of individuals affected by cancer and advance the field of oncology.

Once again, welcome to the 4th Uganda Conference on Cancer and Palliative Care. I encourage you to actively participate, share your expertise, and engage in meaningful conversations that will shape the future of cancer care in our country.

Thank you, and I wish you all a successful and enriching conference.

Sincerely,

Dr. Jackson Orem

Executive Director - Uganda Cancer Institute



Message from the Executive Director Palliative Care Association of Uganda

Dear Conference delegates and invited guests,

Welcome to the 4th Uganda Conference on Cancer and Palliative Care. This is our first in-person conference post the COVID-19 pandemic. In 2021, we could only meet online. We thank God that we can now gather physically for this important scientific event.

The theme of this conference resonates well with the vision of the Palliative Care Association of Uganda (PCAU). One of the aims of PCAU is to enhance research work that is dedicated to palliative care. This biennial conference is therefore an important activity of the association. By choosing to participate in this conference, you have subscribed to support the mission and vision of PCAU. Thank you!

This year, we mark 30 years since Prof. Anne Merriman founded Hospice Africa Uganda (HAU) the pioneer standalone hospice in Uganda. As you will learn from the various scientific papers at this conference, the availability of palliative care in Uganda has been progressive over time. There are several milestones, and we celebrate these.

Congratulations and thank you to all who have contributed to the 30-year journey!

The need for quality palliative care is rising faster. It is therefore important that while making recommendations at this conference, we focus on the notion

of quality which entails the following domains: **effective, safe, people-centered, timely, equitable, integrated, and efficient care.**

The conference program is rich. It offers a variety of learning, sharing, fun, and networking opportunities. I hope that you will utilize these opportunities fully and that your stay at the conference will be very valuable to you and to the patients and families that you touch.

Executing this conference takes many hours of preparation. Please join me in thanking the conference Co-Chairs and committees.

They did a great job. We thank the leadership of the Uganda Cancer Institute (UCI) for the good working relationship and partnership to deliver this conference.

Lastly, I would like to urge all delegates and invited guests to join PCAU. Membership in the association is for all individuals and institutions with the interest of supporting palliative care. We have already provided membership forms. Please sign up and join today.

Thank you for coming and I wish you all a great conference experience.

Mark-Donald Mwesiga Bikosa

MPH, MMS BA (SS)
Executive Director – Palliative Care
Association of Uganda (PCAU)



Message from the Chair of the Board Uganda Cancer Institute

Dear participants, distinguished guests, and colleagues,

As the Board Chair of the Uganda Cancer Institute, it is an honor to extend my warmest welcome to all of you on the occasion of the 4th Uganda Conference on Cancer and Palliative Care. This conference serves as a testament to the commitment and dedication of all those involved in the fight against cancer and the pursuit of palliative care in our country.

Cancer continues to be a significant health burden, affecting countless individuals and families across Uganda. It is imperative that we join forces and harness our collective knowledge and resources to combat this disease effectively. This conference provides us with a valuable platform to share evidence-based practices, innovative strategies, and research findings that can help us navigate the complexities of cancer prevention, early detection, treatment, and palliative care.

The theme of this year's conference, "Scaling up availability, accessibility, and equity," is particularly timely and resonates deeply with our mission. We recognize that there are disparities in access to cancer care services, especially in rural areas and among underserved populations. It is therefore crucial for us to explore ways to bridge these gaps and ensure that all individuals, regardless of their background or location, have equal and timely access to quality cancer care and palliative services.

Over the course of this conference, we will have the opportunity to hear from experts in the field who will share their experiences, challenges, and successes. We will engage in thought-provoking discussions and collaborative workshops that will help shape policies and interventions aimed at improving cancer outcomes and palliative care services in Uganda.

I would like to express my deepest gratitude to the Uganda Cancer Institute team, Palliative Care team, the Ministry of Health and the conference organizing committee for their unwavering dedication and hard work in making this event possible. Their commitment to advancing cancer care and palliative care in our country is commendable.

Lastly, I would like to extend my heartfelt appreciation to all the participants and sponsors for their continued support and active involvement. Your presence and contributions play a vital role in the success of this conference, and I am confident that the knowledge and connections gained during this event will contribute significantly to our collective efforts in the fight against cancer.

Thank you for being part of this important gathering, and I wish you all a productive, enlightening, and inspiring conference.

Warm regards,

Prof. William Bazeyo

Chairperson Board - Uganda Cancer Institute



Message from the Chair of the Board Palliative Care Association of Uganda

Dear delegates and guests

It is with great honor that I welcome you all to the 4th Uganda Conference on Cancer and Palliative Care.

Since 2017, the Uganda Cancer Institute (UCI) and the Palliative Care Association of Uganda (PCAU) have harnessed their potential to host this important biennial scientific event which has gained an international reputation. Professional colleagues from the region and outside Africa are joining us again as the conference offers a wonderful opportunity for peer learning and evaluation of practice. It is also an important advocacy and networking platform.

Colleagues and guests, we all appreciate the fact that the need for cancer and palliative care services is on the rise. We all should, therefore, intensify the efforts to make everyone aware of what needs to be done through platforms of a conference like this one and beyond to share and exhibit the science and innovations of our work. Hitherto conference reports have also been published to contribute to the existing body of knowledge.

I would like to commend the Uganda government for its progressive investment in cancer and palliative care work. Having a Division of Palliative Care in the Ministry of Health, establishing Palliative Care positions in the public service structure, and integrating palliative care into the Health Management Information System are all good steps. To achieve these, Uganda is riding on earlier efforts that made oral morphine available.

This conference comes at a time when we commemorate 30 years since Dr. Anne Merriman established Hospice Africa Uganda, the pioneer hospice in Uganda. I would like to congratulate Dr. Merriman and the entire palliative care fraternity in Uganda for the successes registered over the years.

Lastly, I would like to thank the conference organizing committees for a job well done. I also extend the appreciation of the Board of PCAU to the Board and Management at UCI for the continued partnership to co-host this important conference.

I wish you all an enriching experience at this conference.

Dr. Henry Ddunga

Board Chair – Palliative Care Association of Uganda



Message from the Chairs of the Scientific Committee



Dr. Nixon Niyonzima
Scientific Co-Chair

Prof. Julia Downing
Scientific Co-Chair

The Scientific co-chairs, Prof. Julia Downing and Dr. Nixon Niyonzima warmly welcome you to the 4th Uganda Conference on Cancer and Palliative Care 2023. This year our theme focuses on “Scaling up availability, accessibility, quality, and equity for Cancer and Palliative Care services in Uganda.

Our 2021 conference was in the midst of the COVID-19 pandemic and this year we are excited to welcome you in person. The 4th Uganda Conference on Cancer and Palliative Care will be held from the 14th to 15th of September at the Speke Resort Munyonyo, a relaxing resort on the shores of Lake Victoria. We are planning an action-packed conference that will feature exciting science across a range of tracks including; innovation and new technologies; education, advocacy, policy, and the law; health promotion, prevention, and early detection; family and community involvement and empowerment; clinical care and symptom management; and psychological, social and spiritual care, with the cross-cutting themes of communication, research, and paediatrics.

We therefore hope that there will be something for everyone and we look forward to seeing you there.



About the Uganda Cancer Institute



The **Uganda Cancer Institute** was founded in 1967 through a joint venture with the American National Cancer Institute, the Makerere Department of Surgery, and the British Empire Cancer Campaign. The two original wards of the Institute, the Lymphoma Treatment Centre (LTC) and Solid Tumour Centre (STC), were designed to facilitate clinical trials of chemotherapy on cancers that were highly prevalent in East Africa, such as Burkitt's Lymphoma and Kaposi's sarcoma.

Presently it's a leading provider of cancer treatment and research in Uganda with a mission to provide comprehensive and state-of-the-art cancer services, promote early detection, and improve outcomes for individuals affected by cancer.

With a team of highly skilled oncologists, surgeons, radiologists, and support staff, we deliver personalized treatment plans, advanced diagnostics, supportive care services, and participate in clinical trials and research to advance cancer care.

It is a body corporate established by an Act of Parliament, the Uganda Cancer Institute Act 2016, and its functions include but are not limited to:

- (a) Developing policy on the prevention, diagnosis, and treatment of cancers and on the care for patients with cancer and cancer-related diseases.
- (b) Undertaking and coordinating the prevention and treatment of cancers in Uganda.

- (c) Providing comprehensive medical care services to patients affected with cancer and cancer-related diseases.
- (d) Providing palliative care and rehabilitation services to patients with cancer.
- (e) Overseeing the management of cancer and cancer-related services in public and private health centres; and
- (f) conducting or coordinating cancer-related research activities in Uganda and outside Uganda.

UCI maintains an in-patient facility and attends to an average of about 200 patients daily and is focusing on research, training, cancer prevention and cancer treatment in areas of Paediatrics, Oncology, Gynaecology, Radiotherapy, surgery, and pharmacy and recently venturing into bone marrow transplants. The patients served also receive palliative care and rehabilitation services.

Uganda Cancer Institute is committed to extending services to the masses through our strategy of setting up Regional Cancer centers in the Northern (Gulu), West Nile (Arua), Eastern (Mbale), Western (Mbarara)

At the moment, the Northern Uganda Regional Cancer Center (Gulu) is up and running, and Western-Mbarara is partially operational, offering pediatric and Gynaecology services.



About the Palliative Care Association of Uganda



The **Palliative Care Association of Uganda (PCAU)** is the National Association for Palliative Care Providers and well-wishers in Uganda. PCAU was established in 1999 and registered as a Non-Governmental Organisation (NGO) in 2003 with the aim of supporting and promoting the development of palliative care in Uganda. This year, PCAU is commemorating 24 years of coordinating and advocating for palliative care in Uganda. PCAU is composed of 28 Member Organizations and over 1300 individual Members.

PCAU works in partnership with the Ministry of Health, other line government ministries, agencies, departments, civil society and individuals to accelerate the integration of palliative care into the health care system in Uganda.

Our Vision

Palliative Care for All in Uganda

Our Mission

To accelerate the provision and integration of palliative care in Uganda's healthcare system through capacity building, advocacy, research, governance and resource mobilization.

Our Goal

Universal provision and access to culturally appropriate palliative care in Uganda.

Our Focus Areas and Objectives

1. Capacity Building - To strengthen the capacity of palliative care providers in Uganda through supporting training, continuous professional education, mentorship and supervision.
2. Advocacy and Awareness Creation - To advocate for a supportive environment and increase understanding of palliative care among stakeholders in Uganda.
3. Palliative Care Research and Information - To establish a hub of research and information on palliative care in Uganda.
4. Governance and Support Functions - To enhance effective and efficient governance and management of palliative care services in Uganda.
5. Sustainability and Financial Efficiency - To enhance resource mobilization and financial efficiency for palliative care in Uganda.



The Conference Theme: “Scaling up Availability, Accessibility, Quality, and Equity” for Cancer and Palliative Care services



Cancer and other life-limiting illnesses continue to be an increasing public health concern in Uganda and the region. The recent COVID-19 pandemic, Ebola outbreaks, sporadic natural disasters, and the humanitarian situation in the region emphasize the need to scale up cancer and palliative care services to reach geographically remote communities and also a better focus on vulnerable/special groups. Due to the nature of highly centralized, urbanized,

non-inclusive, and out-of-pocket expenditure of services, communities in remote settings, the poor, and other vulnerable groups are disproportionately deprived of continued access to essential services amidst public health emergency situations.

The chosen theme for the conference is “Scaling up availability, accessibility, quality, and equity”. The theme was carefully selected to cause the attention of all stakeholders to discuss the barriers

that impede the provision of cancer and palliative care services and work towards eliminating them and ensuring the availability, accessibility, quality, and equitable services.

The conference brings together, professionals in the field of cancer and palliative care, healthcare providers, students, policymakers, eminent researchers, academicians, donors, and partners in corporate and businesses, patients, and the public.

The Conference Tracks

The conference will feature the following tracks each with cross-cutting themes including communication, research, Paediatrics, communication, care of special groups e.g. refugees, albinos and survivors.

- 1) Innovations and new technologies
- 2) Education, advocacy, policy, and the law
- 3) Health promotion, prevention, and early detection
- 4) Family and community involvement and empowerment
- 5) Clinical care and symptom management
- 6) Psychological, social, and spiritual care



Committees organising the Conference

Steering Committee / General Committee

Name	Organisation
Co-Chairpersons	
1. Dr. Eddie Mwebesa	Hospice Africa Uganda
2. Dr. Nixon Niyonzima	Uganda Cancer Institute
Committee Secretary	
3. Bernadette Basemera	Palliative Care Association of Uganda
Committee Members	
4. Dr. Jackson Orem	Uganda Cancer Institute
5. Mark Donald Mwesiga	Palliative Care Association of Uganda
6. Irumba Lisa Christine	Palliative Care Association of Uganda
7. Anita Balikobaku	Palliative Care Association of Uganda
8. Joyce Zalwango	Palliative Care Association of Uganda
9. Rita Nanyomo	Palliative Care Association of Uganda
10. Dr. Doreen Agasha	Hospice Africa Uganda
11. Prof. Julia Downing	International Children Palliative Care Network/ Palliative Care Education and Research Consortium
12. Dr. Nixon Niyonzima	Uganda Cancer Institute
13. Mukago Paulina	Uganda Cancer Institute
14. Christine Namulindwa	Uganda Cancer Institute
15. Dr. Alfred Jatho	Uganda Cancer Institute
16. Ezra Anecho	Uganda Cancer Institute
17. Irene Judith Nassozi	Uganda Cancer Institute
18. Bashir Ngobi	Uganda Cancer Institute
19. Dr. Benjamin Mwesige	Uganda Cancer Institute
20. Dr. Muwanga Moses	Ministry of Health
21. Dr. Emily Tumwakire	Ministry of Health
22. Dr. Karamagi Yvonne	Mildmay Uganda
23. Niwagaba Gerever	Palliative Care Association of Uganda



Scientific Committee

Name	Organisation
Co-Chairpersons	
1. Prof. Julia Downing	International Children Palliative Care Network/ Palliative Care Education and Research Consortium
2. Dr. Nixon Niyonzima	Uganda Cancer Institute
Committee Secretary	
3. Lisa Christine Irumba	Palliative Care Association of Uganda
Committee Members	
4. Mark Donald Mwesiga	Palliative Care Association of Uganda
5. Rinty Kintu	American Cancer Society
6. Dr. Henry Ddungu	Uganda Cancer Institute / Palliative Care Association of Uganda
7. Dr. Ludoviko Zirimenya	MRC / Uganda Virus Research Institute
8. Rose Kiwanuka	Lweza Community Health Program
9. Dr. Ekiria Kikule	Institute of Hospice and Palliative Care
10. Dr. Elizabeth Namukwaya	Palliative Care Education Research Consortium
11. Dr. Eve Namisango	African Palliative Care Association
12. Hajjati Mwazi Batuli	Islamic University in Uganda
13. Dr. Peace Bagasha	Palliative Care Education Research Consortium
14. Dr. Mukooza Edward	Uganda Christian University
15. Dr. Ddamulira Christopher	Uganda National Council for Science and Technology
16. Dr. Kirungi Gloria	Palliative Care Association of Uganda
17. Harriet Kebirungi	Uganda Cancer Institute
18. Kamate Antonia	Mobile Hospice Mbarara
19. Dr. Alfred Jatho	Uganda Cancer Institute
20. Dr. Benjamin Mwesige	Uganda Cancer Institute
21. Dr. Alfred Komakech	Uganda Cancer Institute
22. Dr. Solomon Kibudde	Uganda Cancer Institute
23. Dr. Joyce Balagadde	Uganda Cancer Institute
24. Dr. Noleb Mugisha	Uganda Cancer Institute



Name	Organisation
25. Dr. Geriga Fadhil	Uganda Cancer Institute
26. Dr. Bogere Naghib	Uganda Cancer Institute
27. Isaac Mulyowa	Uganda Cancer Institute
28. Misk Kemigisha	Uganda Cancer Institute
29. Susan Nabakooza	Uganda Cancer Institute
30. Ndagire Mariam	Uganda Cancer Institute
31. Shauna Aro	Uganda Cancer Institute

Thank you, our Abstract Reviewers!

Name of Reviewer	Organisation
1. Prof Julia Downing	International Children Palliative Care Network/ Palliative Care Education and Research Consortium
2. Dr. Nixon Niyonzima	Uganda Cancer Institute
3. Lacey Ahern	Center for Hospice Care / Global Partners in Care
4. Atsedere Aregay (PhD)	Associate Professor, Faculty of Health and Sport Sciences, Department of Health and Nursing Sciences, University of Agder
5. Rinty Kintu	American Cancer Society
6. Dr. Henry Ddungu	Uganda Cancer Institute / Palliative Care Association of Uganda
7. Dr. Ludoviko Zirimenya	MRC / Uganda Virus Research Institute
8. Dr. Ekiria Kikule	Institute of Hospice and Palliative Care
9. Dr. Eve Namisango	African Palliative Care Association
10. Hajjati Mwazi Batuli	Islamic University in Uganda
11. Dr. Peace Bagasha	Palliative Care Education Research Consortium
12. Dr. Ddamulira Christopher	Uganda National Council for Science and Technology
13. Kamate Antonia	Mobile Hospice Mbarara
14. Dr. Alfred Jatho	Uganda Cancer Institute
15. Dr. Solomon Kibudde	Uganda Cancer Institute
16. Dr. Geriga Fadhil	Uganda Cancer Institute
17. Ndagire Mariam	Uganda Cancer Institute
18. Kirungi Gloria PhD	Uganda Christian University / Palliative Care Association of Uganda
19. Dr. Elizabeth Namukwaya	Palliative Care Education Research Consortium



Publicity Committee

Name	Organisation
Committee Co-Chairs	
1. Dr. Emily Tumwakire	Ministry of Health
2. Christine Namulindwa	Uganda Cancer Institute
Committee Secretary	
3. Anita Balikobaku	Palliative Care Association of Uganda
4. Zalwango Joyce	Palliative Care Association of Uganda
Committee Members	
5. Mark Donald Mwesiga	Palliative Care Association of Uganda
6. Irumba Lisa Christine	Palliative Care Association of Uganda
7. Christine Ebong	National Medical Stores
8. Joanita Kawalya	Goodwill Ambassador PCAU / HIV Activist
9. Zaitun Nalukwago	CEHURD
10. Jacob Ampeire	Ministry of Health
11. Tadeo Atuhura	Mildmay Uganda
12. Patricia Batanda	African Palliative Care Association
13. Miriam Ahumuza	Joint Medical Stores
14. Sylvia Nakami	Rays of Hope Hospice Jinja
15. Deborah Masiira	Joint Clinical Research Centre
16. Kukundakwe Mercy	Infectious Diseases Institute
17. Nabaggala Annet Ssenkibirwa	NCD / Pathology Program Officer - Ministry of Health
18. Dr. Edward Kakungulu	Uganda Cancer Institute
19. Nkwasiabwe Timothy	Uganda Cancer Institute



ICT Committee is a subset of the Publicity Committee

Name	Organisation
Committee Members	
20. Cynthia Kabagambe	Palliative Care Association of Uganda
21. Dennis Kawuma	Uganda Cancer Institute
22. Collins Gyezaoh	Uganda Cancer Institute
23. Frank Kayondo	African Palliative Care Association
24. Joseph Serebe	Palliative Care Association of Uganda

Resources Mobilization & Finance Committee

Name	Organisation
Committee Co-Chairs	
1. Niwagaba Gerever	Kawempe Home Care / PCAU
2. Mukago Paulina	Uganda Cancer Institute
Committee Secretary	
3. Rita Nanyomo	Palliative Care Association of Uganda
Committee Members	
4. Josephine Kampi	Palliative Care Association of Uganda
5. CPA Dr. Basiimampora Timothy	Palliative Care Association of Uganda
6. Doreen Nalwadda	Palliative Care Association of Uganda
7. Kavuma David	Mildmay Uganda
8. Fiona Siima	Palliative Care Association of Uganda
9. Zipporah Kyomuhangi	Palliative Care Association of Uganda
10. Mark Donald Mwesiga	Palliative Care Association of Uganda
11. Irumba Lisa Christine	Palliative Care Association of Uganda
12. Anita Balikobaku	Palliative Care Association of Uganda
13. Dr. Nixon Niyonzima	Uganda Cancer Institute
14. Ezra Anecho	Uganda Cancer Institute
15. Irene Judith Nassozi	Uganda Cancer Institute
16. Bashir Ngobi	Uganda Cancer Institute
17. Yovan Omojong	Uganda Cancer Institute



Invited Conference Speakers

Keynote Speaker

Meg O'Brien, PhD

Vice President, Global Cancer Treatment,
American Cancer Society



Dr. Meg O'Brien is an infectious disease epidemiologist who has spent more than 20 years working with health ministries and health care providers to expand access to affordable, high-quality treatment for HIV and cancer.

As Vice President for Global Cancer Treatment at the American Cancer Society (ACS), O'Brien has established innovative partnerships to get treatment to more patients around the world through Allied Against Cancer, an alliance of organizations working together to improve access to cancer care in low and middle-income countries, with a focus on Sub-Saharan Africa. These have included partnering with the Clinton Health Access Initiative (CHAI) to reshape the global market for cancer treatment by establishing market access agreements with leading global suppliers that have reduced the cost of the most common cancer treatments by more than half,

and increased availability of high-quality products in African markets. A collaboration with over 100 cancer experts in African cancer centers and the National Comprehensive Cancer Network (NCCN) developed the NCCN Harmonized Guidelines™ for Sub-Saharan Africa, a package of more than 50 cancer treatment guidelines adapted for use in the region to standardize and improve treatment.

Prior to her role with the American Cancer Society, O'Brien worked on the scale-up of HIV treatment programs as the Research Director of the Consortium for Strategic HIV Operations Research at the Clinton Health Access Initiative and worked for three years in HIV treatment clinics in Tanzania for the Harvard School of Public Health during the initial scale-up of the US President's Emergency Plan for AIDS Relief (PEPFAR). Earlier in her career, she worked in the United States at a public HIV clinic in New Orleans, Louisiana, and worked on influenza and malaria vaccine development for Statistics Collaborative, a biostatistical consulting firm in Washington, DC.

Dr. O'Brien holds a Ph.D. in infectious disease epidemiology from the Tulane School of Public Health, a Master's Degree in International Health from the George Washington School of Public Health and Health Services (now the Milken Institute School of Public Health) and a bachelor's degree in Biology and certificate in African Studies from Georgetown University.



Other Speakers

11:30 – 13:00

Plenary Session 1: Speke Ballroom

Innovations, Education, and Policy

The Role of Parliament in Planning, Financing, and Policy in ensuring Accessibility and Availability for Cancer and Palliative Care Services in Uganda

Hon. Dr. Ayume Charles,
Member of Parliament for
Koboko, Chair Committee of
Health Parliament of Uganda



Hon. Dr. Charles Ayume is a Ugandan medical doctor and politician. He is a member of the Ugandan Parliament representing Koboko Municipality. In parliament, he also serves as the Chair of the Committee on Health.

Education and Training for Human Resources for Health to Enhance the Delivery of Cancer and Palliative Care

Hajjati Safina Museene, Ph.D. Commissioner
Health Training Institutions at the Ministry of
Education and Sports Uganda



Dr. Safinah Kisu Museene is Nurse/ Midwife/ and a Health Tutor. She attended school up to university education where she obtained a Bachelor of Science in Nursing from Aga Khan University, a Post Graduate Diploma in Public Administration and Management, a master's degree in medical education from Moi University and a Doctor of Philosophy in Nursing from the University of Cape Town.

Her Ph.D. work focused on empowering clinical preceptors with appropriate skills to support clinical-based training and learning. She developed a preceptors' clinical teaching and training model entitled the Structured and Collaborative Clinical Teaching Training Model.

About 300 preceptors have been trained using this Model. Currently, Dr. Safinah is the Commissioner in charge of Health Education and Training (C/HET) at the Ministry of Education and Sports.

She serves on various boards and task forces including UNMEB, UAHEB, UNMC, Amref, and Labour productivity of Ministry of Labour.

She is a recipient of the Uganda Gold Jubilee Independence Anniversary and Agha Khan University Best Clinical Practice. She is also a recipient of the Nurses' DAISY award and was a coordinator for Patriotism for Health Training Institutions.



Social Justice in Health Care: What are the Gaps and Key Recommendations for Universal Coverage for Cancer and Palliative Care Services in the East African Region?

Ms. Grace Nayiga, Executive Director, Uganda Network on Law, Ethics and HIV/AIDS (UGANET)



Ms. Grace Nayiga is a Practicing Advocate of the High Court of Uganda, a Team Leader at the Uganda Network on Law, Ethics and HIV/AIDS (UGANET), a Board Secretary, and a Member of the Executive Committee at the Palliative Care Association of Uganda, a Board Member and General Secretary to The Legal Aid Service Providers Network (LASPNET) and a graduate of the CIV Source Africa GROW! Leaders Mentorship program for Chief Executive Officers.

As a Health and Human Rights Advocate of over 10 years, Grace is passionate about social justice for women, PLHIVs, Persons living with Disabilities, and Palliative Care patients, drawing from personal experiences. She is passionate about Trial Advocacy for Lawyers in Legal Aid Practice and is a trained facilitator with Justice Advocacy Africa.

At UGANET Grace leads a team of 33 staff to deliver UGANET's mandate on Access to Justice, advocacy, and strategic litigation to address HIV discriminatory laws and policies, Ending Violence against women and girls, and working with Leaders, Institutions, and Communities to address inequities that hinder Social Justice in the context of HIV, Health, and Gender

The Development of Novel Therapies for Pediatric Burkitts Lymphoma

Prof. Turner Suzanne, Director of Teaching, Deputy Head Department of Pathology, University of Cambridge



Prof Turner obtained her PhD from the world-renowned Paterson Institute for Cancer Research in Manchester, UK before moving to a research post at the Babraham Institute in Cambridge. Since 2005, Prof Turner has been leading an academic research group at the University of Cambridge within the Department of Pathology. In 2007, Prof Turner was awarded the prestigious Leukaemia and Lymphoma Research (LLR; now Blood Cancer UK) Bennett Fellowship and in 2012 she received a further 5-year LLR senior lectureship award. Amongst her achievements are the inception and establishment of the European Research

Initiative on ALCL, a study group that brings together scientists from across Europe to foster collaboration and advancement in this important area of health research.

Prof Turner was also the lead of 'ALKATRAS', a European Union Marie Curie Innovative Training Network of 14 research groups in 7 EU countries and was also the non-clinical chair of the European Inter-Group for Collaboration into Childhood Non-Hodgkin Lymphoma (EICNHL). She now holds the post of deputy head of department and director of teaching as well as co-chair of the Cancer Research UK (CRUK) Cambridge Centre Paediatric Programme and biological lead for the National Cancer Research Institute (NCRI) paediatric lymphoma Clinical Study Group (CSG).



She also leads the EU Marie Curie FANTOM PhD training programme and is a member of the scientific committee of the international society for paediatric oncology (SIOP). Prof Turner collaborates with a wide spectrum of scientists and labs around the world with a focus on childhood cancer, most notably the Uganda Cancer Institute in Kampala with whom she is working towards finding better therapies for children with cancer.

What are the Current Innovations and New Technologies for Cancer and Palliative Care Services?

Dr. Katumba Andrew, College of Engineering, Design and Technology Makerere University, & Uganda Cancer Institute



Dr. Andrew Katumba is a lecturer in the Department of Electrical and Computer Engineering, at Makerere University where he also serves as the Lead for the Marconi Research and Innovation Lab (Marconi Lab). He holds a Ph.D. in Photonics Engineering from Gent University, Belgium, and an MSc. in Optics and

Photonics from the Karlsruhe Institute of Technology, Germany. His current research focuses on applying Artificial Intelligence to Healthcare and Medicine in low-resource settings. Andrew leads a number of ongoing projects focused on screening cancer (cervical, breast, and prostate) using various medical imaging modalities ranging from ultrasound, and mp-MRI to CT, in collaboration with the Uganda Cancer Institute.

He is also a champion for the digitization of healthcare workflows and for example, co-leads the joint effort between the UCI and Makerere University to establish a national cancer Health Information Exchange.

Building Capacity for Cancer Genomics in East Africa

Prof. Edus Houston Warren, MD, Ph.D., Program Head Global Oncology Program, Fred Hutch



Prof. Edus Houston Warren is a Professor in Immunology Clinical Research Division, Fred Hutch, Program Head Global Oncology Program, Fred Hutch and the Professor

Vaccine and Infectious Disease Division, Fred Hutch.

He is a physician-scientist who contributed to the development of adoptive T-cell therapy, which harnesses the body's immune system to block cancers. He currently leads the Global Oncology Program at the Fred Hutchinson Cancer Center, whose mission is to do research that will improve the prevention and treatment of cancers in low- and middle-income countries. The Hutch Global Oncology Program is physically based in Kampala, Uganda at the UCI – Fred Hutch Cancer Centre, on the campus of the Uganda Cancer Institute.

Career Highlights:

- As an oncologist, Dr. Warren specializes in the treatment of patients with blood cancers such as leukemia, lymphoma, and multiple myeloma.
- He has considerable experience as an investigator on clinical trials of novel agents for the treatment



of blood cancers and served as the Principal Investigator on a Phase I clinical trial of T cell immunotherapy for patients with relapse of acute leukemia or high-grade myelodysplasia after allogeneic hematopoietic cell transplantation.

- The overall focus of Dr. Warren's laboratory is cancer immunology. His group studies the mechanisms and molecules that mediate tumor regression after treatment with immunotherapy such as immune-checkpoint inhibition and adoptive T-cell therapy.
- His lab has extensive experience with the characterization and manipulation of human T and B lymphocytes, identification of antigens recognized by T and B lymphocytes, and assessment of adoptive cellular therapy in preclinical models.
- With two Fred Hutch colleagues, Dr. Warren co-developed an innovative next-generation DNA sequencing approach that enables comprehensive analysis of T- and B-lymphocyte repertoires.
- Dr. Warren's laboratory also has a strong research focus on lymphomas that affect children and adults in sub-Saharan Africa, particularly Burkitt lymphoma and diffuse large B-cell lymphoma.

Education:

Fellow, Medical Oncology; University of Washington 1993-1996

Intern and Resident, Internal Medicine; Massachusetts General Hospital; 1991-1993

MD, Harvard Medical School, 1991

PhD, Neurobiology; Harvard University, 1988

AB, Applied Mathematics; Harvard College, 1982

16:00 – 17:30

Panel Discussion 1: Acacia Hall

Health Promotion, Prevention, Early Detection, and Community Empowerment

16:00 – 16:15

Uganda's Overarching Strategy of Health Promotion, Prevention, and Education: What are the Roles of Key Stakeholders?

Dr. Richard Kabanda,
MPH, MBA, PhD, F.A.I.P.H
Commissioner Health Promotion,
Education and Health Communication, at
Ministry of Health, Uganda



Richard is a Public Health Specialist with expertise in Health Promotion and Disease Prevention. Currently, he heads the Department of Health Promotion, Education and Health Communication, at Ministry of Health, Uganda. Richard is charged with leading the Health Promotion and Disease Prevention agenda in the country through policy, strategy and Public Health interventions design and implementation.

He also lectures at the Faculty of Health Sciences, Uganda Martyrs University and serves as an external examiner to several Universities. He has mentored and supervised over twenty (20) Master of Public Health students to completion.



Previously, Richard worked with various Districts Local Governments, Non-profit Government Organizations and the Private sector. He has authored/co-authored a number of papers in Peer Reviewed Journals on public health Issues with a focus on Disease Prevention & Control; Health Education; Public Health Risk Communication, and Community Health Systems Strengthening.

Dr. Kabanda is a Chair and member to several health policy boards (Buganda Kingdom Health & Gender Committee; Nkozi Hospital Board; Mubende Regional Referral Hospital Board; MoES Uganda Allied Health Examinations Board; and Mildmay Uganda Community Advisory Board).

He holds a Doctor of Philosophy (PhD) in Public Health, a Master of Public Health specializing in Health Promotion; and a Master of Business Administration from Uganda Martyrs University & University of South Wales, United Kingdom respectively. Other professional qualifications trained in are; Dentistry, Health Education, and Health Management. Richard is also a Fellow of Public Health at the African Institute of Public Health; and a Member of International Society for Global Health (M – ISoGH), Edinburgh, UK.

16:15 – 16:30

Contextualizing the WHO Public Health Approaches to Cancer and Palliative Care in the Region

Dr. Hafisa Kasule, Country Team Advisor, Non-Communicable Diseases, World Health Organisation

16:30 – 16:45

Harnessing the Civil Society and Community Movement's Role in Advancing Access and Provision of Cancer and Palliative Care

Gertrude Nakigudde - Co-founder and Chief Executive Officer of the Uganda Women's Cancer Support Organisation (UWOCASO).



Gertrude has been developing cancer advocacy, awareness campaigns, and patient support programs for the last 20 years. Mobilizing women who have survived cancer to share testimonies and provide hope to cancer patients and families to cope and adhere to treatment. As leader of a cancer survivors' group I have taken the lead in community mobilization for cancer awareness and screening.

She participated in developing Uganda Breast Health Care Guidelines 2022 supported by the Uganda Cancer Institute and

partners, and has been part of several working groups including Breast Health Global Initiatives (BHGI), European School of Oncology (ESO) Advanced Breast Cancer (ABC) Consensus all working to improve survival of breast cancer patients. Gertrude is a member of the Board of Directors of Uganda Cancer Institute. Prior to this, Gertrude participated and graduated in a scientist-survivor programs run by the American Association for Cancer Research (AACR) a program that jumpstarted her advocacy and devotion to create a better understanding of cancer in Uganda and make cancer treatment affordable, timely and of high quality for all cancer patients. Gertrude holds a Bachelor of Commerce from Makerere University, a diploma in Business Administration and a certificate in Leadership in Strategic Communication.



16:45 – 17:00

Global North and South Partnerships for Health Systems Strengthening: What are the Lessons for Sustainable Initiatives?

Lacey N. Ahern, Program Director of Global Partners in Care



Lacey Ahern is the program director of Global Partners in Care, a U.S.-based Organisation that supports access to hospice and palliative in low-resources settings through developing collaborative partnerships and advancing research and education in palliative care. Lacey is also an adjunct assistant professor of the practice at the University of Notre Dame's Eck Institute for Global Health. Lacey has nearly 20 years of experience working in global health and development with a focus on program development and community engagement in both not-for-profit organizations and

universities. She has more than 13 years of experience at the University of Notre Dame in various teaching, research and administration roles. Lacey served on a global health curriculum committee within the Consortium of Universities of Global Health and helped build the global health training programs at Notre Dame. She has worked with numerous students over the years on research projects related to public health surveillance and evaluation, palliative care, lead exposure and maternal and child health. She holds a Master of Public Health degree in Global Health from the Rollins School of Public Health at Emory University. Her current areas of focus are palliative care and the role of partnerships in global health.

17:00 – 17:15

Health Policies for Funding for Cancer and Palliative Care in the Region: What are the Lessons for Uganda?

Dr. Emmanuel Luyirika, Executive Director African Palliative Care Association



Dr Emmanuel Luyirika is Executive Director of the African Palliative Care Association a pan-African palliative care Organisation with programmes in several African countries. He is a board member of the Worldwide Hospice Palliative Care Alliance.

He has served as President of the Board of CoRSU Hospital for the last 8 years.

Previously, he was clinical and country director of Mildmay International in Uganda from 2002 to 2011. He also worked for the Department of Health in South Africa and lectured in Family Medicine at the Medical University of Southern Africa. He has served on several

technical committees at the Ministry of Health Uganda, Uganda AIDS Commission, WHO, UNICEF, and UNAIDS and as Vice Chairperson of the Council of the Institute of Hospice and Palliative Care in Africa. He has also been part of the International Atomic Energy Agency/WHO ImPACT missions in Africa.

He has also served on a committee of the American Academy of Sciences, Engineering and Medicine reviewing PEPFAR funded programme in Rwanda.

He studied medicine at Makerere University in Uganda, Medical University of Southern Africa, and the University of Stellenbosch in South Africa.

He is a co-investigator on ongoing studies in palliative care and has been an investigator and published on several HIV, cancer and palliative care research projects and served on Data Safety Monitoring Boards and technical steering committees of research studies in Africa. He has been a co-author of several chapters in cancer and palliative care books.



8:30 – 10:30

Plenary Session 2: Speke Ballroom

Symptom Management, Psychosocial, and Spiritual Support

From Zero to Ten: Building Capacity for Radiation Oncology in Uganda

Dr. Solomon Kibudde, Program Director for the UCI Radiation Oncology fellowship at the Uganda Cancer Institute.



Dr. Solomon Kibudde serves as a Clinical Radiation Oncologist within the Division of Radiation Oncology and holds the role of Program Director for the UCI Radiation Oncology fellowship at the Uganda Cancer Institute. Following his completion of a fellowship in Cape Town, Dr. Kibudde returned to Uganda and played a crucial role in propelling the progress of radiotherapy practices in the country. His efforts led to a transformative shift from conventional 2-Dimensional radiotherapy to more advanced approaches, including 3-Dimensional Radiotherapy, Intensity Modulated Radiotherapy, and Volumetric Modulated Arc Therapy.

Dr. Kibudde possesses an in-depth understanding of the radiotherapy landscape in Uganda and sub-Saharan Africa, and has been at the forefront of establishing a dynamic, comprehensive fellowship program in Radiation Oncology. This initiative aims not only to bridge the expertise gap for radiation oncologists in Uganda but also to contribute significantly to the advancement of radiation medicine across the broader East Africa region.

Dr. Kibudde's professional interests encompass both clinical and academic domains, with a focus on radiation therapy treatment planning and administration for Cervical cancer, Breast Cancer, and Gastrointestinal cancers. Currently, he is investigating hypofractionation, and the utilization of artificial intelligence to optimize clinical workflow and access to radiotherapy within high-volume clinics in resource-constrained environments. With a portfolio of over 10 published works, he has also shared his expertise as a speaker at various international scientific conferences.

The National Cancer Control Program Plan

Dr. Oyoo Charles Akiya, the Commissioner of Health Services-Non-Communicable Diseases at the Ministry of Health.



Before then, he served in the district local government as the District Health Officer and in many other capacities.



Emerging Trends in the Holistic Management of Haematologic Malignancies

Dr. Henry Ddungu, Senior Consultant (Hematology-Oncology) Uganda Cancer Institute and Board Chair Palliative Care Association of Uganda



Dr. Ddungu graduated from Makerere University in 1998 and later did his MMed (Internal Medicine) from the same University in 2003.

Dr. Ddungu is currently a Senior Consultant (Hematology/Oncology) at the Uganda Cancer Institute, where he is the Head of the Division of Medical Oncology and Hematology. He is interested in advancements in the treatment of both classical and malignant hematological illnesses including immunotherapy and cellular therapies (BMT).

He is an Honorary Lecturer at Makerere University College of Health Sciences, School of Medicine, an Associate Clinical Professor (Adjunct),

at McMaster University, Faculty of Health Sciences Department of Medicine, and an Honorary Lecturer, at the Department of Medicine, Mbarara University of Science and Technology.

Dr. Ddungu has a Fellowship in International Pain Policy obtained at the Pain and Policy Studies Group, University of Wisconsin, Madison, and was a member of an International Expert Collaboration (IEC) for advancing opioid availability globally.

For a long time, Dr. Ddungu worked with Palliative Care Organizations in Uganda and Africa, initially as a clinician providing palliative care services to terminally ill cancer and AIDS patients and later as an Advocacy Manager for the African Palliative Care Association. He has extensive experience in palliative care in Africa, where he has been involved in the care of patients as well as advocating for improved access to palliative care services.

He was an International Pain Policy Fellow at the University of Wisconsin, Madison and currently a member of an International Expert Collaboration (IEC) for advancing opioid availability globally.

Dr. Ddungu is active in research and has been a principal investigator and co-investigator on several clinical studies. He has also supervised several Master of Medicine dissertations and has published papers in referenced journals.

HIV and Cancer: Developing Tools for Early Detection of Epidemic Kaposi Sarcoma

Dr. Aggrey S. Semeere, MB,ChB., M.Med (Int. Med), MAS, FCP (ECSA) Leads the Prevention, Care and Treatment Program



Dr. Semeere is an Internal Medicine Specialist with advanced training in Epidemiology and Implementation Science. He currently leads the Prevention, Care and Treatment Program, and a number of NIH funded research projects at the Infectious Diseases Institute (IDI), Makerere University College of Health Sciences (MUCHS). He has worked on cancer among people living with HIV for 13 years now focusing on epidemiology and enhancing diagnosis.

In the last 10 years, he has led a number of NIH funded research initiatives to enhance cancer diagnosis. These have included the use of DNA amplification, digital image analysis of lesions and pathology to enhance the diagnosis of Kaposi's sarcoma and cervical cancer.



Advances in the Management of Breast Cancer in Uganda

Dr. Naghib Bogere,

Medical Oncologist Uganda Cancer Institute



Dr. Naghib Bogere, MBChB, MMED, is a highly accomplished medical professional specializing in oncology and internal medicine. With a wealth of experience, he currently serves as a Medical Oncologist at the renowned Uganda Cancer Institute, combining his deep clinical expertise with a strong passion for academic teaching and clinical research.

Dr. Bogere obtained his Bachelor of Medicine and Bachelor of Surgery (MBChB) as well as his Master of Medicine (MMED) in Internal Medicine from the prestigious Makerere University in Kampala. He further honed his clinical acumen through a fellowship in Adult Medical Oncology and Hematology at the Uganda Cancer Institute. To enhance his organizational leadership capabilities, he is currently pursuing a Master of Business Administration from Makerere University

Business School.

Driven by his dedication to advancing medical education, Dr. Bogere holds esteemed faculty positions. He presently holds the position of Lecturer in the Department of Internal Medicine at Habib Medical School. Additionally, he assumes critical responsibilities in teaching medical students rotating in Oncology at Makerere University, ensuring their preparedness through comprehensive instruction and examination.

Within the Uganda Cancer Institute, Dr. Bogere has demonstrated exceptional leadership. He serves as the Focal Person and Head of the Quality of Oncology Practice Initiative (QOPI) in LMICs for the American Society of Clinical Oncology (ASCO).

Dr. Bogere actively engages in ongoing research endeavors, assuming various roles such as co-investigator for numerous cancer clinical trials and Principal Investigator of studies on Breast Cancer and Lung Cancer Survival in Uganda. These efforts underscore his unwavering commitment to advancing cancer care. His scholarly contributions to the medical field are evident through multiple publications in reputable journals, showcasing his expertise and dedication.

Beyond his academic and research contributions, Dr. Bogere makes a significant impact on the public through his televised awareness talks on various cancer types, reaching a wide audience and raising awareness about this critical issue.

Addressing Spiritual and Psychosocial Dimensions of Children in Oncology and Palliative Care

Prof. Julia Downing

PhD RGN, Chief Executive, International Children's Palliative Care Network (ICPCN)



Professor Downing is an experienced palliative care nurse, educationalist, and researcher. She is the Chief Executive of the International Children's Palliative Care Network (ICPCN) and a Professor at several universities.

She supports the Palliative Care Education and Research Consortium (PcERC) here in Kampala and is a life member of the Palliative Care Association of Uganda. She has extensive experience in Global palliative care, research, and education, and is on the editorial board of *ecancer*, *APM*, and the *IJPN*.

She has worked in palliative care for >30 years, with 23 of those working in Uganda.



Professor Downing serves on the Boards of several NGOs including the International Society of Nurses in Cancer Care, the Worldwide Hospice and Palliative Care Alliance, the International Society of Nurses in Cancer Care, the African Palliative Care Association UK, and ehospice.

Palliative Care Transforming Patients with Sickle Cell Disease

Prof. Francis Ssali, MBChB, MSc, DTM&H, MMed, FCP(ECSA): Deputy Executive Director; Research and Clinical Services of Joint Clinical Research Center (JCRC)



Prof. Francis Ssali is the Deputy Executive Director; Research and Clinical Services of Joint Clinical Research Center (JCRC). He trained in Medicine at Makerere University and in Clinical Hematology at McMaster University in Hamilton, Ontario Canada. He is a Fellow of the East Central and Southern Africa Association of Physicians and a member of the American Society of Hematology.

He is a physician involved in HIV care and research with over 20 years of experience and involved in elective and emergency therapeutic Apheresis. Francis is the Chairman of the Uganda HIV/ART technical Committee and is a member of the Uganda National HIV Drug Resistance Committee. He is a Co-PI of the CAPRI adoptive cell research at JCRC and is leading its establishment at the Centre. Francis teaches HIV Medicine and Hematology in the Internal Medicine Residence program at the Makerere University College of Health Sciences and in the Hematology-Oncology Fellowship program at the Uganda Cancer Institute.

16:00 – 17:30

Panel Discussion 2

The Future Advancements in Cancer Treatment and Palliative Care in Uganda

Prof. William Bazeyo, Chairperson
Board, Uganda Cancer Institute



Prof. William Bazeyo is a Retired Ugandan Professor of Occupational Medicine. He holds a Bachelor of Medicine and Bachelor of Surgery degree (MB ChB) Makerere University, a Master of Medicine (Occupational Medicine) (M Med OM) National University of Singapore, a Doctor of Philosophy (PhD)-Atlantic International University and a Doctor of Science (Honorary Degree) from Tufts University in recognition of his service to humanity in Public Health in Africa and has a certificate in Authentic Leadership Development (ALD) from Harvard Business School. While at Makerere University, he served as Head University Grants and Management Support Unit, Deputy Vice Chancellor (Finance and Administration), and Dean School of Public Health among others.

Currently Prof. Bazeyo is the Chief Executive Officer of Africa One Health University Network (AFROHUN), Chief of Party and Director of Resilient Africa Network (RAN), Director of Africa Centre for Tobacco Control (CTCA)



Prof. Bazeyo serves on several National committees, is Chairman of the Business Process Outsourcing (BPO) and Innovation Council, Ministry of ICT and National Guidance, Member Board of Trustees of the MTN Uganda Foundation, Chair to the Board of Uganda Cancer Institute and Government representative on Busitema University Council and Chair of Uganda National Research Innovation Fund at the Ministry of Science and Technology Office of the President. His research has been funded by USAID, CDC, Bill and Melinda Gates Foundation, IDRC, and has published more than 100 articles in peer-reviewed journals. He is a Melvin Jones Fellow (MJF) of Lions International and was awarded Gold Medal, Highest Civilian Honor of Uganda by the HE President of Uganda 2018.

In November 2022 he was awarded the Lifetime achievement award among Heroes in Health Awards (HIHA) in Uganda for leading effectively and efficiently responding to community health emergencies.

Dr. Jackson Orem, Conference Co-host and Executive Director, Uganda Cancer Institute



Dr. Jackson Orem, MBChB, MMed, PhD, is a medical oncologist, an Executive Director of the Uganda Cancer Institute, and an honorary lecturer at Makerere University.

He spearheaded the creation of the

East Africa's Centre of Excellence in Oncology at the Uganda Cancer Institute with a mandate to provide specialized cancer care research and training for the entire East Africa region under the East African Community (EAC) network of Centers of Excellence.

Dr. Orem is also leading the development of several international collaborations with renowned international cancer centres and institutions for infrastructure, human resource capacity development. Such institutions include Fred Hutchinson Cancer Research Center, the University of Washington, Case Western Reserve University, the National Cancer Center of Korea (NCC), and lately the University of Cambridge.

Mark Donald Mwesiga, Conference Co-Host and Executive Director Palliative Care Association of Uganda



Mark Donald Mwesiga is the Executive Director of the Palliative Care Association of Uganda (PCAU). He holds a Master of Public Health (health promotion option) degree, a Master of Management Studies, and a Bachelor of

Social Sciences from Makerere University. He has various short course qualifications including Drug Policy, Diplomacy, and Public Health from The Graduate Institute in Geneva, Switzerland.

He is among the alumni of the various OMI Seminars, Schloss Arenberg in Salzburg, Austria. He has been engaged in university academic and research work. At the height of the COVID-19 pandemic in Uganda, he was highly engaged in advocacy, risk communication, and resource mobilization work to ensure the continuity of palliative care as an essential service.



Dr. Henry Ddunga, Senior Consultant
(Hematology-Oncology) Uganda Cancer
Institute and Board Chair Palliative Care
Association of Uganda



Dr. Ddunga graduated from Makerere University in 1998 and later did his MMed (Internal Medicine) from the same University in 2003.

Dr. Ddunga is currently a Senior Consultant (Hematology |Oncology) at the Uganda Cancer Institute, where he is the Head of the Division of Medical Oncology and Hematology. He is interested in advancements in the treatment of both classical and malignant hematological illnesses including immunotherapy and cellular therapies (BMT).

He is an Honorary Lecturer at Makerere University College of Health Sciences, School of Medicine, an Associate Clinical Professor (Adjunct), at McMaster University, Faculty of Health Sciences Department of Medicine, and an Honorary Lecturer, at the Department of Medicine, Mbarara University of Science and Technology.

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Dr. Ddunga is active in research and has been a principal investigator and co-investigator on several clinical studies. He has also supervised several Master of Medicine dissertations and has published papers in referenced journals.



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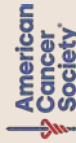
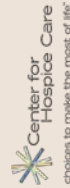
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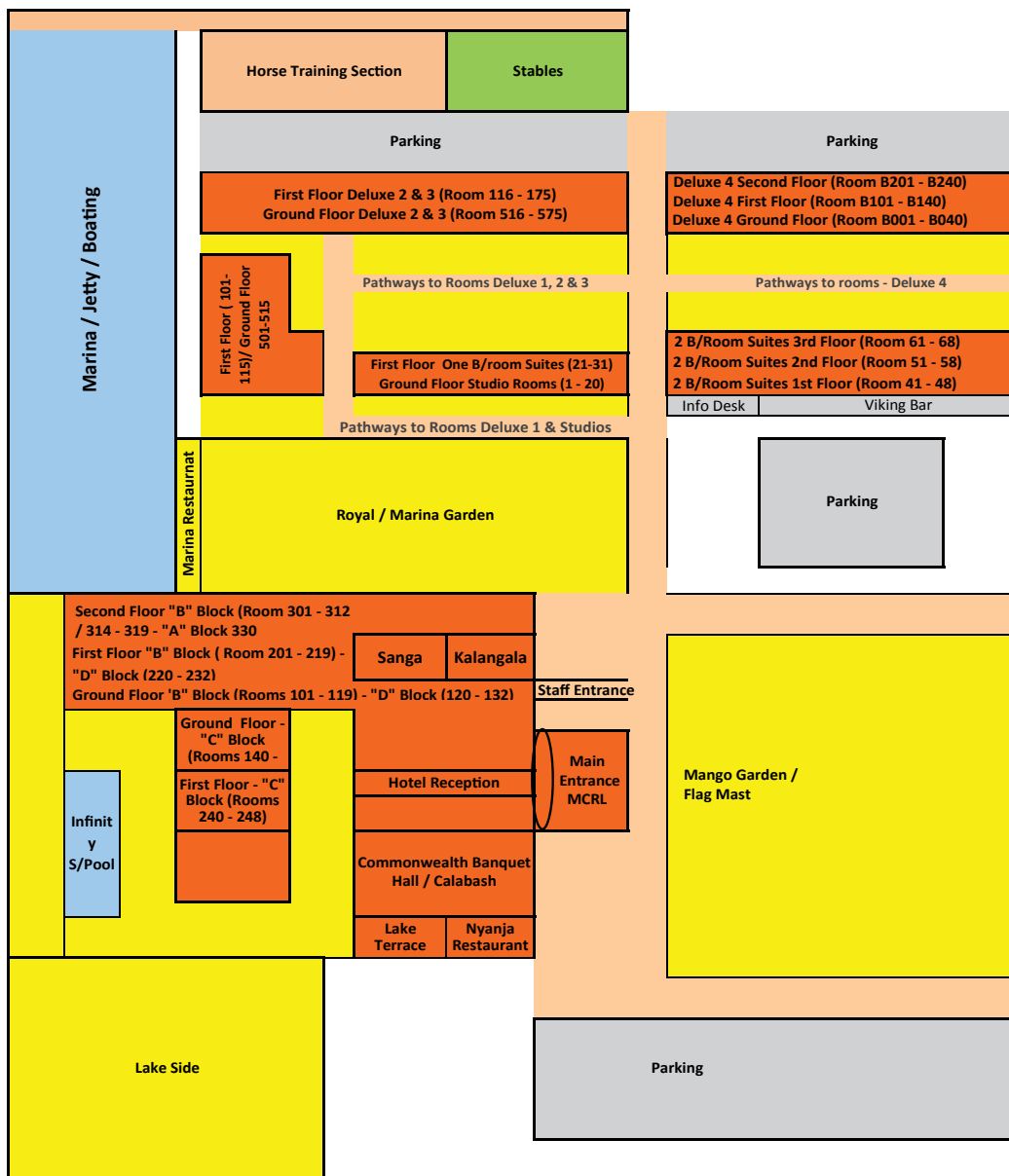


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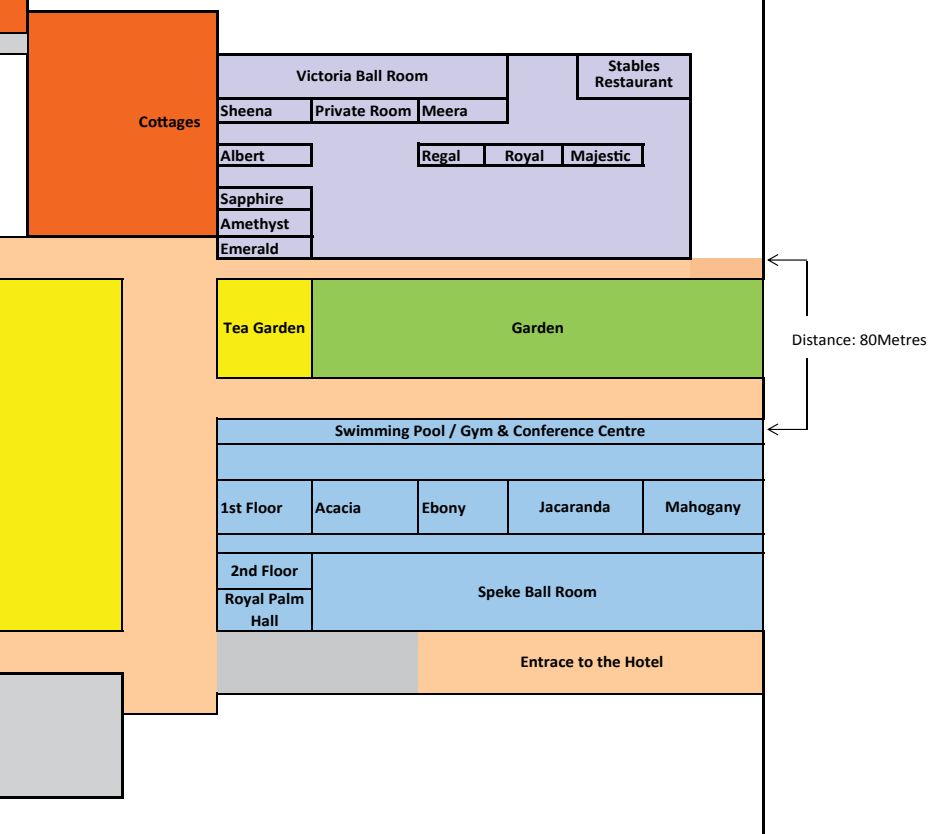
a) Venue Plan





Floor Plan - SRM - Updated MAP

Speke Resort Munyonyo





b) Program at a Glance.

Pre-Conference Day: Wednesday 13th September 2023					
14:00 – 18:00	Conference Registration and Inquiries				
Conference Day 1: Thursday 14th September 2023					
8:00 – 8:30	Registration of Delegates				
8:30 – 11:00	Conference Opening Ceremony – Speke Ballroom				
11:00 – 11:30	Break Teas and Coffee & Poster Viewing in Speke Ballroom				
11:30 – 13:00	Plenary 1 Speke Ball Room : Innovations, Education, and Policy				
13:00 – 14:00	Lunch Break at the Poolside and Poster Viewing				
14:00 – 15:30	Presentation of Oral Papers in Tracks				
	Track 1: Acacia Hall Psychological, social, and spiritual care	Track 2: Ebony Hall Clinical care and symptom management	Track 3: Jacaranda Hall Family and community involvement and empowerment	Track 4: Mahogany Hall Education, advocacy, policy, and the law	Side Event: Majestic Hall Governance and Compassionate Leadership
15:30 – 16:00	Break Teas and Coffee & Poster Viewing in Speke Ballroom				Invite Only Event
16:00 – 17:30	Panel Discussion 1 Acacia Hall : Health promotion, prevention, early detection & Community empowerment				
18:00 – 21:00	Conference Gala Dinner – Speke Ballroom (Theme and Dress code – Smart in African Touch)				
Conference Day 2: Friday 15th September 2023					
8:00 – 8:30	Registration of Delegates				
8:30 – 10:30	Plenary 2 Speke Ballroom : Symptom Management, Psychosocial, and Spiritual Support				



10:30 – 11:00	Break Teas and Coffee & Poster Viewing in Speke Ballroom				
11:00 – 13:00	Special Workshops				
	Workshop 1: Acacia Hall Access to Essential medicines for patients with Cancer and Palliative Care Needs in Uganda	Workshop 2: Ebony Hall Enhancing National Palliative Care Data Reporting and Utilization	Workshop 3: Jacaranda Hall Research and Education	Workshop 4: Mahogany Hall Ageing and Ageism	
13:00 – 14:00	Lunch Break at the Poolside and Poster Viewing				
14:00 – 15:40	Presentation of Oral papers				
	Track 1: Speke Ballroom Innovations and new technologies	Track 2: Acacia Hall Health promotion, prevention, and early detection	Track 3: Ebony Hall Clinical care and symptom management	Track 4: Jacaranda Hall Family and community involvement and empowerment	Track 5: Mahogany Hall Education, advocacy, policy, and the law
15:40 – 16:00	Break Teas and Coffee & Poster Viewing in Speke Ballroom				
16:00 – 17:10	Panel Discussion 2 & Conference Closing Ceremony: Speke Ballroom Panel Discussion 2 – The Future Advancements in Cancer Treatment and Palliative Care in Uganda				



Conference Program September 2023

Pre-Conference Day: Wednesday 13 th September 2023		
14:00 – 18:00	Conference Registration and Inquiries	
Conference Day I: Thursday 14 th September 2023		
8:00 – 8:30	Arrival and Registration of Conference Speakers and Delegates	Joyce Zalwango
8:30 – 11:00	Conference Opening Ceremony – Speke Ballroom	
8:30 – 8:50	Short Video on the Status of Cancer and Palliative Care in Uganda	Lisa Christine Irumba
8:50 – 8:55	Ugandan Anthem and East African Anthem	Lisa Christine Irumba
8:55 – 9:00	Conference Chairs Introductions and Welcome Remarks	Dr. Nixon Niyonzima and Dr. Eddie Mwebesa
9:00 – 9:10	Thanksgiving and Prayer by the Assistant Bishop of Kampala	Rt Rev. Bishop Hannington Mutebi
9:10 – 9:20	Welcome Remarks by the Executive Director, Palliative Care Association of Uganda (PCAU)	Mark Donald Mwesiga
	Welcome Remarks by the Executive Director, Uganda Cancer Institute (UCI)	Dr. Orem Jackson
9:20 – 9:30	Conference Opening Remarks by the Director-General, World Health Organization (WHO)	Dr. Tedros Adhanom Ghebreyesus
9:30 – 9:40	Since 1993: The Journey Towards Reducing Health-Related Suffering in Uganda, Presented by the First Palliative Care Nurse and Expert	Rose Kiwanuka, Palliative Care Expert
9:40 – 9:50	Entertainment Session by Hospice Africa Uganda	Performance by: Dance with Valentino, Choreography: Donlynn Fischer Graphics: George Stanley Nsamba
9:50 – 10:20	Keynote Address: The Prerequisites for Scaling Up the Availability, Accessibility, Quality, and Equity to All in Need: Lessons from the American Cancer Society Treat the Pain Initiative	Dr. Meg O'Brien, Vice President Global Cancer Treatment at the American Cancer Society
10:20 – 10:30	Official Opening of the Conference	Dr. Jane Ruth Aceng Otero, Minister of Health Uganda
10:30 – 10:40	Awards Ceremony	Joyce Zalwango
	Launch of Prof. Anne Merriman's Autobiography <i>"That's How the Light Got in"</i>	Ambassador: Mr. Kevin Colgan, Irish Ambassador to Uganda
	East African Anthem and Ugandan Anthem	Lisa Christine Irumba
10:40 – 11:00	Conference Group Photo	Christine Namulindwa
	Press Briefing	Jacob Ampaire & Christine Namulindwa
11:00 – 11:30	Break Teas and Coffee & Poster Viewing in the Speke Ballroom	
11:30 – 13:00	Plenary Session I: Speke Ballroom Innovations, Education, and Policy Session Chairs: Rev. Prof. Dr. Samuel Abimerech Luboga, Chairperson, Education Service Commission and Vice-Chancellor, Mildmay Institute of Health Sciences, and Dr. Ekiria Kikule, Principal, Institute of Hospice & Palliative Care in Africa (IHPCA).	
11:30 – 11:45	The Role of Parliament in Planning, Financing, and Policy in ensuring Accessibility and Availability for Cancer and Palliative Care Services in Uganda – Dr. Ayume Charles, Member of Parliament for Koboko, Chair Committee of Health Parliament of Uganda	
11:45 – 12:00	Education and Training for Human Resources for Health to Enhance the Delivery of Cancer and Palliative Care Hajjati Safina Museene, Ph.D., Commissioner, Health Training Institutions, Ministry of Education and Sports Uganda	



12:00 – 12:15	Social Justice in Health Care: What are the Gaps and Key Recommendations for Universal Coverage for Cancer and Palliative Care Services in the East African Region? Grace Nayiga, Executive Director, Uganda Network On Law, Ethics, and HIV/AIDS (UGANET)				
12:15 – 12:30	The Development of Novel Therapies for Pediatric Burkitts Lymphoma Professor Suzanne Turner, Director of Teaching, Deputy Head Department of Pathology, University of Cambridge				
12:30 – 12:45	What are the Current Innovations and New Technologies for Cancer and Palliative Care Services? Dr. Katumba Andrew, Lecturer, College of Engineering, Design, and Technology, Makerere University				
12:45 – 13:00	Building Capacity for Cancer Genomics in East Africa Prof. Warren Edus Hootie, Program Head, Global Oncology Program, Fred Hutch Cancer Centre				
13:00 – 14:00	Lunch Break at the Poolside and Poster Viewing in Speke Ballroom				
14:00 – 15:30	Presentation of Oral Papers				
	Track 1: Acacia Hall Psychological, Social, and Spiritual Care <i>Session Chairs:</i> Rev. Diana Nkesiga, Nkesiga Cancer Foundation Dr. Ddamulira Christopher, Uganda National Council for Science and Technology	Track 2: Ebony Hall Clinical Care and Symptom Management <i>Session Chairs:</i> Dr. Okuku Fred, Uganda Cancer Institute Dr. Mukooza Edward, Uganda Christian University	Track 3: Jacaranda Hall Family and Community Involvement and Empowerment <i>Session Chairs:</i> Dr. Noleb Mugisha, Uganda Cancer Institute Kebirungi Harriet, Uganda Cancer Institute	Track 4: Mahogany Hall Education, Advocacy, Policy, and the Law <i>Session Chairs:</i> Nasur Buyinza, Institute of Hospice and Palliative Care in Africa Sr. Allen Mayanja Namala, Uganda Cancer Institute	Track 5: Majestic Hall Sustainable Corporate Governance Practice in the Post-COVID-19 Pandemic Era "Invite Only Event"
14:10	The Effects of the COVID-19 Pandemic on the Mental Health and Psychosocial Support of Ugandan Palliative Care Providers <i>Simon Kizito (Makerere University)</i>	Sepsis in Post-Chemotherapy Infection, 30-Day Case Fatality Rate, and Optimal Mortality Risk Score for Sepsis in Cancer Patients Admitted at Oncology Ward Mbarara Regional Referral Hospital <i>Ambaru Jacinta Ojia (Mbarara University of Science and Technology)</i>	Understanding VHT's Experiences of Providing Palliative Care and Offering Mentorship to Other VHT's to Provide Palliative Care in Refugee and Host Communities of Obongi and Adjumani Districts <i>Elizabeth Namukwaya (Palliative Care Education and Research Consortium)</i>	Enhancing Primary Care Providers' Role in Breast Cancer Care in Uganda: The Impact of Training Program <i>Collins Jackson Mpamani (Uganda Cancer Institute)</i>	
14:20	Caring for Those in Pain When in Pain – It Doesn't Have to Happen. The Role of Self-Care in Palliative Care <i>Irumba Lisa Christine (Palliative Care Association of Uganda)</i>	Prevalence and Factors Associated with Treatment Abandonment of Pediatric Cancer Patients with Solid Tumors at Uganda Cancer Institute <i>Zana Regina (Uganda Cancer Institute)</i>	The Lived Experiences of People with Serious Chronic Illness Among the Refugee and Host Communities of Obongi Districts <i>Vicky Opia (Peace Hospice, Adjumani)</i>	Cancer Control Through Surveillance: Harmonised Cancer Registration Guidelines for East Africa <i>Annet Nakaganda (Uganda Cancer Institute)</i>	
14:30	Predictors of Psychological Well-Being Among Cancer Patients Accessing Hospice Africa Uganda <i>Sylvia Dive (Hospice Africa Uganda)</i>	Factors That Affect the Timely Diagnosis and Treatment of Neutropenic Fever in Ugandan Patients with Cancer and HIV <i>Fred Bwogi (Fred Hutch Center, Uganda Cancer Institute)</i>	Personal Experience on Conducting Family Meetings in Palliative Care Provision in a Hospital Setting in Uganda <i>Bernadette Basemera (Palliative Care Association of Uganda)</i>	Capacity Building for Health Care Workers in Pain Assessment and Management in Uganda <i>Joyce Zalwango (Palliative Care Association of Uganda)</i>	
14:40	Coping Strategies for HIV and Mental Illness Comorbidity Among	Breast Cancer Treatment in Uganda: A Retrospective Analysis of Survival in	The Caring Experiences of Family Caregivers for Patients with Advanced Cancer at a National	Barriers and Facilitators to Oral Liquid Morphine Use Among Cancer Patients: A Qualitative Study at	



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	Adult Patients in Southwestern Uganda <i>Prosper Katugume (Mbarara University of Science and Technology)</i>	Patients Treated for Breast Cancer at a Tertiary Oncology Centre <i>Joseph Leeta (Uganda Cancer Institute)</i>	Referral Cancer Care Facility in Uganda: A Qualitative Study <i>Najjuka Maria Sarah (Makerere University)</i>	Kitagata District Hospital – Sheema <i>Catherine Nakasita (Kitagata Hospital)</i>
14:50	Dancing Colours <i>Angella Namatovu (Mbarara University of Science and Technology)</i>	One-Year Survival and Prognosticators of Adults with Acute Leukemia at the Uganda Cancer Institute <i>Natukunda Barbra (Uganda Cancer Institute)</i>	Experiences and Challenges of Home-Based Care at Mbale Regional Referral Hospital <i>Taaka Esther (Mbale Hospital)</i>	Strengthening the Availability of National Palliative Care Data Through the Rollout of National Palliative Care Health Management Information System Tools <i>Cynthia Kabagambe (Palliative Care Association of Uganda)</i>
15:00	Using Music Therapy in Improving Quality of Life Among Elderly Cancer Patients <i>Jane Frank Nalubega (Mildmay Institute of Health Sciences)</i>	Knowledge, Attitudes, and Practices of Nurses on Pain Management Among Cancer Patients at the Uganda Cancer Institute <i>Prossy Nakabugo (Uganda Cancer Institute)</i>	Empowering Child Caregivers for Economic Sustainability Through Vocational Education at the Palliative Care Association of Uganda <i>Zipporah Kyomuhangi (Palliative Care Association of Uganda)</i>	Advocacy for a Palliative Care Unit at Uganda Cancer Institute <i>Ivan Muwanguzi (Uganda Cancer Institute)</i>
15:10	Palliative Care Nurses' Emotional Toll in Offering Care to Terminally Ill Patients and Strategies to Improve Their Emotional Well-Being <i>Harriet Nalubega (Hospice Africa Uganda)</i>	Clinical Presentation and Outcome of Children with Kaposi Sarcoma in the ART Era in Uganda <i>Fadhil Geriga (Uganda Cancer Institute)</i>	Community Palliative Health Advocates: An Answer to the Growing Ageing Population of Uganda <i>Richard Semanda (Geriatric Respite Care Foundation)</i>	Experience of Carers Looking after Children Diagnosed with Childhood Cancer at Little Hospice Hoima <i>Octavia Nazziwa Evelyn (Hospice Africa Uganda)</i>
15:20	Q&A	Q&A	Q&A	Q&A
15:30 – 16:00	Break: Teas and Coffee & Poster Viewing in the Speke Ballroom			
16:00 – 17:30	Panel Discussion 1: Acacia Hall Health promotion, prevention and early detection & Family and community involvement and empowerment Moderator: Dr. Rony Bahatungire, Ag. Commissioner Health Services in Charge of Clinical Services, Ministry of Health			
16:00 – 16:15	Uganda's Overarching Strategy of Health Promotion, Prevention, and Education: What are the Roles of Key Stakeholders? Richard Kabanda, Ph.D., Commissioner, Health Promotion, Education and Communication, Ministry of Health			
16:15 – 16:30	Contextualizing the WHO Public Health Approaches to Cancer and Palliative Care in the Region Dr. Hafisa Kasule, Country Team Advisor, Non-Communicable Diseases, World Health Organization			
16:30 – 16:45	Harnessing the Civil Society and Community Movement's Role in Advancing Access and Provision of Cancer and Palliative Care Ms. Gertrude Nakigudde, Chief Executive Officer, Uganda Women's Cancer Support Organisation (UWOCASO)			
16:45 – 17:00	Global North and South Partnerships for Health Systems Strengthening: What are the Lessons for Sustainable Initiatives? Lacey Ahern, Program Director, Global Partners in Care			
17:00 – 17:15	Health Policies for Funding for Cancer and Palliative Care in the Region: What Are the Lessons for Uganda? Dr. Emmanuel Luyirika, Executive Director, African Palliative Care Association (APCA)			
17:15 – 17:30	Question and Answer Session from the Audience			
18:00 – 21:00	Conference Gala Dinner – Speke Ballroom Theme and Dress Code – Smart in African Touch			



Conference Day 2: Friday 15th September 2023

8:00 – 8:30	Arrival, Registration of Delegates			
8:30 – 10:30 Plenary Session 2: Speke Ballroom				
Symptom Management, Psychosocial, and Spiritual Support <i>Session Chairs: Dr. Joyce Balagadde, Head, Paediatric Oncology Services, Uganda Cancer Institute and President, SIOP Africa, and Dr. Yvonne Karamagi, Director, Medical Services, Mildmay Uganda</i>				
8:30 – 8:45	From Zero to Ten: Building Capacity for Radiation Oncology in Uganda Dr. Solomon Kibudde, Program Director, UCI Radiation Oncology Fellowship, Uganda Cancer Institute (UCI)			
8:45 – 9:00	The National Cancer Control Program Plan Dr. Charles Oyoo Akiya, Commissioner for Non-Communicable Diseases, Ministry of Health (MoH)			
9:00 – 9:15	Emerging Trends in the Holistic Management of Haematologic Malignancies Dr. Henry Ddungu, Consultant Hematology/Oncology, Uganda Cancer Institute (UCI)			
9:15 – 9:30	HIV and Cancer: Developing Tools for Early Detection of Epidemic Kaposi Sarcoma Dr. Aggrey Semeere, Head of Department, Prevention, Care and Treatment, Infectious Diseases Institute (IDI)			
9:30 – 9:45	Advances in the Management of Breast Cancer in Uganda Dr. Naghib Bogere, Medical Oncologist, Uganda Cancer Institute			
9:45 – 10:00	Addressing Spiritual and Psychosocial Dimensions of Children in Oncology and Palliative Care Prof. Julia Downing, Executive Director, International Children's Palliative Care Network (ICPCN)			
10:00 – 10:15	Palliative Care Transforming Patients with Sickle Cell Disease Prof. Ssali Francis, Deputy Executive Director, Research and Clinical Services, Joint Clinic Research Centre (JCRC)			
10:15 – 10:30	Question and Answer Session			
10:30 – 11:00	Break: Teas and Coffee & Poster Viewing in Speke Ballroom			
11:00 – 13:00	Workshops			
	Workshop 1: Acacia Hall Access to Essential Medicines for Patients with Cancer and Palliative Care Needs in Uganda <i>Session Chairs: Dr. Sebisubi Fred, Rtd Commissioner Pharmacy and Natural Medicines, Ministry of Health</i> <i>Rinty Kintu, Consultant, Global Cancer Treatment, American Cancer Society</i>	Workshop 2: Ebony Hall Enhancing National Palliative Care Data Reporting and Utilization <i>Session Chair: Dr. Muwanga Moses, Assistant Commissioner Palliative Care and Hospice Services, Ministry of Health</i> <i>Locey Ahern – Program Director Global Partner in Care, USA</i>	Workshop 3: Jacaranda Hall Research and Education <i>Session Chairs: Dr. Ludoviko Zirimenya, Research Fellow, London School of Hygiene and Tropical Medicine</i> <i>Dr. Eve Namisanga, Research Development M&E and Learning Manager, African Palliative Care Association</i>	Workshop 4: Mahogany Hall Ageing and Ageism <i>Session Chairs: Kezia Mukasa, Grandmothers Consortium</i>
13:00 – 14:00	Lunch Break at the Poolside and Poster Viewing in Speke Ballroom			
14:00 – 15:40	Presentation of Oral Papers			
	Track 1: Speke Ball Room Innovations and New Technologies <i>Session Chairs:</i>	Track 2: Acacia Hall Health Promotion, Prevention, and Early Detection <i>Session Chairs:</i>	Track 3: Ebony Hall Clinical Care and Symptom Management <i>Session Chairs:</i>	Track 4: Jacaranda Hall Family and Community Involvement and Empowerment <i>Session Chairs:</i>
				Track 5: Mahogany Hall Education, Advocacy, Policy, and the Law <i>Session Chairs:</i>



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	Dr. Rose Nakasi, Makerere University Dennis Kidde – Centre For Hospice Care, USA	Dr. Kirungi Gloria, Uganda Christian University Dr. Alfred Jatho, Uganda Cancer Institute	Dr. Kakungulu Edward, Uganda Cancer Institute Dr. Ludoviko Zirimenya, London School of Hygiene and Tropical Medicine	Hajati Mwazi Batuli, Islamic University in Uganda Dr. Geriga Fadhil, Uganda Cancer Institute	Dr. Joyce Balagadde Kambugu, Uganda Cancer Institute Joyce Zalwango, Palliative Care Association of Uganda
14:10	Scaling Up Excellence: Optimising Electronic Medical Records for Quality and Equity in Palliative Care Mumanye Timothy (Hospice Africa Uganda)	Establishment of Cancer Care at Kawempe National Referral Hospital Mubiru Musa (Kawempe Hospital)	Implementation of In Vivo Dosimetry as Part of Radiotherapy Quality Assurance Program Komakech Ignatius (Uganda Cancer Institute)	Experience of Training Home Caregivers at the Institute of Hospice and Palliative Care in Africa (IHPCA) Harriet Nakiganda Muganga (Institute of Hospice and Palliative Care in Africa)	Impact of Training on Breast Cancer Knowledge, Practice, and Confidence of Community Patient Navigators in Uganda Judith Asasira (Uganda Cancer Institute)
14:20	Estimating Regional and National Cancer Incidence in Uganda: A Retrospective Population-Based Study, 2013-2017 Annet Nakaganda (Uganda Cancer Institute)	Breast Cancer Screening Outreach Program in Uganda: Effectiveness of Community-Based Triple Assessment for Early Detection Solomon Kibudde (Uganda Cancer Institute)	How Low Can You Go: What Is the Safe Threshold for Platelet Transfusions in Patients with Hematologic Malignancy in Sub- Saharan Africa? Henry Ddunga (Uganda Cancer Institute)	Leveraging Trained Village Health Teams and Community Volunteer Workers to Improve Access to Cancer Care and Palliative Care in Rural Uganda Germans Natuhwera (Hospice Africa Uganda)	Uganda Children's Palliative Care Nurses Leadership Fellowship Programme Florence Nalutaya (Palliative Care Education and Research Consortium)
14:30	The Development of a Palliative Care Services Directory for Uganda by the Palliative Care Association of Uganda	The Most Common Cancers by Sub- Regions of Uganda: Population-Based Data from 2017-2020	Influence of Social- Cultural Factors on Palliative Care Services Atuhaire Auleria Kakwara (Kawempe Home Care)	Depression in Ugandan Caregivers of Cancer Patients: The Role of Coping Strategies and Social Support	Pulmonary Ks at Presentation in Sub- Saharan Africa Herriethsiah Noah (Ocean Road Cancer Institute, Tanzania)
	Sheena Asimwe (Palliative Care Association of Uganda)	Alfred Jatho (Uganda Cancer Institute)		Najjuka Maria Sarah (Makerere University)	
14:40	Mapping of Digital Resources on Cervical Cancer in Africa Richard T. Odera (Kenya Network of Cancer Organizations, Kenya)	Common Cancers and Associated Risk Factors in Arua District Agenda 2017 to 2021 Angucia Bridget Sharon (Uganda Cancer Institute)	Implementation of Rwanda Pain-Free Hospital Initiative (PFHI): An Observational Prospective Descriptive Study of Short-Term Achievements Since 2018 Vedoste Hategekimana (Rwanda Biomedical Centre, Rwanda)	Insights into Advance Care Planning in Africa Dianah Basirika (Hospice Africa Uganda)	Factors Affecting the Turn Up of Patients for Palliative Care in Arua Regional Referral Hospital in Arua Central Division, Arua City Osoru Caroline (Arua Regional Referral Hospital)
14:50	Mobile Technologies for Palliative Cancer Care in Uganda: Qualitative Secondary Analysis of Health Professional Perspectives Elizabeth Nabirye (Palliative Care Education and Research Consortium)	Prevalence of Human Papilloma Virus and Cervical Pre-Cancerous Lesions Among Women in Malongo Sub-County, Mayuge District, Eastern Uganda Rogers Mukwaya (Uganda Cancer Institute)	Building a Care Model to Address the Barriers to Access to Palliative Care in Rural Uganda: The Case of Rays of Hope Hospice Jinja Sylvia Nakami (Rays of Hope Hospice Jinja)	Telling Our Story: Experience of Living with a Chronic Illness; Community-Generated Data Using Photovoice in Adjumani and Obongi Districts Toko Friday Santiago (Palliative Care Education and Research Consortium)	"Clinical Commitment Without Political Commitment is Meaningless": Perceived Policy-Related Barriers to the Implementation of Palliative Care in the Rural and Regional Healthcare Facilities Atsedegay (University of Agdar, Norway / Ethiopia)



15:00	Impact of Patient Mapping Information System Integration in Palliative and Hospice Care <i>Kyomuhendo Milliam</i>	Palliative Care Knowledge, Attitudes, and Perceptions Towards Advanced Care Planning <i>Natusiima Jovinah (Institute of Hospice & Palliative Care in Africa)</i>	The Reality of Nurses Multitasking Versus a Multidisciplinary Team: A Case Study of Mobile Hospice Mbarara <i>Antonia Kamate Tukundane (Hospice Africa Uganda, Mobile Hospice Mbarara)</i>	Assessment of the Impact of Business Centers on Patients' Well-Being and Their Families in West Nile <i>Ndemaru Patricia (New Life Hospice Arua)</i>	Examining the Impact of Diploma in Paediatric Palliative Care Academic Programme on Access for Children's Palliative Care Services in Selected Public Health Facilities of Uganda <i>David Kavuma (Mildmay Institute of Health Sciences)</i>
15:10	Apheresis at the Uganda Cancer Institute: A Unique Nursing Experience <i>Bafumba Ritah (Uganda Cancer Institute)</i>	Improving Access to Cancer Diagnosis and Treatment Among Children in Southwestern Uganda: The Experience of Kitagata Hospital <i>Catherine Nakasita (Kitagata Hospital)</i>	Strengthening the Availability of Palliative Care for Persons Living with Disabilities – The Palliative Care Association of Uganda's Experience in Becoming Disability Inclusive <i>Esther Namara (Palliative Care Association of Uganda)</i>	Challenges Facing the Informal Caregivers and Lessons Learnt in Provision of Palliative Care – Experience at Rays of Hope Hospice Jinja <i>Mukiibi Henry Kikonyogo (Rays of Hope Hospice)</i>	Oncology Nursing Training at Uganda Cancer Institute <i>Kemigisha Misk (Uganda Cancer Institute)</i>
15:20	Fighting Cervical Cancer in Africa	Correlates of Late-Stage Esophageal Cancer at Diagnosis Among Patients Attending Mbarara Regional Referral Hospital Oncology Unit	Rural Palliative Care Outreach Team Confronts Barriers to Cancer Care	Characterization of Human Papillomavirus Genotypes and Their Correlates Among Women Living with HIV Attending Antiretroviral Therapy Clinic in Mukono, Uganda	Impact of Stigma in Accessing Palliative Care Services in West Nile
	<i>Mbabazi Joanita (Rays of Hope Hospice Jinja)</i>	and Mobile Hospice Mbarara <i>Nagujja Francisca (Mobile Hospice Mbarara)</i>	<i>Prossy Nafula (Nagalama Hospital)</i>	<i>Nantale Prossy Nabatte (AMREF International University)</i>	<i>Daniel Dribale Dratibi (Voice of Restoration International)</i>
15:30	Q&A	Q&A	Q&A	Q&A	Q&A
15:40 – 16:00	Break: Teas and Coffee & Poster Viewing in the Speke Ballroom				
16:00 – 17:30					
Panel Discussion + Conference Closing Ceremony – Speke Ballroom					
Panel Discussion 2 – The Future Advancements in Cancer Treatment and Palliative Care in Uganda					
Moderators: Ms. Fatia Kiyange , Executive Director Center for Health, Human Rights and Development (CEHURD), and Dr. Nixon Niyonzima, Head of Research and Training, Uganda Cancer Institute					
16:00 – 17:00	Prof. William Bazeyo, Board Chair, Uganda Cancer Institute (UCI) Dr. Jackson Orem, Executive Director, Uganda Cancer Institute (UCI) Dr. Henry Ddungu, Board Chair and President, Palliative Care Association of Uganda (PCAU) Mark Donald Mwesiga, Executive Director, Palliative Care Association of Uganda (PCAU)				
17:00 – 17:30	Awards to Best Oral and Poster Presenters Dr. Nixon Niyonzima and Dr. Eddie Mwebesa				
	Conference Summary of the 4 th Uganda Conference on Cancer and Palliative Care: Prof. Julia Downing, International Children's Palliative Care Network (ICPCN)				
	Closing of the Conference and Announcements Dr. Nixon Niyonzima and Dr. Eddie Mwebesa				



Poster Presentations

Clinical Care and Symptom Management

1.	Human Herpesvirus-8 Replication and Kaposi Sarcoma Response to Treatment at Uganda Cancer Institute (UCI)	Peter Mooka (Fredhutch Cancer Research Institute Uganda)
2.	Barriers in the Use of Oral Liquid Morphine for Pain Treatment in Palliative Care for Hospice Africa Uganda – Health Professionals' Perspective	Harriet Nakiganda Muganga (Institute of Hospice and Palliative Care in Africa, HAN University of Applied Sciences, Netherlands)
3.	A Phase I Study of Subcutaneous Rituximab Hyaluronidase Combined with Local Standard-of-Care Chemotherapy for the Treatment of Burkitt Lymphoma, Diffuse Large B-Cell Lymphoma or as Monotherapy for Kaposi Sarcoma Herpesvirus Associated Multicentric Castleman Disease, in Pediatrics and Adults in Uganda	Rosemary Namagembe (Uganda Cancer Institute)
4.	Implementation of the SIOP Paediatric Oncology Nursing Foundation Course in Cameroon	Jator Brian Kobiin (Cameroon Baptist Convention, Cameroon)
5.	Independent Calculation of Monitor Units and Doses as Part of Radiotherapy Patient-Specific Quality Assurance Program	Komakech Ignatius (Uganda Cancer Institute)
6.	Costing of Breast Cancer Treatment Based on Stage at Diagnosis at Mbarara Regional Referral Hospital Cancer Unit	Deo Kyambadde (Uganda Cancer Institute)
7.	Uptake and Integration of the NCCN Harmonized Guidelines for Sub-Saharan Africa: A Survey	Racheal Angom (Uganda Cancer Institute)
8.	Unearthing and Addressing Barriers to Cancer and Palliative Care Access Through Collaboration: An Experience of a Hospice and a Regional Cancer Center in Southwestern Uganda	Martha Rabwoni (Hospice Africa Uganda)
9.	Total Pain and Making a Nursing Diagnosis Plan: Experience at St. Francis Hospital Nsambya	Elizabeth Babirye (St. Francis Hospital Nsambya)
10.	The Practice of Health Workers in Physical Pain Assessment Among Children at Mobile Hospice Mbarara	Kabigarire Miriel (Hospice Africa Uganda)
11.	Thyroid Cancer in Uganda: Clinico-Pathological Patterns and Management Disparities at a Major Tertiary Centre	Kintu Luwaga (Mulago Hospital)
12.	Strengthening Medical Teams for Improved Palliative Delivery in a Refugee Hosting Community	Germans Natuhwera (Hospice Africa Uganda)
13.	Does Concurrent Prescription of Morphine with Laxatives Happen at Joy Hospice Mbale?	John Mawogole (Kaberamaido General Hospital)
14.	Knowledge and Practices Among Caregivers of Children Receiving Radiation Therapy Regarding Skin Care at Parirenyatwa Radiotherapy Centre	Tendai Chisamba (Parirenyatwa School of Nursing)
15.	Patients' Satisfaction with Nursing Care Among Pediatric Cancer Patients Attending Uganda Cancer Institute – Mulago, Kampala, Uganda	Beatrice Rukundo (Uganda Cancer Institute)
16.	Clinicopathologic Features Associated with Disease Recurrence Beyond 6 Months of Post Mastectomy: A Study from Addis Ababa Oncology Center	Ephrem Abathun (University of Gondar, Ethiopia)
17.	Prevalence of Anxiety and Depression Among Patients in a Palliative Care Setting During COVID-19 Pandemic: A Mixed Methods Cross-Sectional Study	Germans Natuhwera (Hospice Africa Uganda)
18.	Effectiveness of Low-Dose Immunotherapy in Triple Negative Breast Cancer Treatment	Benjamin Mwesige (Uganda Cancer Institute)

Education, Advocacy, Policy, and the Law

19.	Final-Year Undergraduate Nursing and Medical Students' Knowledge and Perceptions of and Orientation Towards Palliative Care: A Multicenter Mixed Methods Study in Uganda	Germans Natuhwera (Hospice Africa Uganda)
20.	Online Sickle Cell Learning and Awareness	Prosper Katugume (Mbarara University of Science and Technology)



21.	Providing Access to Cancer Treatment – Even for the Poorest Among Us	Susan Walusansa (Rays of Hope Hospice)
22.	Education in Dealing with the Impact of Working in Palliative Care	Dorien van de Ven (HAN University of Applied Sciences, Netherlands)
23.	Assessing Knowledge, Attitudes, and Behaviors About Gender-Based Violence Through the Lens of Palliative Care Providers in Africa	Emily Karalus (University of Notre Dame, USA)
24.	The Experiences Of Families with Terminally Ill Breastfeeding Mother Receiving Palliative Care At HAU	Dorcus Aciro (Hospice Africa Uganda)
25.	Strengthening the Availability and Accessibility to Essential Medicines and Supplies for Patients with Palliative Care Needs in Uganda – An Experience at the Palliative Care Association of Uganda	Joyce Zalwango (Palliative Care Association of Uganda)
Innovations and New Technologies		
26.	A Machine Learning Approach to Mortality Forecasting for Advanced Breast Cancer Patients to Enhance Referral to Palliative Treatment at the Uganda Cancer Institute	Collins Gyeza (Uganda Cancer Institute)
27.	Minimizing the Cost of Palliative Parenteral Chemotherapy Through a Dose Rounding Strategy at Uganda Cancer Institute, Mbarara, Uganda	John Isiiko (Uganda Cancer Institute)
28.	Development, Implementation, and Evaluation of Palliative Care Service in Uganda, Ankole Subregion	Nduhukire Moses (Mobile Hospice Mbarara) and Nakasita Catherine (Kitagata Hospital)
29.	More Than Defensive Driving: The Multi-Faceted Role of Transport Officers in an Interdisciplinary Palliative Care Team	Kazibwe Siragi (Hospice Africa Uganda)
Health Promotion, Prevention, and Early Detection		
30.	Effective Mobilization Is Key to Ensure High Cervical Cancer Screening Uptake	Naleba Irene (Rays of Hope Hospice Jinja)
31.	A Survey of Attitudes Relative to Engagement in Cancer Screening and Prevention Practices in Uganda	Nantayi Martha (Uganda Cancer Institute)
32.	Cervical Cancer Screening Among HIV-Positive Women in Urban Uganda: A Cross-Sectional Study	Najjuka Maria Sarah (Makerere University)
33.	Using Multiple QI Interventions to Increase Cervical Cancer Screening Among Women Living with HIV (WLHIV) at St. Francis HCIII Migyera, Nakasongola District (Ug)	Kwefuga Stephen (St Francis HCIII)
34.	Increasing Cervical Cancer Screening Among People Living with HIV/AIDS in Kyere Sub-County, Serere District	Awany Bosco (Kyere Health Centre 3)
35.	Evaluation of Palliative Care Services	Siema Limited (Mbarara Regional Referral Hospital)
36.	Barriers to and Facilitators of Prostate Cancer Screening Among Men in Uganda Prisons: Findings From a Survey of 2565 Prisoners	Alfred Jatho (Uganda Cancer Institute)
37.	Infection-Related and Lifestyle-Related Cancer Burden in Kampala, Uganda: Projection of the Future Cancer Incidence up to 2030	Judith Asasira (Uganda Cancer Institute)
38.	Characterizing Oncology-Related Emergencies Among Cancer Patients Attending the Emergency Unit of Uganda Cancer Institute, Kampala, Uganda in 2019	Hanifah Nabbanja (Uganda Cancer Institute)
39.	A Study to Determine Factors Leading to Delayed Presentation for Treatment by Cervical Cancer Patients	Maria Kapuya (Parirenyatwa Group of Hospitals)
40.	Estimation of Cancer Incidence in Eastern Uganda, 2015-2019	Catherine Amuge (Uganda Cancer Institute)
Psychological, Social, and Spiritual care		
41.	Establishment of Caregiver Dilemmas in West Nile	Candia Richard (Arua Regional Referral Hospital)
42.	Spiritual Care in Palliative Care in Uganda	Bernadette Basemera (Palliative Care Association of Uganda)
43.	Empowering Child Caregivers Through Psychosocial Support to Promote Their Mental Health and Well Being	Anita Balikobaku (Palliative Care Association of Uganda)
Family and Community Involvement and Empowerment		
44.	Impact of Cancer Diagnosis Among Care-Givers of Paediatric And Adolescents Parirenyatwa Ward A4 Special, Zimbabwe	Lomtunzi Chidziwa (Parirenyatwa Group of Hospitals)
45.	A Ugandan Father's Experience of the Childhood Cancer Treatment Journey	Joseph Kkeeya Mwanje (Ahavah Child Cancer Care Uganda)
46.	Effect of Patient Navigation Program Services on Patients' Experience of Cancer Care and Adherence to Treatment at UCI	Fatina Tina Nakalembe (Uganda Cancer Institute)
47.	Prevalence, Trends, and Distribution of Lifestyle Cancer Risk Factors in Uganda: A 20-Year Systematic Review	Annet Nakaganda (Uganda Cancer Institute)



Conference Workshops and Side Events

Conference Side Event (Invite only event)

This event will happen on **14th September 2023** and will run **from 2:00 pm – 5:30 pm** in **Majestic Hall**.

During this conference, an inaugural conference side event for Chief Executive Officers (CEOs) and Board Members of institutions working in cancer, palliative care, and partners will be held. The event aims at equipping participants with post-COVID-19 leadership acumen for sustainable governance. The inaugural conference side event sessions will focus on: ***Harnessing Social Corporate Responsibility***, Sustaining Resourceful transcontinental partnerships, and the evolving role of the Board of Directors in the post-COVID-19 era. The special side event will be facilitated by the following seasoned leaders:

Topic: Sustainable Corporate Governance Practice in the Post-COVID-19 Pandemic Era



Mr. Fabian Kasi is a Fellow Member of the Association of Chartered Certified Accountants (FCCA) and Managing Director of Centenary Bank. He will speak about ***Harnessing Corporate Social Responsibility: Lessons for CEOs and Boards***.



Dr. Stephen Asimwe (MBChB, MS, DrPH) is a physician-scientist, senior medical epidemiologist, and Director of the Global Health Collaborative (GHC), a partnership between the Mbarara Regional Referral Hospital and Mbarara University of Science and Technology (MUST). He will speak about ***Sustaining partnerships and sponsorships for resource mobilization***.



Keith T. Everett, MBA, MHA, CPHQ, CSSBB, MBNQA Fellow/Judge, SHRM-IWCS President & Chief Executive Officer Hospice of Acadiana, Inc USA, He will speak about: ***The evolving role of the Board of Directors in the post-Covid-19: USA Non for Profit perspective***.



Workshops at the conference on **15th September 2023** from
11:00 – 13:00 hours

The following workshops are all open to registered conference delegates.

Workshop 1: Acacia Hall

Access to Essential medicines for patients with Cancer and Palliative Care Needs in Uganda

This is a strategic workshop on Access to anticancer and pain medicines in Uganda. Gaps in access to quality essential medicines remain a major impediment to the effective care of patients with cancer in low and middle-income countries (LMICs).

A preliminary report presented at the European Society for Medical Oncology Congress 2022 shows that in many low and middle-income countries access to WHO essential medicines, including traditional chemotherapy agents at the backbone of every cancer protocol, is very limited, with substantial out-of-pocket expenditure for patients.

The global annual expenditure on

anticancer medicines was estimated to be \$100 billion in 2017 and was estimated to rise to more than \$150 billion by 2020. The factors contributing to high drug costs are many; they are partly related to costs with respect to drug development and clinical research required to get regulatory approval for the drug.

The special conference workshop is intended to bring together key players contributing to availability and accessibility of anticancer and pain medicines in Uganda to present and discuss the overview of the national policy and logistics framework, challenges impacting universal access and come up with actionable points and recommendations

to address the challenges.

The workshop will be facilitated by experts on the subjects from the Ministry of Health, National Drug Authority, National Medical Stores, Palliative care Association of Uganda, Hospice Africa Uganda, and partners from the American Cancer Society and Clinton Health Initiatives.

A key expected outcome of the workshop is to have a stakeholder working group on access to anticancer and pain medicines composed that will draft a memorandum to guide national stakeholders involved in the decision-making process for short, medium, and long term drawn.



Workshop 2: *Ebony Hall*

Enhancing National Palliative Care Data Reporting and Utilization

The Ministry of Health with support from the Palliative Care Association of Uganda and partners completed the development of data collection tools for palliative care that are integrated within the Health Management Information System (HMIS). These data collection tools were developed on realizing that the indicators previously included in the HMIS were insufficient to inform Palliative Care policy formulation, decision-making, and research.

The tools are:

- i. The HMIS OPD 008 Unit Palliative Care Register
- ii. HMIS 105c Health Unit Palliative Care Monthly Report.

Regional dissemination and facility-level trainings have been ongoing in several palliative care accredited health facilities. Training on the tools shall continue at the facility level through the already trained palliative care providers as palliative care data champions in the regions.

This workshop aims to bring together healthcare professionals, researchers, policymakers, and advocates to strengthen national palliative care efforts through the effective collection, reporting, and utilization of data.

Objectives of the workshop

- i. Share Best Practices: To showcase the successful Health initiative that evolved into the HMIS tool.
- ii. Strengthen Capacity: To provide a comprehensive understanding of the importance of palliative care data reporting and utilization in Uganda.
- iii. Promote Collaboration: To facilitate networking opportunities to foster collaboration among healthcare professionals, organizations, and policymakers.
- iv. Drive Policy Impact: To demonstrate how high-quality palliative care data can influence policymaking and resource allocation at the national level.

Topics

- a) Essentials of Palliative Care Data: Understand the core data points to collect, the importance of data accuracy, and ethical considerations.
- b) Data Collection Methods: Explore various methods for collecting palliative care data, including patient cards, patient registers, electronic health records, and other relevant sources.



- c) Data Reporting and Analysis: Learn techniques for reporting and analyzing palliative care data, identifying trends, and assessing the quality of care.
- d) Utilizing Data for Quality Improvement: Discover how data insights can drive continuous quality improvement in palliative care services.
- e) Data-Driven Policy Decisions: Explore real-world examples of how palliative care data can influence healthcare policies and discuss strategies for advocating its importance to policymakers.
- f) Technology in Data Management: Discuss the role of technology in simplifying data collection, reporting, and analysis in palliative care.

Structure and Methodology

This workshop will be conducted over 2 hours combining theoretical sessions, practical exercises, and interactive discussions. The workshop will be led by experienced data and Health Informatics experts, who will employ the following methodologies:

- a) Interactive lectures: Presentations covering the core concepts of HMIS, data management and best practices.
- b) Case Studies: Analyze real-life palliative care cases to understand the practical application of data reporting and utilization.
- c) Group discussions: Participants will be encouraged to share their experiences and ideas, fostering a collaborative learning environment.
- d) Q&A sessions: Regular opportunities will be provided for participants to seek clarification and address specific concerns.

Expected Outcomes

Participants will leave the workshop with a comprehensive understanding of the role of data in strengthening national palliative care efforts. They will be equipped with practical skills to enhance data reporting through the District Health Information System (DHIS2) and utilization in their respective roles, fostering improved patient care, policy making, and resource allocation in the field of palliative care.

Additionally, the workshop will create a platform for ongoing collaboration and the exchange of best practices among stakeholders, promoting a unified approach to palliative care at the national level.

Overall, participants shall nominate and form a committee – National Palliative Care Data and Information Committee whose role is to discuss further improvement in palliative care data management, reporting and use in the country. The committee shall report to the national HMIS review committee.



Workshop 3: *Jacaranda Hall*

Research and Education

The Research and Education workshop aims to bring together key stakeholders for a focused meeting in the field of academia, research, health training institutions, and the other delegates to discuss and draw a way forward on strengthening evidence-based care and education for cancer and palliative care in Uganda.

Specific Objectives for the Workshop

The specific objectives for the workshop will be:

- i) To review the research journey right from idea formation to publication.
- ii) To learn about available research opportunities
- iii) To review the education journey in cancer and palliative care with a focus on reflective practice which is key in palliative care.
- iv) Discuss the challenges in the research journey and how to address them.

Expected participants at the workshop.

This is an open meeting to conference delegates with the main target being members in academia, research, and health training institutions as well as the other delegates.

The flow of discussions at the workshop

The workshop will be managed in the best way that fosters discussion and consensus building on the best course of action for strengthening evidence-based practices and education for cancer and palliative care in Uganda. There will be presentations from selected stakeholders and open discussions on the topics of discussion.



Workshop 4: *Mahogany Hall*

Ageing and Ageism

This is a special interest workshop on ageing and ageism. Age is one of the first things we notice about other people. However, age is often used to categorize and divide people in ways that sometimes lead to discrimination, harm, disadvantage, and injustice and erode solidarity across generations. According to the World Health Organization, by 2050, 80% of older people will be living in low and middle-income countries.

All countries face major challenges to ensure that their health and social systems are ready to make the most of this demographic shift. At the biological level, aging results from the impact of the accumulation of a wide variety of molecular and cellular damage over time. This leads to a gradual decrease in physical and mental capacity, a growing risk of disease, and ultimately death. Ageism entails stereotypes (how we think), prejudice (how we feel), and discrimination (how we act) towards others or ourselves based on age.

This workshop is intended to explore the concepts of ageing and ageism and how these interact with the availability and access to cancer and palliative care services. The workshop will feature presentations on ageing, ageism, and on case scenarios of caring for older persons with palliative care needs.

The workshop will be facilitated by experts on the subjects from Uganda Reach the Aged Association (URAA), Mildmay Uganda, Aged Family Uganda, Health Age International, Grandmothers Consortium Uganda, and the Ministry of Health.

A key expected outcome of the workshop is a draft position paper on the challenges faced by older persons with palliative care needs and how these can be addressed. The position paper will be developed into a guiding document for Ugandan stakeholders on cancer and palliative.



Conference Abstracts

Thursday: 14th September

Track 1: Psychological, social, and spiritual care

14:00 – 14:10

The Effects of the COVID-19 Pandemic on the Mental Health and Psychosocial Support of Ugandan Palliative Care Providers

Authors: *Mariah Horvath¹, Simon Kizito², Lacey Ahern^{1,3}, Mark Donald Mwesiga⁴, Lisa Christine Irumba⁴*

Affiliation: *¹University of Notre Dame, ²Makerere University, ³Global Partners in Care, ⁴Palliative Care Association of Uganda*

Background: The COVID-19 pandemic placed stress on healthcare workers. Palliative care providers were especially affected as pandemic restrictions disrupted their ability to provide in-person support to patients and their families. Research shows that palliative care providers were affected by personal stress, fear, anxiety, grief, and fatigue caused by the pandemic.

Aims: This research described the prevalence of depression, anxiety, and psychological distress among Ugandan palliative care providers and highlighted the psychosocial challenges they faced during the pandemic.

Methods: Using mixed-methods, data was collected from palliative care providers across Uganda via 123 surveys and 11 in-depth interviews. Depression, anxiety and psychological distress were measured through the Patient Health Questionnaire-9 (PHQ-9), the Generalized Anxiety Disorder-7 (GAD-7), and the Self Reporting Questionnaire (SRQ-20). The Multidimensional Scale of Perceived Social Support (MSPSS) gathered perceived level of social support. Interviews gathered information on mental health challenges during the pandemic and the availability of mental health resources. Support services were offered to participants.

Results: Participants ranged in age, gender, religion, marital status, clinical position, and years in palliative care. Surveys indicate that 20% of respondents show signs of moderate to severe depression, 14% show signs of moderate to severe anxiety, 33% show signs of psychological distress, and 50% perceive low social support. A majority of respondents express a desire for additional mental health resources at their workplace. Providers already faced existing challenges to doing their work effectively and felt the pandemic hindered their ability to help patients.



Discussion/Conclusion: A workshop with the Ministry of Health and palliative care leaders explored mental health interventions to support providers better. Ugandan palliative care providers faced significant mental health challenges during the COVID-19 pandemic. This research will allow palliative care organizations to better understand and plan for the mental health needs of their providers, especially during times of crisis.”

14:10-14:20

171: Caring for those in Pain when in Pain, It doesn't have to happen. The Role of Self-Care in Palliative Care

Authors: *Irumba Lisa Christine¹, Joyce Zalwango¹, Fiona Siima¹*

Affiliation: *¹Palliative Care Association of Uganda*

Background: 14 million Ugandans suffer a form of mental illness the commonest being depression and the number of palliative care providers battling mental health challenges is unknown in Uganda. Serving in palliative care can sometimes be very demanding even when it is enormously rewarding. The health professionals and volunteers engaged in this work need to always consider ways of appropriate self-care to avoid burnout and compassion fatigue which is detrimental to their health. Being a part of professional networks, personal groups and hobbies is essential in supporting professionals and volunteers in their work. The Palliative Care Association of Uganda (PCAU) is an association of palliative care providers and well-wishers in Uganda and beyond. PCAU members are provided with different opportunities to enhance their learning and self-care.

Aim: To strengthen access to resources that support the self-care activities of palliative care providers and volunteers to prevent possible effects of stress and burnout.

Approach Taken: Palliative care providers and volunteers are equipped with the knowledge to take responsibility for their needs at different levels i.e. quarterly update meetings and webinars which are continuous medical education sessions. In addition to these opportunities, members are able to consult with one another and discuss common challenges as well as receive mentorship and support supervision visits. Members participate in social events like the annual dinner, advocacy campaigns like the commemoration of the World Hospice and Palliative Care Day, Annual general meetings, and conferences.

Results: From 2020 to 2022, we conducted 9 update meetings, 15 webinars, 3 annual dinners, 3 annual general meetings, 3 advocacy campaigns, and 1 conference which facilitated the discussion of self-care of members.



Conclusions and Lessons Learnt: It is valuable for health workers and volunteers to understand the importance of self-care and to be aware of the support of each other when caring for patients and their families.

14:20-14:30

77: Predictors of psychological well-being among cancer patients accessing Hospice Africa Uganda

Authors: Dive Sylvia¹, Miriam Ondia²

Affiliations: Hospice Africa Uganda, ²Clarke International University

Background: Psychological distresses are inherently painful, hence, the need to help to cancer patients find effective ways of accepting and coping with the disease through adjustment of attitudes and adoption for overcoming cancer-induced stresses.

Aims: This study sought to establish the predictors of psychological wellbeing among cancer patients accessing Hospice Africa Uganda.

Methods: This study applied an analytical cross-sectional research design employing a mixed methods approach to data collection. The data collection tools constituted a questionnaire and Key Informants guide. The WHO-5 Well-Being Index was used as a questionnaire to measure the dimensions of psychological wellbeing of patients.

The quantitative data was entered into the Epi-Data and exported to SPSS. Analysis was done at univariate, bivariate, and multivariate levels.

Results: A significant proportion of the respondents (32%) felt calm but the majority (41%) reported not feeling calm and relaxed at any time.

The results show that there is a significant association between individual coping traits and psychological wellbeing of cancer patients, 62.5% of patients who rarely or never practiced this reported poor psychological wellbeing compared to 37.5% of those who did.

Taking time to engage in enjoyable hobbies or activities was also associated with better psychological wellbeing, with 93.8% of patients who rarely did this reporting poor psychological well being.

Finally, talking about feelings or sharing concerns with friends and relatives was also associated with better psychological wellbeing, with 50% of patients who did this nearly every day reporting good psychological wellbeing compared to 12.5% of those who did this rarely.



Conclusion/Discussion: Overall, these findings suggest that individual coping traits can have a significant impact on the psychological wellbeing of cancer patients, and healthcare providers should encourage patients to engage in coping strategies that have been found to be effective in improving psychological wellbeing.

14:30-14:40

84: Coping strategies for HIV and mental illness comorbidity among adult patients in southwestern Uganda

Authors: *Prosper Katugume¹*

Affiliation: *¹Mbarara University of Science and Technology*

Background: People living with HIV (PLHIV) are more vulnerable to mental disorders and vice-versa due to their bidirectional relationship. In Uganda, HIV prevalence in severe mental illness was estimated to be 11.3%, with 7.3% in men and 14.3% in women (Lundberg et al., 2013). A number of strategies for coping with HIV and mental illness comorbidity have been reported for individual states but there is limited data on comorbidity state.

OBJECTIVES: To establish coping strategies for HIV and mental illness comorbidity among adult patients

To establish challenges encountered in coping with the HIV and mental illness comorbidity.

To explore possible interventions that can mitigate the challenges and enhance coping among adult patients with for HIV and mental illness comorbidity.

Methods: A cross-sectional qualitative study involving 21 participants aged 18 years and above with both HIV and Mental illness was conducted. Study approval was obtained from the MUST Research Ethics Committee and Uganda National Council of Science and Technology. Purposive sampling for participants attending their healthcare services at Kitagata Hospital and Kabuyanda health Centre IV in southwestern Uganda. Data was collected using in-depth interviews with prior informed consent from participants. Data was managed and thematically analysed using ATLAS.ti software.

Results: A total of 21 participants were interviewed (9 males and 12 females) with mean age of 43 years, and 1/3 reached post primary level. Avoidance of emotional stressors was the most common and relatively new, status disclosure and seeking medical care were reported. Challenges encountered



were financial crisis, mental illness re-occurrence, bad dreams and hallucination, social neglect, stigmatization. Key interventions suggested were scaling up healthcare education for all, Tailored trainings, adopting financial aid programs.

Conclusion: While avoidance of emotional stressors was a new finding, integrating it in the public healthcare trainings and systems may improve the quality of life of the people.

14:40-14:50

86: DANCING COLORS (dance choreography)

Authors: Angella Namatovu¹

Affiliation: ¹Mbarara University of Science and Technology

Maya, a 12-year-old girl battling cancer or a life-limiting illness, discovers the transformative power of dance as a means of expressing her emotions and finding strength. In this skit, Maya embarks on a journey of self-discovery through various dance styles.

Maya's ballet solo, "Shadows of Strength" portrays her vulnerability and struggles with her illness while showcasing her resilience.

In the hip-hop solo, "Breaking Chains," Maya breaks free from the constraints imposed by her illness, exhibiting determination and defying limitations.

The contemporary solo, "Whispers of Hope," explores Maya's emotions and longing for hope, emphasizing her resilience and belief in the beauty of life.

In the Latin dance solo, "Rhythm of Life," Maya exudes joy, embracing the present moment and celebrating the vibrancy of life.

The finale "Colours of Courage," brings together all the dance styles, symbolizing the complexity of Maya's journey and the triumph of her spirit. Throughout the skit, Maya reflects on the transformative power of dance, recognizing how it has given her a voice when words fail and revealed her inner strength.

"Dancing Colours" inspires empathy and highlights the therapeutic and empowering effects of dance, demonstrating how it can help individuals facing life-limiting illnesses to express themselves, find courage, and celebrate life's beauty.



14:50-13:00

Using Music Therapy in Improving Quality of Life Among Elderly Cancer Patients

Authors: *Jane Frank Nalubega¹*

Affiliation: *¹Mildmay Institute of Health Sciences*

"A research study was conducted to prove a model developed. The elderly were reached out to in their homes.

This particular qualitative study focused on using music as therapy among the frail elderly on palliative care.

The elderly reported increased well-being under the soothing effect of music with many feeling absorbed in the music as their aches and pains disappeared. Spiritual music was most preferred compared to sensational music.

The therapeutic effects of music as therapy, on the physical, psychological, emotional, and spiritual well-being of the old-old under palliative and end-of-life care are enormous. To maximize health outcomes and promote good quality of life in this population, health management programs for the elderly receiving palliative care should harness the use of music as therapy in end-of-life care"

3:00-3:10

92: Palliative Care Nurses' Emotional Toll in Offering Care to Terminally ill Patients and Strategies to Improve Their Emotional Well-Being

Authors: *Harriet Nalubega¹, Buyinza Nasur¹, Emma Mathews¹, Dianah Basirika¹*

Affiliation: *¹Hospice Africa Uganda*

Background: Palliative care delivery to patients and families with terminal illnesses is part of the nurses' daily work in hospitals, hospices and homes to provide holistic care. Many Nurses have fears of emotional attachment when providing care to patients which results in poor quality care hence the need to consider the challenges they face while performing their duties.

Aim: To share palliative care nurses' experiences of the emotional toll and distress of offering Palliative care for terminally ill patients and strategies to support nurses.



Design, Methods And Approach: A descriptive and interpretive study design was used. Findings were based on personal observations, interviews and informal feedback from nurse colleagues. Topics included the emotional difficulty of caring for terminally ill patients, approaches to deal with emotional burnout and grief.

Results: Through care provided to patients with life-limiting conditions, nurses become attached to their patients which affects them psychologically, causing emotional burnout and other distresses like emotional drainage which brings physical exhaustion, thoughts of guilt, sadness which often affect self-care and family care.

Nurses interviewed reported that traumatic feelings continue to affect their work and personal life. However, there are interventions that provide substantial stress relief and improvement in emotional well-being. These include self-care supports like sleep therapy, diversionary sports therapy, connecting with nature, taking short breaks to refresh.

Training in mindfulness and resilience offers skills in self-awareness to recognize and appreciate their efforts in coping with stresses related to patient care.

Letting one's colleagues know their feelings about the cases of terminally ill patients seen and seeking professional counselling can be therapeutic.

Conclusion: Palliative care nurses face psychological distresses as they care for terminally ill patients hence the need for support in stress management by organizations employing them to address the emotional stress that comes with their challenging roles.

Track 2: Clinical care and symptom management

14:00-14:10

103: Experience of carers looking after children diagnosed with childhood cancer at Little Hospice Hoima

Authors: Octivia Nazziwa Evelyn¹

Affiliation: 'Hospice Africa Uganda- Mbarara branch

Background: Childhood cancer usually presents unexpectedly, giving parents little opportunity to prepare for the demands of caring for their newly diagnosed child.



Aim: This study explored Carer's lived experiences of looking after a child diagnosed with childhood cancer on the Little Hospice Hoima program, the challenges they faced, and how they coped with the situation.

Methodology: The study was qualitative research and a phenomenological approach describing the lived experiences of carers of children diagnosed with childhood cancer on the Little Hospice Hoima program. The participants were purposively selected among 15 participants with an average age of 34 and sampling continued until thematic saturation was reached. Information was collected using a semi-structured interview guide which enabled the participants to tell their stories naturally. Interviews were audio recorded with permission and then transcribed verbatim.

Results: Findings revealed themes like financial constraints, the psychological impact of knowing the diagnosis, spending a lot of time in the Hospital, change in gender roles, cultural beliefs, side effects of treatment, difficult questions from children, fear surrounding going to Uganda Cancer Institute- Mulago, support for each other and resilience.

Conclusion: Carers of children with cancer experienced significant psychosocial, financial, spiritual, and cultural challenges related to cancer treatment that need to be identified and managed appropriately in order to improve the quality of life of children with cancer and their carers.

14:10-14:20

64: Prevalence and factors associated with treatment abandonment of pediatric cancer patients with solid tumors at Uganda Cancer Institute.

Authors: Regina zana¹, Benjamin Mwesige¹, Yusuf Mulumba¹

Affiliation: ¹Uganda cancer institute

Introduction: Treatment abandonment is a major cause of treatment failure and poor survival outcomes in children with cancer in low and middle-income countries. Treatment abandonment was a lapse of 4 weeks or longer in treatment. This study aimed at determining the prevalence of treatment abandonment and the associated factors in pediatric patients with solid tumors at Uganda Cancer Institute between January 1st and 31st December 2021.

Methodology: A total of 76 pediatric patients below 18 years who were histologically diagnosed with solid tumors between January 1st and 31st December 2021 were analyzed retrospectively with data extracted from medical records.



Result: Data from 76 children diagnosed with malignant solid tumors was analyzed of which 55.3% were female and the average age in years was 8. Of the 76 children, 34 (44.7%) abandoned treatment, and of these, 73.5% had peasant caretakers, 35.3% died and 50.0% escaped from the hospital. Among the participants enrolled, Wilms (25.0%), osteosarcoma (19.7%,) and RMS (10.5%) were the most common tumors. Most children enrolled were in the late stages of III (25%) and IV (60.55%). Most participants received the first cycles of chemotherapy (92.1%), 23.5% did not go for surgery, 29.4% did not receive radiation and only 52.6% received their complete course of treatment. The survival rate was high among patients who completed treatment at 30.3%.

Conclusion: Treatment abandonment prevalence of solid tumors in Uganda Cancer Institute is high and closely related to socio-demographical factors. Treatment outcomes could be substantially improved by strategies that help prevent abandonment of therapy for example patient tracking and follow-up to improve adherence based on these results.

14:20-14:30

67: Factors that affect the timely diagnosis and treatment of neutropenic fever in Ugandan patients with cancer and HIV

Authors: Elizabeth Gulleen, MD^{1,2}, Johnblack Kabukye^{3,4}, Fred Bwoji⁵, Catherine Liu^{1,2}, Jackson Orem³, Warren Phipps^{1,2}

Affiliation: ¹Vaccine and Infectious Diseases Division, Fred Hutchinson Cancer Research Center, Seattle, Washington, USA; ²Allergy and Infectious Diseases Division, Department of Medicine, University of Washington, Seattle, WA, USA; ³Uganda Cancer Institute, Kampala, Uganda; ⁴Department of Computer and Systems Sciences, Stockholm University, Stockholm, Sweden; ⁵Hutchinson Center Research Institute – Uganda, Kampala, Uganda

Background: Febrile neutropenia (FN) is associated with high morbidity and mortality for those receiving cancer treatment. Rapid initiation of guideline-recommended antibiotics significantly decreases FN-associated mortality. At the Uganda Cancer Institute (UCI), we found that it took a median of 3 days for guideline-recommend antibiotics to be prescribed. Thus, our objective was to map the current antibiotic delivery process and identify barriers to rapid antibiotic initiation.

Methods: We recruited an interdisciplinary team of UCI healthcare workers to complete a series of focus discussion groups (FDGs). We used group consensus to develop a swim lane process map detailing the steps of antibiotic delivery



from the time of NF detection until a guideline-recommended antibiotic is administered. We will analyze this process map using failure modes effects analysis (FMEA). FMEA is a team-based approach, in which the group identifies potential failure modes (places where things can go wrong), determines high-risk modes of failure, and develops recommendations to mitigate these risks.

Results: From March – May 2023, we conducted a series of 12 FDGs. Thirteen UCI healthcare workers participated in the process maps: 5 medical officers, 4 nurses, 2 pharmacists, 1 laboratory personnel, and 1 information technologist. We identified 14 sub processes that were required for antibiotic initiation. Key vulnerabilities included delayed fever identification, the prescriber's need to know on-site antibiotic stocks when choosing the antibiotic, limited on-site pharmacy hours during evenings and weekends, the need for patient family members to travel to outside pharmacies to procure medications, and patient financial constraints.

Conclusions: There are numerous challenges with initiating antibiotics for patients with NF at UCI. In future studies, we will conduct additional in-depth analysis to identify barriers to antibiotic initiation. This information will be used to design and test strategies to improve rapid antibiotic delivery, which could be disseminated to other cancer centers in sub-Saharan Africa.

14:30-14:40

Breast cancer treatment in Uganda: a retrospective analysis of survival in patients treated for breast cancer at a tertiary oncology Centre

Author: *Leeta Joseph¹, Solomon Kibudde¹*

Affiliation: *¹Uganda Cancer Institute*

Purpose: Breast cancer is the third commonest cancer in Uganda accounting for nearly 8% of all new cases. Despite recent advances in treatment of breast cancer, there remains huge disparities in outcomes. We describe the treatment approach, and five-year overall survival in breast cancer patients treated at a single tertiary oncology centre in Uganda.

Methods: A retrospective chart review of 463 breast cancer patients files treated at the Uganda Cancer Institute (UCI) between January 2015 and December 2016 was conducted. Overall survival, and predictors of survival were analyzed using Kaplan-Meier methods with a focus on treatment approach.

Results: A total of 463 breast cancer patients were analysed, of whom 98.5% were women, median age of diagnosis at 46 years (IQR 38-56), 92.4% had histological diagnosis of invasive ductal carcinoma. The stages I, II, III and IV



were 8.6%, 15.1%, 43.8% and 25.1% respectively. HIV infection was confirmed in 9.1% participants. Nearly all patients received systemic chemotherapy (99.6%), 60.5% received primary breast surgery, 18% received radiotherapy, and 41.5% received endocrine therapy. The 1-, 3-, and 5-year overall survival rates were 90.6%, 78.7%, and 58.4%. On bivariate analysis, we found a protective effect with a combination of surgery and chemotherapy ($p < 0.001$), especially in patients receiving surgery followed by adjuvant chemotherapy ($p = 0.004$), but not neo-adjuvant chemotherapy followed by surgery ($p = 0.118$). There was a two-fold increase in mortality among patients receiving chemotherapy alone (crude HR 2.2 95% CI 1.39-3.49, $p = 0.002$).).

Conclusions: The five-year breast cancer overall survival rate is 58.5%, demonstrating an upward trend compared to previous studies. Patients receiving initial surgery followed by adjuvant chemotherapy had higher survival."

14:40-14:50

91: One-Year Survival and Prognosticators of Adults with Acute Leukemia at The Uganda Cancer Institute

Authors: *Natukunda Barbra¹*

Affiliation: *¹Uganda Cancer Institute*

Background: Acute leukemias are associated with substantial morbidity and mortality, particularly in the adult population. Despite an increasing burden of acute leukemia in developing countries, there is limited data on clinical outcomes and prognostic factors in this setting. In this study, we aimed to describe the clinical characteristics, survival, and prognostic factors of adults with acute leukemia at the Uganda Cancer Institute (UCI).

Methods: A retrospective cohort study was conducted between January 2009 and December 2018, reviewing data of patients aged 18 years or older with a cytopathological diagnosis of acute leukemia at UCI. Data was extracted on clinical characteristics, treatment response and survival. Cox-proportional hazards regression and survival analysis was performed to determine survival rates and associated factors. $P < 0.05$ was considered statistically significant.

Results: Participants were enrolled. Most (59.2%. $n=138$) participants were male, with a median age of 32 years (IQR :23-48 years), and 136 (58.4%) had acute myeloid leukemia. Overall, 1-year survival was 16.5%, with a median survival time of 47 days. Predictors of mortality were being female (adjusted hazard ratio (aHR): 2.8, 95% CI: 1.2 – 6.7, $p=0.022$), and overweight



Conclusions: Patients with acute leukemia in Uganda have poor overall survival. Prospective studies are recommended to better understand causes of early mortality.

14:50-13:00

158: Knowledge, attitudes, and practices of nurses on pain management among cancer patients at the Uganda Cancer Institute

Authors: Prossy Nakabugo¹, Elizabeth Situma²

Affiliation: ¹Uganda Cancer Institute, ²Clerk International University

Background: Pain control is a vitally important goal because untreated pain has detrimental impacts on the patients' quality of life. This study was conducted to assess the knowledge, attitudes, and practices of nurses on pain management among cancer patients.

Methods: A cross sectional study among nurses at Uganda Cancer Institute (UCI), Mulago Hospital. Respondents were selected using the convenience sampling technique. Data was analyzed using SPSS version 25 and results were presented in frequency tables, graphs, and pie charts.

Results: We enrolled 50 nurses working at the UCI to participate in the study and most of the respondents were knowledgeable about cancer pain management. For instance, all 50 (100%) of the respondents had ever heard about cancer pain management. 50% agreed that pain control improved patients' well-being. 30 (60%) of respondents reported uncontrolled pain would result in poor patient well-being and outcomes. Nurses had positive attitudes towards cancer pain management and 32 (64%) reported that a pain assessment tool was very important to determine pain intensity. Non-pharmacological pain interventions were reported by 66% of nurses as effective in pain control. On the contrary, 35 (70%) nurses thought that patients with a history of substance abuse should not be given opioids, but 40 (80%) agreed that the spiritual beliefs of a patient could determine their response to pain. Most, 30 (60%), respondents reported not having guidelines to follow in managing cancer pain, and assessment tools.

Conclusion: The study revealed that although most nurses at UCI were knowledgeable and with positive attitudes towards pain management, this was not translated into good practices. We recommend regular training and workshops on cancer pain management, including effective use of pain assessment tools at all times.



15:00-15:10

107: Clinical Presentation and Outcome of Children With Kaposi Sarcoma in The Art Era In Uganda.

Author: *Fadhil Geriga¹*

Affiliation: *¹Uganda Cancer Institute*

Background: The spectrum of presentation and outcome of children with Kaposi sarcoma is imagined to have changed in the ART era and hence we set to describe the presentation and outcome of children with KS in ART era.

Methods: Medical records of all children 1-18 years with KS treated at Uganda Cancer Institute from January 2010 to December 2019 were reviewed for age, sex, HIV status, KS disease sites at Presentation, CD4T-cell count, Hemoglobin, ART use, KS treatment and survival at 1 year.

Results: 118 children with KS were identified with an average age of 9.8 years (range 1-18), 66% were boys. 83% were HIV positive. The average symptom duration was 4 weeks (range 1-180) with mean duration of 6 months and 18.4months for HIV positive and negative respectively. Lymph node presentation was 57(67.1%) in HIV positive and 14(73%) of HIV negative cases. Tuberculosis was diagnosed in 39 cases. 72(84%) and 9(47.4%) of the children were anemic in HIV positive and negative respectively, the median CD₄ T-cell count was 322 cells/ml (range 2-1566).

69 (70%) of the HIV positive children had at least been on first line ART while 22% were on second line ART. The range of ART use was 4-676 weeks to diagnosis of KS disease.

Of the 98 patients with complete data, 83% completed first line Chemotherapy (BV) and only 11.9% were crossed to second line chemotherapy (paclitaxel). And 48(56%) of HIV positive cases survived compared to (12) 63% of HIV negative cases, as 21(24.7%) and 4(21.1%) were lost to follow-up comparing HIV positive and negative respectively.

Conclusions: The HIV negative children present similarly to HIV positive cases except for longer duration of symptoms and the survival of children with HIV negative cases is better than HIV positive cases and yet lost to follow up is similar in both groups.



Track 3: Family and community involvement and empowerment

14:00-14:10

144: Understanding VHT's experiences of providing palliative care and offering mentorship to other VHTs to provide Palliative Care in refugee and host communities of Obongi and Adjumani districts.

Authors: *Elizabeth Namukwaya¹, Elizabeth Nabirye³, Florence Nalutaaya³, Toko Friday Santiago³, Vicky Opia⁴, Godfrey Oziti⁶, Julia Downing^{3,5}, Mhoira Leng^{3,6,7}*

Affiliation: *¹Mulago hospital, ²Makerere University, ³Palliative care Education and Research Consortium, ⁴Peace Hospice Adjumani, ⁵International Children's Palliative Care Network, ⁶Cairdeas International Palliative Care Trust, ⁷Global Health Academy University of Edinburgh*

Background: Our previous experience of training Village health teams (VHTs) in Palliative care (PC) revealed that they are a crucial resource in bridging the gap for PC provision among refugee and host communities. Understanding the VHTs experiences of offering PC and mentoring others is vital in planning support and ensuring sustainability for this essential human resource.

Aim: To understand the experiences of VHTs in caring for patients and in offering mentorship to other VHTs to provide PC to patients in need in the refugee and host communities of Obongi and Adjumani districts.

Methods: Following ethical approval, 22 VHT mentors were trained in PC provision, training and mentorship of peers. In-depth interviews were conducted among VHT mentors at 3 months following training to explore their experiences. The VHT mentors were purposively sampled to include those in refugee and host communities in both districts. Thematic analysis was done, and saturation was achieved at sample size of 15.

Results: The following themes were identified: i) VHTs empowered to care for people with chronic illness, ii) holistic care provided, iii) attitude change, iv) benefits of program to VHTs (improved skills, respect , trust and love from community, v) motivators for offering services (faith in God, love for community, feeling valued) vi)challenges faced when offering services (travel, lack of job aid) vii) VHT needs (more training and supervision and job aids) viii) mentorship impact (cascading knowledge and provision of PC) ix) improved networking with health centers.



Conclusion: VHTs are an invaluable resource in improving access to PC services for those in refugee settings where PC services are scarce. Having peer VHT mentors is important for sustaining the services in these areas and there are mutual benefits for the community and VHTs. VHTs need support in key areas and collaborative working. Community engagement is an essential pillar for PC.

14:10-14:20

140: Telling our story; experience of living with a chronic illness; community generated data using Photovoice in Adjumani and Obongi districts

Authors: Mhoira Leng^{1,2,3,4}, Toko Friday Santiago², Simon Maku³, Vicky Opia⁵, Godfrey Oziti³, Elizabeth Nabirye¹, Hannah Ikong², Elizabeth Namukwaya^{1,2}

Affiliation: ¹Makerere University, ²Palliative Care Education and Research Consortium, ³Cairdeas International Palliative Care Trust, ⁴Global Health Academy, ⁵Peace Hospice Adjumani

Background: Previous situational analysis, needs assessments and training interventions have revealed much about the palliative care (PC) provision in Adjumani and Obongi districts. Community generated data is essential in ensuring interventions match the priorities of those directly affected yet is often missing.

Aims: A novel approach to explore in depth the experience of living with a serious chronic illness for the host and refugee populations

Methods (design, data collection, analysis): Following methodological training and ethics approval we developed and implemented a pilot in 4 villages working with local implementers and 8 Village Health Team (VHT) mentors who had been previously trained in PC and mentorship. They had 3 days of training in taking narrative photographs using a smartphone. Participating patients were consented then photographs taken by the VHT. Researchers visited fortnightly holding a qualitative critical dialogue using the SHOWED criteria focusing on 2 selected pictures by the VH. All patients were visited at home. 32 critical dialogue interviews were recorded and analysed by 2 experienced researchers; then discussed with the VHT mentors and health leaders.

Results: Thematic analysis revealed 4 key themes and associated subthemes 1.living positively; community contribution, self-management, living not dying, hope, health literacy 2.challenges faced; access to healthcare, unrelieved symptoms, caregiver burden, health literacy, social issues such as poverty, food insecurity, isolation, stigma 3.VHT role; identification, advocate, holistic care, supporting health access, opinion leaders 4.messages for health leaders;



collaborative working, health literacy, strengthened health systems, social welfare, research. All themes will be presented with quotes.

Conclusion: Engaging community members and those directly affected by serious chronic illness through Photovoice methodology is feasible and important. In addition, VHTs and patients appreciated being seen, including down to their homes, and having their stories told. One VHT said “do you mean this time we get to choose what story to tell and now they can believe us?”

14:20-14:30

160: Personal experience on conducting family meetings in palliative care provision in a hospital setting in Uganda

Authors: *Bernadette Basemera¹, ²Florence Nalutaaya, ²Elizabeth Nabirye, ²Elizabeth Namukwaya, ³Mhoira Leng, ³Cathy Magoola*

Affiliation: *¹Palliative Care Association of Uganda, ²Palliative Care Education and Research Consortium, ³Kiruddu Hospital*

Goal: Palliative care Family meeting allows the patient, family, and healthcare team share information and concerns regarding all areas of the patient’s care, including physical, psychosocial, and spiritual care, and the role family members will play in the care. Family meetings in palliative care aim at providing information, ask questions and clarify goals of care and other decisions to be made. They help palliative care teams to plan together with patients and family about future care and End of Life.

Approach taken: Palliative care teams usually plan for a family meeting with the patient and family. The planning includes who should attend, place, date and time. Preparations include the PC team having information regarding the patient’s illness and care given by the ward doctors. Family meetings take place on wards in a private room if available. Topics discussed include the patient’s diagnosis, prognosis, possible outcome and management plan. Questions asked include goals of care and expectations from the PC team while the family have questions about care options and prognosis.

Results: Family meetings with caregivers present results in many beneficial shared care goals. It supports family members and patients in deciding on goals and how to support one another. The meetings resolve hopelessness, promote confidence, and create a bond between family members and the patient. The family and health professionals are able to overcome challenges as they work together to plan the way forward. The main challenges encountered include language barrier and patients at the end of their lives who are unable to speak.



Lessons learnt: Planning ahead of time is critical because it allows both parties to prepare. If a side room or area outside the ward is not available, the PC may improvise and hold family meetings on the ward. If meetings have been emotionally draining, PC providers may require debriefing.

14:30-14:40

173: Cervical cancer screening among HIV-positive women in urban Uganda: A cross-sectional study

Authors: *Najjuka Sarah Maria¹, Connie Olwit¹, Mark Mohan Kaggwa², Rose Chalo Nabirye³, Tom Denis Ngabirano³*

Affiliation: *¹College of Health Sciences Makerere University Kampala, Uganda, ²Department of Nursing, School of Health Sciences, College of Health Sciences Makerere University,*

³Department of Psychiatry, Faculty of Medicine Mbarara University of Science and Technology, Mbarara, Uganda

Background: Women living with Human Immunodeficiency Virus (HIV) are at a high risk for early development of cervical cancer. Adherence to cervical cancer prevention strategies in this population is vital for the early detection and treatment of cervical cancer. This study aimed to determine the prevalence and factors associated with cervical cancer screening among HIV-positive women attending an urban HIV care center in Uganda.

Methods: This cross-sectional study included 205 HIV-positive women receiving care at an urban HIV care center. An interviewer-administered questionnaire was used to capture sociodemographic information, history of screening for cervical cancer, and reproductive health characteristics. Logistic regression analysis was used to determine the factors associated with cervical cancer screening.

Results: Of the 205 HIV-positive women with a mean age of 37 that participated in the study, the majority (98%) were aware of cervical cancer screening. Ninety participants (44%) had ever been screened for cervical cancer and only 33 (16.1%) had been screened in the past year. Obtaining information about cancer of the cervix and cervical cancer screening from health care professionals was significantly associated with higher levels of cervical cancer screening (adjusted odds ratio = 5.61, 95% confidence interval: 2.50–12.61, $p < 0.001$).



Conclusion: This study highlights the low prevalence of cervical cancer screening among HIV-positive women and underscores the role of health professionals as an effective source of information on cervical cancer and cervical cancer screening. Patient education programs in HIV prevention and care facilities should emphasize cervical cancer screening messages to enhance the uptake of screening services.

14:40-14:50

63: Experiences and challenges of home-based care at Mbale Regional Referral Hospital

Authors: Taaka Esther¹, Dr. Alision Wolfe¹

Affiliation: ¹Mbale Hospital

Objectives: Mbale Regional Referral hospital is one of the 16 regional referral hospitals in Uganda and its the only government hospital where home based palliative care is done in the country amidst challenges. The program is available to patients who attend the hospital plus those in the community by use of Village health teams who are able to identify patients with chronic conditions after which follow up is made by home visit or telephone contact.

Methodology: We reviewed medical records of all patients on our home care program between January 2016 to December 2018. Data was collected on demographic characteristics, patient's diagnosis, common distressing symptoms presented during home visit/ telephone contacts, interventions offered, problems and challenges encountered in providing care to different patients.

Results: A total of 312 patients (females 204, males 108) were enrolled in the program. This accounted for 19.21% of all patients cared for during the years under review. The commonest diagnosis was cancer of the cervix (47%) followed by prostate cancer (19%) and end stage HIV/ AIDS (16%). Pain was the most distressing frequent symptom with 39%, followed by anorexia 24% and body weakness 13%, 6.4% died and 2.8% discharged. The main areas of patient's concern were pain and symptom control, counselling, financial issues and lack of committed caretakers. Transport was also a major issue as some of them could not be taken back to the hospital in case of worsening symptoms which could need hospital attention. Average duration of stay on the program was 2 years as the service improved their quality of life.

Conclusion: 90% of palliative care patients require home based care for symptom management and improved quality of life.



14:50-15:00

172: Empowering child caregivers for economic sustainability through vocational education at the Palliative Care Association of Uganda.

Authors: Zipporah Kyomuhangi¹, Mark Donald Mwesiga¹

Affiliation: ¹Palliative Care Association of Uganda

Background: Over 2 million orphans and other vulnerable children (OVC) in Uganda live below the poverty line. The Palliative Care Association of Uganda (PCAU) in partnership with the Center for Hospice Care/Hospice Foundation (CHC/HF), started the Road to Hope (RTH) Program in 2012 to help vulnerable child caregivers acquire an education and to support their need to thrive financially.

Aims: The programme aims at increasing the economic sustainability of primary child caregivers to improve their quality of life and their families with sick persons receiving palliative care and those that died receiving the same.

Approach Taken: The children are identified in collaboration with palliative care practitioners in the rural districts of Uganda. PCAU then carries out meetings with Parents/guardians to identify what they are passionate about and enroll them in the program. The children are then enrolled in vocational studies and upon completion, they are mentored to gain practical skills for the job market. They are availed all the tools required to aid their career.

Results: There are currently 16 child caregivers on the program 2020-2022. 8 are undertaking vocational studies in hairdressing, fashion and design, building and construction, and automotive mechanics. 5 are undergoing postgraduate mentorship. Of these, 1 beneficiary is able to support her family's essential needs through her earning in mentorship training. 3 children graduated and are in internships.

Conclusion and lessons learned: The results confirm that empowering child care givers has a positive, direct influence in increasing their chance of economic sustainability, and strengthened family bonding.

There is a need to scale up this approach and support more vulnerable children and hope to attract more funding for the Road to Hope program at PCAU.



15:00-15:10

124: Community Palliative Health Advocates an Answer to The Growing Ageing Population of Uganda

Authors: Richard Semanda¹

Affiliation: ¹Geriatric Respite Care Foundation Uganda (GRCF-U)

Introduction: Uganda is at the stage of experiencing the growing population of older persons, nearly 3% of the general population which is 1.66 million older Ugandans. More than 1 in 6 households include an older person and as longevity increases, abuse increases, a serious problem that affects health and can cause death. Older Ugandans have chronic diseases, with poor access to healthcare, faced with financial among other constraints. 75% of their deaths are from NCDs but drugs for old-age related diseases are expensive and are not readily available. Above all is the negative attitude of some health workers who leads many to resist care.

Aims: For preventive and curative care, Geriatric Respite Care Foundation Uganda (GRCF-U) secured a grant from True Colours Trust in collaboration with The African Palliative Care Association with the aim of introducing Community Palliative Care accessibility to older Ugandans reducing unnecessarily suffering, due to lack of geriatricians, poor transportation, which discourages them acquiring health needs. Extending community palliative care was also in the struggle to meet the SDG3 and the Decade of Health Ageing.

Methods: GRCF-U in partnership with Palliative Care Association of Uganda trained 109 Community Palliative Care Health Advocates in Makindye with principles of palliative care skills which raised the standard services of GRCF-U offers end of Life in Uganda's communities.

Results: There is currently improving symptom management, dignity and social change of families and friends with people approaching the end of life in Makindye

Conclusion: Considering the absence of Palliative Care for older persons, GRCF-U is ready to scale up better palliative care programs to older persons in Uganda's communities as it is urgently needed



Track 4: Education, Advocacy, Policy, and the Law

14:00-14:10

133: Enhancing Primary Care Providers' Role in Breast Cancer Care in Uganda: The Impact of Training Program

Authors: Collins Mpamani¹, Solomon Kibudde¹, Joseph Leeta¹, Noleb Mugisha¹, Alfred Jatho¹, Judith Asasira¹, Nixon Niyonzima¹, Jackson Orem¹.

Affiliated: ¹Uganda Cancer Institute

Introduction: Primary care providers (PCPs) play a crucial role as a bridge between the community and the healthcare system

Objective: To evaluate the impact of training programs on knowledge and confidence levels of primary care providers in breast cancer prevention, screening, diagnosis, and treatment.

Methods: A total of 100 primary care providers from 20 hospitals in Uganda participated in the training program. Pre-test and post-test assessments were conducted to measure the participants' knowledge and confidence levels.

Results: Training resulted in a significant improvement in knowledge and confidence levels among primary care providers. In terms of knowledge, there was a significant increase in understanding the rising number of breast cancer cases in Uganda ($p \leq 0.001$). The majority of participants correctly identified the association between female gender, older age, and genetic mutations with breast cancer development. However, there was no significant change in knowledge regarding the most frequently seen histological type of breast cancer ($p = 0.052$). The participants demonstrated improved knowledge regarding common signs and symptoms of breast cancer ($p = 0.0007$) and appropriate diagnostic work-up steps for invasive breast cancer ($p = 0.0124$). There was also a significant increase in knowledge about the recommended treatment options for early-stage breast cancer ($p = 0.0253$). In terms of confidence levels, the participants reported a significant increase in their confidence in talking to women about breast cancer ($p \leq 0.001$), discussing breast cancer screening and awareness ($p \leq 0.001$), explaining diagnostic tests ($p \leq 0.001$), discussing treatment options ($p \leq 0.001$), and providing follow-up care after cancer treatment ($p \leq 0.001$).

Conclusions: The findings of this study highlight the positive impact of training programs on the knowledge and confidence levels of primary care providers in Uganda regarding breast cancer prevention, screening, diagnosis, and treatment. Continued investment in training programs and knowledge dissemination is crucial to further improve breast cancer outcomes in Uganda.



14:10-14:20

150: Estimating regional and national cancer incidence in Uganda: A retrospective population-based study, 2013-2017

Authors: Annet Nakaganda¹, Collins Mpamani¹, Cissy Nassolo², Sarah Namboozee², Jackson Orem¹, Henry Wabinga²

Affiliation: ¹Uganda Cancer Institute, ²Kampala Cancer Registry.

Background: Cancer control requires accurate estimates of the cancer burden for planning and monitoring cancer control strategies. However, cancer estimates for Uganda are mainly based on one population-based cancer registry (PBCR), located in Kampala capital city. This study aimed at estimating regional and national cancer incidence in Uganda.

Methods: A retrospective study, using a catchment population approach, was conducted from June 2019 to February 2020. The study registered all newly diagnosed cancer cases, in the period of 2013 to 2017, among three geographical regions: Central, Western, and Eastern regions. Utilizing regions as strata, stratified random sampling was used to select the study populations. Cases were coded according to the International Classification of Diseases for Oncology (ICD-0-03). Data was analysed using CanReg5 and Microsoft Excel.

Results: 11598 cases (5157 males and 6441 females) were recorded. The overall age-standardized incidence rates (ASIR) were 82.9 and 87.4 per 100,000 people in males and females respectively. The regional ASIRs were: 125.4 per 100,000 in males and 134.6 per 100,000 in females in the central region; 58.2 per 100,000 in males and 56.5 per 100,000 in females in the Western region; and 46.5 per 100,000 in males and 53.7 per 100,000 in females in the Eastern region. Overall, the most common cancers in males over the study period were cancers of the prostate, esophagus, Kaposi sarcoma, stomach, and liver. In females, the most frequent cancers were: the cervix, breast, esophagus, Kaposi sarcoma, and stomach.

Conclusion: The identified overall cancer incidence rates from this study are different from the documented national estimates for Uganda. Studies like this one have great relevance for public health; by strengthening the cancer surveillance system to estimate the regional and national cancer incidence and allow for the implementation of evidence-based cancer control strategies at all levels.



14:20-14:30

178: Capacity Building for health care workers in Pain Assessment and Management in Uganda

Authors: Joyce Zalwango¹, Lisa Christine Irumba¹, Mark Donald Mwesiga¹, Rinty Kintu²

Affiliation: ¹Palliative Care Association of Uganda, ²American Cancer Society

Background: Pain is the main concern for patients seeking health care. Ineffective assessment and inappropriate pain management put patients at risk of long hospitalization and uncalled-for out-of-pocket expenditure as they move from place to place. The incapacity of healthcare professionals to identify and assess pain is a significant impediment to the provision of quality pain treatment in many health institutions.

Aim: To support the integration of effective pain treatment into hospital services through training.

Method: PCAU introduced Pain-Free Hospital Initiative in hospitals to support the integration of effective pain treatment into the ongoing service delivery. Hospitals were mapped out, conducted baseline hospital assessments on pain management, results were shared with the hospital management, and together tailored the Initiative activities to the unique needs of each hospital. A team of champions from different departments were trained in the first cohorts who then led the subsequent cohort training of other hospital staff. These involved Knowledge and Attitudes Surveys Regarding Pain" using questionnaires administered to participants pre-and post-training.

Results: A total of 14 hospitals participated in the implementation of PFHI with 1847 health workers trained in pain assessment and management over a 5 year period. The average mean post-test score for all the hospitals was significantly higher than the pre-test score at 89% versus 49% and Pain was adopted as a 5 vital sign in the patient's observation tools. Moderate pain was recorded as the average pain grade self-reported score by patients, and a reduction in the use of Pethidine for pain control was recorded in the monthly opioid consumption data attributed to the proper use of the analgesic ladder across all hospitals.

Conclusion: To close the knowledge gap on pain assessment and management, healthcare professionals need frequent training and retraining in order to enhance pain management using non-opioids and opioids for optimal patient pain control.



14:30-14:40

168: Improving access to cancer diagnosis and treatment among children in Southwestern Uganda: The experience of Kitagata Hospital

Authors: Catherine Nakasita¹, Ethan Harned², Christine Akatukunda³, Angella Namatovu³, Mark Donald Mwesiga⁴

Affiliation: ¹Kitagata Hospital, ²Global Partners in Care/University of Notre Dame, ³Mbarara University of Science and Technology, ⁴Palliative Care Association of Uganda

Background: Nearly 3,000 children are diagnosed every year with cancer in Uganda. The global paediatric cancer survival rate is 80%, while Uganda sits closer to 50%. There are many barriers that prevent children from completing their cancer treatment with one of the largest being the cost of transport to and from cancer centres. Kitagata Hospital with support from PCAU started a project to follow up with and support children facing cancer with transport, meals, etc. during the Covid-19 lockdown to access cancer treatment called the Special Hearts to Nurture Every Child SHINE programme.

Aim: To provide transport, meals and psychosocial support for children and their families so that cancer treatment is completed.

Methods: Kitagata Hospital identified twenty-seven children across five districts in western Uganda who could benefit from these services. Funding was provided to these families for their transport to Mbarara Regional Referral Hospital and for their upkeep during their time at the hospital. Bimonthly home visits were conducted by the palliative care team at Kitagata Hospital to evaluate the needs of each patient and their family, provide psychosocial support and monitor adherence to treatment.

Results: Out of the twenty-seven children supported by the SHINE programme, four have completed treatment. Two children died, and bereavement services were provided to their families. The rest have remained on treatment.

Lessons learned: The SHINE programme was successful in allowing paediatric cancer patients to continue treatment despite financial barriers. Support services offered to families reduced the burden of caregivers throughout their child's treatment. Further challenges were identified through discussions with caregivers such as the inability to continue a child's education, provide nutritious meals after a child has returned home, and reduce the stigma surrounding a cancer diagnosis within their communities. Future partnerships will need to be formed to sustain and grow this programme and address these needs.



14:40-14:50

169: Strengthening the Availability of National Palliative Care Data through the Rollout of National Palliative Care Health Management Information System Tools.

Authors: *Sheena Asiimwe¹, Cynthia Kabagambe¹, Lisa Irumba¹, Joyce Zalwango¹, Mark Mwesiga¹*

Affiliation: *¹Palliative Care Association of Uganda*

Background: The Ministry of Health Uganda with the support of the Palliative Care Association of Uganda developed data collection tools for palliative care that are integrated within the Health Management Information System (HMIS). I.e. HMIS OPD 008 Unit Palliative Care Register and the HMIS 105c Health Unit Palliative Care Monthly Report.

These tools were developed on realizing that the indicators previously included in the HMIS were insufficient to inform Palliative Care policy formulation, decision-making, and research.

Aim: Identify the lessons learned and draw recommendations during the process of rolling out palliative care HMIS tools country wide.

Approach Taken: Centralized and regional trainings were conducted by the Ministry of Health and Palliative Care Association of Uganda. Champions from the trainings were identified from the different regions that conducted facility-level trainings. Support supervision visits were then conducted for quality improvement.

Results:

- i). 30% of the accredited facilities have been trained
- ii). 68 facilities are reporting into the DHIS2.
- iii). 2 centralized CMES have been conducted for champions to cascade the tools to lower facilities.
- iv). Support supervision visits have been conducted to 11 facilities.

Conclusion: There is a need to train more palliative care providers, distribution of tools, and frequent support supervision with support from MOH and partners.



Recommendations: There is a need for;

- i). A soft copy register for facilities with large volumes of patients e.g. hospices and private facilities.
- ii). Support supervision to other facilities to ensure that reporting is done.
- iii). Routine CMEs on PC data collection through the identified regional champions.
- iv). More trained PC-trained health workers in every accredited facility.

14:50-15:0

Advocacy for a Palliative care unit at Uganda Cancer Institute

Author: Ivan Muwanguzi¹, Mary Lubega¹

Affiliation: ¹Uganda Cancer Institute

"Palliative Care is the active holistic care of individuals across all ages with serious health-related suffering due to severe illness and especially of those near end of life.

It includes prevention, early identification, comprehensive assessment and management of pain and other distressing symptoms, psychosocial, spiritual and social needs.

Provision of quality palliative Care requires commitment and cooperation of a multiplicity of health Care providers, community organizations, professionals and volunteers. It is a patient centered approach that aims at the well being of the patient.

There is growing evidence supporting palliative Care in oncology practice.

RATIONALE: Integration of palliative Care is associate with:

Improved quality of care, quality of end of life Care, decreased rates of depression, illness understanding, patient satisfaction and improved patient outcome in particular symptom management, quality of life and patient and family satisfaction.

Why palliative Care at Uganda Cancer institute: Uganda cancer institute treats cancer which is chronic therefore, all patients with cancer require palliative Care right from entry at Uganda Cancer institute and this helps them to be pain-free and have hope.



In conclusion, due to the growing evidence supporting need for palliative Care in oncology practice, there is need for a palliative Care unit at Uganda Cancer Institute”

15:00-15:10

126: Implementation of The Siop Paediatric Oncology Nursing Foundation Course in Cameroon.

Authors: Jator Brian Kobuin¹

Affiliation: ¹Cameroon Baptist Convention, Health Services

Background/Aim: Cancer is the leading cause of mortality in children and adolescents 0-19 years with approximately 400.000 cases yearly. Competent paediatric oncology nurses have been identified as an essential component in the improvement of cancer cure rates. Paediatric Oncology nurses have limited access to specialized education and training. The aim was to provide foundation training to nurses new to paediatric oncology that meet international baseline standards for paediatric oncology nursing.

Methods: The International Society of Paediatric Oncology in Africa launched a pediatric oncology foundation course package in 2022. Two Cameroonian nurses attended a training of trainers’ course in December 2022 for delivering the package. A two-week didactic training was conducted at Mbingo Baptist Hospital from 27 February to 10 March 2023. The twelve modules of the foundation course were delivered by a team of 8 facilitators, including one medical oncologist, one pharmacist, and 6 senior nurses. Knowledge acquisition was assessed using a pre and post-test evaluation. Participant evaluation was obtained at the end of training.

Results: Seventeen nurses from five hospitals were trained over 10 days. The Mean knowledge score significantly increased from 35.41% (SD 10.4) in the pre-test to 60.82% (SD 17.1) in the post-test ($p = 0.001$). Overall, 76% rated the training as good or excellent. Most (88.2%) of participants rated both the facilitators and the quality of handouts as good or excellent. However, only 41% of participants rated the duration of the training as good or excellent.

Conclusion: Induction training was successfully conducted for nurses new to paediatric oncology using trained nurse trainers and a standard foundation package for sub-Saharan Africa. Next steps are for trainees to undergo three months of observed clinical practice and competency assessment. This method is expected to provide the skills needed by nurses to provide quality essential nursing care to children with cancer in Cameroon.



FRIDAY: 15TH SEPTEMBER

Track 1: Innovations and New Technologies

14:00-14:10

142: Scaling Up Excellence: Optimizing Electronic Medical Records for Quality and Equity in Palliative Care

Authors: Mumanye Timothy¹

Affiliation: ¹Hospice Africa Uganda

Aim: To highlight the importance of Electronic Medical Records (EMR) in effective administration of palliative care and give recommendations for better implementation and utilization.

Design, Methods And Approach: This abstract is based on my personal observations and interactions with the Electronic Medical Records system at Mobile Hospice Mbarara (MHM), clinical staff, patients and their caretakers over my five-month tenure as a volunteer data clerk.

Results: The utilization of a medical records system enables expedited retrieval of patient records in contrast to the conventional file system. Furthermore, it simplifies the retrieval process for patients who are unable to present their patient cards or have misplaced them. Additionally, the system facilitates timely generation of reports pertaining to various aspects, such as the total count of enrolled patients, the frequency of patient interactions within a specified time frame, the medications dispensed, and the monitoring of remaining drug inventory, thereby ensuring transparency and accountability across all levels. Although the EMR system offers numerous advantages, its potential benefits can be further optimized, for example, by leveraging the accessibility of information through the internet, and enabling clinical staff to utilize portable devices such as tablets while working in the field. The utilization of the EMR system enhances efficiency and streamlines healthcare delivery. By embracing this aspect, healthcare providers can harness the full potential of the EMR system, leading to improved patient care and enhanced workflow. The compilation of information using the EMR system can also facilitate research endeavors as interested researchers can utilize data in the system.

Conclusion: Every palliative care team should innovatively use the EMR system to scale up availability, accessibility, and quality of palliative care services.



14:10 - 14:20

150: Estimating regional and national cancer incidence in Uganda: A retrospective population-based study, 2013-2017

Authors: *Annet Nakaganda¹, Collins Mpamani¹, Cissy Nassolo², Sarah Namboozee², Jackson Orem¹, Henry Wabinga²*

Affiliation: *¹Cancer Institute, ² Kampala Cancer Registry*

Background: Cancer control requires accurate estimates of the cancer burden for planning and monitoring cancer control strategies. However, cancer estimates for Uganda are mainly based on one population-based cancer registry (PBCR), located in Kampala capital city. This study aimed at estimating regional and national cancer incidence in Uganda.

Methods: A retrospective study, using a catchment population approach, was conducted from June 2019 to February 2020. The study registered all newly diagnosed cancer cases, in the period of 2013 to 2017, among three geographical regions: Central, Western, and Eastern regions. Utilizing regions as strata, stratified random sampling was used to select the study populations. Cases were coded according to the International Classification of Diseases for Oncology (ICD-0-03). Data was analysed using CanReg5 and Microsoft Excel.

Results: 11598 cases (5157 males and 6441 females) were recorded. The overall age-standardized incidence rates (ASIR) were 82.9 and 87.4 per 100,000 people in males and females respectively. The regional ASIRs were: 125.4 per 100,000 in males and 134.6 per 100,000 in females in the central region; 58.2 per 100,000 in males and 56.5 per 100,000 in females in the Western region; and 46.5 per 100,000 in males and 53.7 per 100,000 in females in the Eastern region. Overall, the most common cancers in males over the study period were cancers of the prostate, esophagus, Kaposi sarcoma, stomach, and liver. In females, the most frequent cancers were: the cervix, breast, esophagus, Kaposi sarcoma, and stomach.

Conclusion: The identified overall cancer incidence rates from this study are different from the documented national estimates for Uganda. Studies like this one have great relevance for public health; by strengthening the cancer surveillance system to estimate the regional and national cancer incidence and allow for the implementation of evidence-based cancer control strategies at all levels.



14:20-14:30

170: The Development of a Palliative Care Services Directory for Uganda by the Palliative Care Association of Uganda

Authors: *Sheena Asiimwe¹, Cynthia Kabagambe¹, Lisa Irumba¹, Mark Mwesiga¹, Lacey Ahern², Matt Sisk², Maura Haugaboom³*

Affiliation: *¹Palliative Care Association of Uganda, ²Global Partners in Care, ³University of Notre Dame*

Background: PCAU is an association for all palliative care providers and well-wishers in Uganda and beyond. The need for a directory was realized as many health workers, patients, and caregivers made calls to the secretariat inquiring about the nearest palliative care service point.

Aim: Create a detailed list of palliative care (PC) accredited facilities with contacts to enable health workers, patients, and caregivers to locate PC services in the different districts in Uganda.

Approach Taken: PCAU developed an online form requiring contact information about the hospital director/in-charge, focal persons, and location of the facility. The form was then sent to accredited facilities by email to obtain information. For quality, phone calls, emails, and SMS were made to follow up on unclear information.

The data collected was then sorted in Microsoft Excel alphabetically by district.

Results: Information from 123 facilities out of 232 accredited facilities was obtained. A Google map of accredited facilities with contacts of the palliative care focal person and hospital directors was created to ease access to palliative care service points. It was noted that 60 health workers had been transferred to non-accredited facilities.

Conclusion: The obtained information shall be printed out and distributed to health facilities so that patients in need of palliative care services can be referred.

Recommendations: There is a need to regularly update the directory since health workers are transferred every 3 years for government facilities.

There is a great need for trained palliative care workers in every accredited facility across the country.



14:30-14:40

62: Mapping of digital resources on cervical cancer in Africa

Authors: Richard T. Odera¹, Charles Muya¹, Annet Nakaganda¹, Edna Soomre³, Johnblack K. Kabukye^{2,3}, Elo Mapelu¹, Nancy K. Okenagwa¹, Caroline Ntinyari¹

Affiliation: ¹Kenyan Network of Cancer Organizations, ²Uganda Cancer Institute, ³The Swedish Program for ICT in Developing Regions

Background: Kenyan Network of Cancer Organizations with support from The Swedish Program for ICT in Developing Regions and in collaboration with Uganda Cancer Institute is mapping digital resources on cervical cancer. This exercise will provide information on existing initiatives and opportunities for collaboration, promote integration and interoperability of digital health initiatives, and enable governments and funders to invest in areas where there are gaps.

Objective: This project aims to address the fragmented and uncoordinated digital health landscape around the entire continuum of cervical cancer care in 16 countries in sub-Saharan Africa. Lack of coordination results in sub-optimal use of resources, duplication of efforts, and inadequate impact of digital health initiatives. The project proposes to map digital health initiatives and resources on cervical cancer in the region and develop an online catalogue that will be routinely updated. The Global Cancer Observatory 2020 data on cancer incidence and mortality by cancer site ranks cervical cancer in Sub-Saharan Africa as second highest by incidence and first by mortality at about 14% of all cancer cases and related deaths. The World Health Organisation approved a strategy to eliminate cervical cancer worldwide and The World Health Assembly also passed resolution WHA71.7 on Digital Health to help strengthen member states digital health capabilities.

Methods: An in-depth literature review will complement data collected through interviews. An analysis of the same will result in an online catalogue capturing digital tools' features such as continuum of care addressed, scalability, interoperability, and openness.

Results: Data collection currently ongoing.

Conclusions: As part of the Digital African Network for Cervical Cancer Elimination (DANCCE) initiative, this project aims to maximize use of digital technologies to accelerate achievement of cervical cancer elimination.



14:40-14:50

147: Mobile technologies for palliative cancer care in Uganda: Qualitative secondary analysis of health professional perspectives

Authors: *Elizabeth Nabirye¹, Mhoira Leng¹, Elizabeth Namukwaya¹, Florence Nalutaaya*

Affiliation: *¹Palliative Care Education Research Consortium*

Background: In sub-Saharan Africa (SSA) 80% of cancers are advanced at the time of diagnosis, cancer care is characterized by limited funding and access to curative therapies. Palliative care (PC) need in SSA is huge however, most patients in need have limited access. mHealth (i.e. medical and public health practice supported by mobile devices) approach increases access and communication with PC services. However, there is limited understanding of health professionals' views and perceptions on its use in delivery of cancer care.

Aim: Understanding health professionals' views and perceptions of the use of mHealth as part of PC delivery.

Methods: Ethics approvals were obtained for the parent study and written consents sought before face-to-face qualitative interviews and framework analysis.

Results: 20 health professionals were interviewed, major themes from the analysis were current use of mHealth in palliative cancer care, advantages of using mHealth in palliative cancer care, challenges to providing palliative cancer care using mHealth and preferences for mHealth use in palliative cancer care.

Conclusion: In SSA there is limited access to PC care services and digital technologies, like use of mobile phones, computers are increasingly being used to support communication between health professionals and patients with cancer. Development of mHealth initiatives needs to consider how best to maintain patients' confidentiality and ensure inequities in access to care are not compromised despite its advantages. There is a need to adapt training to improve competencies of PC professionals in delivery of care that leverages digital technologies.



14: 50- 15:00

165: Impact of Patient Mapping Information System Integration in Palliative and Hospice Care

Authors: *Kyomuhendo Milliam¹, Patricia Ndemaru^{2,3}*

Affiliation: *¹Information technology professional, ²New Life Hospice Arua, ³Muni University*

Palliative and hospice care are specialized approaches to healthcare that aim to improve the quality of life for individuals facing serious illness, especially those with advanced or terminal conditions. In Uganda, the Palliative Care Association of Uganda (PCAU) states that approximately 11% of the estimated 500,000 Ugandans require palliative care annually. However, locating these patients by the palliative care volunteers, community members who wish to provide services such as voluntary support or donations can be challenging. This study will investigate the Applicability of the Patient Mapping Information System, Impact of integration in Palliative and Hospice Care and possible hindrances to its optimization.

The researcher intends to employ both qualitative and quantitative methods such as literature review, interviews, and questionnaires, snow balling to obtain data for this research.

This will help to Identify relations of the care givers, understand which category of relatives contribute most in caregiving, areas of unmatching between the patient and the caregivers as its often a concern for the patients when the caregivers make choices on their behalf which affects their psychosocial wellbeing beside the burden of the sickness, finances among others.

Patient mapping plays a crucial role in Individualized Care Planning, resource allocation, proactive Symptom Management, emotional and Psychosocial Support, research, Quality Improvement, and a patient-centered approach to care. It ensures that the specific needs and preferences of individuals in palliative and hospice care are addressed. To achieve patient mapping, this investigation will guide the setup of an Information system to collect patient information, including their location coordinates and the type of care they require increasing awareness and guidance provision for effective care delivery, vulnerable areas and populations can be identified and monitored to initiate timely palliative care. This facilitates efficient resource allocation and decision-making.



15:00-15:10

66: Apheresis at the Uganda Cancer Institute: a unique nursing experience

Authors: *Ritah Bafumba¹, Nakabugo Prossy¹, Atuhaire Barbra¹, Henry Ddungu¹*

Affiliation: *¹Uganda Cancer Institute*

Background: Apheresis refers to any procedure that involves removing whole blood from a donor or patient separating the blood into individual components so that one particular component can be removed. Apheresis may be used to collect a particular blood component such as platelets or plasma (donor apheresis), or it may be used to remove a disease-provoking component of blood (therapeutic apheresis). We share the nurses experience with implementing cellular apheresis procedures at the Uganda Cancer Institute.

Methods: We are using the Trima Accel Version 7 automated blood collection system to collect blood components and the Spectra Optia Apheresis System, to perform various therapeutic apheresis, cell collection, and cell processing procedures.

Results: We have carried out a number of procedures including 4 platelet apheresis in which each donor was able to donate at least two doses of leuko reduced platelet units; one white blood cell depletion (WBCD) in leukemia patients with hyperleukocytosis and leukocytosis; and 2 red blood cell exchanges (RBCX) in patients with sickle cell anemia. WBCD was to a patient with chronic myeloid leukemia with a white cell count of above 500 X 10⁹/L, loss of hearing, and blurred vision who reported tremendous response in just 3 days of depletion. The RBCX procedure was performed on two sickle cell disease patients who presented with history of recurrent transfusions and a stroke, but since the exchange hospital visits for these two have reduced and no transfusion has been administered in the last 6 months.

Conclusion: We believe apheresis can lead to great patient outcomes and can be implemented seamlessly by trained nurses. Our growing experience with cellular apheresis in Uganda can be implemented in other centers with apheresis given more training.



15:10-15:20

99: Fighting Cervical cancer in Africa, A Cross-Sectional Study on Prevalence and Risk Factors for Precancerous Lesions in Rural Uganda

Author: Anna Juul Christensen¹, John Mwayi³, Joanita Mbabazi³, Margrethe Juncker³, Per Kallestrup^{1,2}, Christian Kraef^{4,5}

Affiliation: ¹Department of Public Health, Aarhus University, Denmark, ²Danish Non-Communicable-Disease Alliance, ³Rays of Hope Hospice Jinja, Uganda, ⁴Department of Infectious Diseases, Rigshospitalet Copenhagen, Denmark, ⁵Heidelberg Institute of Global Health, University of Heidelberg, Germany

Background: In Uganda, 80% of all women with cervical cancer present to the health care system in advanced stages of disease. To make best use of limited resources, targeted strategies are needed to identify women at highest risk of cervical cancer.

Aim: To identify risk factors for precancerous cervical lesions and factors associated with treatment delay among women in the rural Busoga Region, Uganda.

Methods: A retrospective cross-sectional study from a regional cervical cancer screening program and from cervical cancer patients enrolled in a region-wide palliative care program. Logistic regression analysis was conducted to assess risk factors for screening positive for precancerous lesions. In a separate analysis, factors associated with treatment delay were assessed among women enrolled in the palliative care program.

Results: 3,946 women were included from the screening program and 339 from the palliative care program. In total, 7.6% of screening participants had precancerous lesions. Within Busoga Region, the highest positivity rate was found in Bugweri and Namayingo Districts. Abnormal vaginal bleeding (aOR 1.60; 95%CI 1.15–2.21; p=0.005) and older age at first menstrual period (aOR 1.08; 95%CI 1.01–1.16; p=0.03) were associated with having a precancerous lesion. Among palliative care patients, treatment delay (≥ 12 months) from first symptom presentation until commencement in palliative care was associated with previous contact with the health care system (aOR 5.23; 95%CI 1.16–36.54; p=0.047). The median delay was 12 months (IQR 7.5–30).

Conclusions: The results underline an unmet need for broad-scale cervical cancer screening programs, training of health care workers, and establishing local awareness campaigns. Further research on both patient and health system-related barriers towards accessing and delivering screening services is needed to achieve global cervical cancer elimination.



Track 2: Health Promotion, Prevention, and Early Detection

14:00-14:10

123: Establishment of Cancer Care at Kawempe National Referral Hospital

Authors: *Mubiru Musa¹*

Affiliation: *¹Kawempe National Referral Hospital*

Background: Incidence of Non communicable diseases like cancer are on a rise in Uganda. There are few centers that specialize in management of these diseases. Only Uganda Cancer Institute (UCI) is specialized to handle and offer free cancer care in Uganda. Patients are admitted after getting a histological confirmation. UCI still gets overwhelmed with patients. Originally, patients with suspected operable gynecological malignancies were being managed from MNRH. Currently, MWNSH is a paying hospital and many poor patients are not able to pay. With the attainment of National Referral Hospital status, we embarked on setting up an oncology division in KNRH to improve on the timely diagnosis and treatment of women with gynecological malignancies and reduce waiting time and congestion at UCI.

Methods: We identified personnel, nurses and doctors with interest in gynecological oncology. We trained the nurses in screening and management of premalignant lesions of the cervix. We partnered with the family planning clinic trained their nurses in cervical cancer screening and encouraged them to screen clients. We sent a gynecologist for a 2-year fellowship in gynecological oncology. We secured space and equipment from administration and other development partners.

Results: We are currently attending to 400 patients per month, majority with suspected cervical cancer. There are improved diagnostics including using HPV DNA testing, colposcopy, visual inspection with acetic acid and management of precancerous cervical lesions with thermocoagulation LLETZ and CKC. We offer surgical care to patients with early-stage gynecological malignancies conducting an average of 8 operations per month.

Conclusions: We have functional oncology services in KNRH working towards decongesting and improved waiting time to diagnosis and treatment. It is envisioned that there will be better survival for patients who present with gynecological malignancies. We hope to build the oncology clinic into a center of excellence for gynecological cancer research care and treatment center.



14:10-14:20

131: Breast Cancer Screening Outreach Program in Uganda: Effectiveness of community-based triple assessment for Early Detection.

Authors: Dr Solomon Kibudde¹

Affiliation: ¹Uganda Cancer Institute

Introduction: Breast cancer remains a significant public health concern globally, including Uganda. However, limited access to screening and diagnostic services poses a challenge to early detection and timely intervention.

Objective: To evaluate the effectiveness of breast cancer screening utilizing mammograms, and breast ultrasound scans at community level during the breast cancer outreach program in Uganda.

Methods: From June 2021 to May 2023, a total of 100 community-based breast cancer outreaches were conducted across four regions in Uganda.

Results: The study included a total of 9,145 participants, with a median age of 36 years (IQR 27-46). Among the participants, 3,389 (37.1%) were aged 30 years and younger, and 714 (8.9%) reported no education level. Self-breast examination (SBE) had been performed by 3,438 (37.7%) participants, while only 1,198 (13.1%) had undergone clinical breast examination (CBE) within the past 12 months. Breast cancer symptoms were reported by 3,755 (41.1%) women, with the most common symptoms being breast lump (21%), nipple discharge (8.0%), and breast pain (32.8%). Among the screened participants, a total of 900 mammograms and 1,231 ultrasound scans were requested, resulting in completion rates of 99.2% and 87.1%, respectively. The mammograms were classified according to the Breast Imaging Reporting and Data System (BIRADS), with 72 cases categorized as BIRADS 4, 8 cases as BIRADS 5, and 1 case as BIRADS 6. Additionally, a total of 82 biopsies were requested, out of which 66 were completed. Among the completed biopsies, 32 cases were identified as malignant.

Conclusions: The outreach program successfully facilitated the utilization of mammograms, ultrasound scans, and biopsies, resulting in the early identification of malignant cases. These findings emphasize the need for continued investment in breast cancer screening initiatives and improved access to diagnostic services in Uganda, ultimately leading to improved outcomes and reduced breast cancer-related morbidity and mortality.



14:20-14:30

72: The most common cancers by sub-regions of Uganda: Population-based data from 2017-2020

Authors: *Francis Okongo^{2,3}, Catherine Amuge¹, Alfred Jatho¹, Nixon Niyonzima¹, Jackson Orem¹*

Affiliation: *¹Uganda Cancer Institute, ²Gulu Population-Based Cancer Registry, ³St Mary Lacor Hospital, Gulu, Uganda.*

Background: Cancer risk may vary from one person or community or region to another. The pattern of cancer type, gender, and age group differential by sub-regions of Uganda is not yet explicitly known, except for the Kyadondo (Kampala and parts of Wakiso district) of central Uganda and the Acholi sub-region provided by the Kampala Cancer Registry and the Gulu Cancer registry.

Aim: The aim of this study was to determine the baseline cancer burden, based on point prevalence, in each sub-region of Uganda.

Method: Medical record reviewal for trend analysis of cancer registry and health facility medical record data was conducted using the Uganda national cancer notification form. The World Health Organisation (WHO) coding rules using ICD-03 and ICD-10 formats were adapted and used to categorize the cancer types and topography. CanReg5 software was used to enter, clean, and analyze the data.

Results: Central region, Lango and Acholi, Busoga, and Ankole Sub-regions have the highest burden of Cancers. Cancers of the Cervix, Breast and Ovaries are common female cancers in all the Sub-regions of Uganda. The commonest male cancer is that of the prostate, while cancers of the liver and oesophagus and KS were common in both sexes. There are increasing risks of developing cancer of the stomach in both male and females especially from western Uganda; Kigezi, Ankole and Rwenzori Sub-regions. Lymphomas, Soft tissue Sarcomas and Malignant bone tumours are very common in children. Myeloid Leukemia is more common than the lymphoid type. The Male child is more at risk of developing cancer than the female child.

Conclusions: Cancer control stakeholders need to prioritize cancer control interventions based on the most common types of cancers per sub-region. Besides, there is a need to strengthen the current population-based cancer registries and set-up additional registries in the sub-regions to improve cancer data quality.



14:30-14:40

96: Common Cancers and Associated Risk Factors in Arua District Uganda 2017 to 2021

Authors: *Angucia Bridget Sharon¹*

Affiliation: *¹Uganda Cancer Institute*

Background: Cancer is the second leading cause of mortality worldwide, with over 19 million cases and 10 million deaths worldwide. Approximately, 50% of all new cancer cases and 70% of all deaths occur in low-and middle-income countries. In Uganda, 34,008 new cancer cases were registered, and 22,992 deaths occurred in 2020.

Aim: The goal of the study was to determine the common cancers and associated risk factors in Arua District from 2017 to 2021. Specifically, the study sought to determine the common cancers, and the risk factors associated with common lifestyle associated cancers among adult men and women from Arua district.

Methodology: A retrospective cohort study, using medical records was used to determine the commonest cancers and a nested case-control study to investigate the associated cancer risk factors.

Results: 1118 new cancer cases were registered by this study, liver cancer was the commonest cancer in Arua accounting for 13.7%, ca Cervix (11.8%), ca Breast (10.7%), ca Esophagus (10.5%) and Burkitt lymphoma (6.4%). The prevalence of a positive history of tobacco use among cases with Ca Esophagus was 59%. Men with a history of tobacco use were 3.2 times more likely to suffer from cancer of the esophagus than those with no history of tobacco use at 95% CI (1.7-5.9). Findings showed that having more children was a protective factor against breast cancer in women from Arua, OR, CI (0.8, 0.7-0.9). The risk of getting breast cancer was 2.1 times higher in pre-menopausal women than post-menopausal women OR, CI (2.1, 1.2-3.7). No history of Contraceptive use was protective against breast cancer, OR, CI (0.5, 0.2-1.0) in the bivariate analysis.

In conclusion, this study suggested that Ca Esophagus and Ca breast were the commonest cancers amongst the men and women hence the need for targeted cancer control interventions against these cancers in Arua district.



14:40-14:50

152: Prevalence of Human Papilloma Virus and Cervical Pre-cancerous Lesions among women in Malongo sub county, Mayuge District, Eastern Uganda.

Authors: *Rogers Mukwaya¹, Sam Kalungi², Wasswa Hassan¹, Nixon Niyonzima¹*

Affiliation: *¹Uganda Cancer Institute ²Mulago National Specialized Hospital*

Background: Human Papilloma Virus (HPV) infects nearly all sexually active women during their lifetime though they spontaneously clear the infection within 24 months. Some of these infections become persistent and can progress to cervical precancerous lesions or invasive cervical cancer when not detected and/or treated early. Extended natural history of HPV infection provides an opportunity for identifying effective screening programs to prevent cervical cancer. The aim of this study was to determine the prevalence of HPV and cervical pre-cancerous lesions in women in Mayuge District.

Method: This was a cross sectional study conducted in March 2023. Among enrolled participants, cervical specimens were collected, PAP testing done, and molecular HPV testing performed using the Cepheid Xpert HPV DNA test. Data was analyzed using Stata version 17.0. Descriptive data was presented using tables, line graphs and pie charts.

Results: We enrolled 325 women among whom, the prevalence of HPV was 20.9% and that of precancerous lesions was at 3.4% with 2.8% having high grade squamous intraepithelial lesions, 0.6% having Low Grade Squamous Intraepithelial Lesions, whereas 314 (96.6%) women had no epithelial lesions on PAP. The most common HPV genotypes were (31, 33, 35, 52, 58) 29 (42.6%) whereas HPV genotypes (39, 56, 68, 66), HPV 16 18 (17.6%), HPV 18 and 45 13(16.2%), HPV 51,59 (4.4%) constituted the least groups and 14.7% with more than one genotype. Most affected age-groups were 35-44 (39.7%) years, 25-34 (26%), and the least affected were those (10.3%)

Conclusion: The findings of this study indicate an increasing evidence and relevance of other high-risk HPV genotypes in precancerous and cervical cancer causation. Therefore, there is need for screening for all genotypes and increase in the current vaccination strategies to cater for different high risk HPV genotypes.



14:50-15:00

149: Palliative care knowledge, attitudes, and perceptions towards advanced care planning among HIV Patients at Kasangati HCIV

Authors: *Natusiima Jovinah¹*

Affiliation: *¹Institute of Hospice and Palliative Care in Africa*

Background: Health policymakers recognize the role of early palliative care and advance care planning in improving health quality and the need is gaining visibility as a major public health issue (Riffin et al., 2015) but misperceptions about palliative care, hospice, and advanced care planning are still common despite the known benefits of palliative care and advanced care planning. The implementation of ACP may be challenging due to the multifaceted and complex decision-making process there as a result of the conflicting needs and perceptions among patients, healthcare professionals, healthcare systems, race, religion and cultural values.

Objective: To explore palliative care knowledge, attitudes and perceptions towards advanced care planning among HIV patients at Kasangati HCIV.

Methods: A mixed cross sectional correlational study design utilizing the explanatory sequential approach will be used. This design implies collecting and analyzing quantitative data and then qualitative data in two consecutive phases within one study. For quantitative data, a pre-coded questionnaire will be pre-tested to check for suitability of various aspects and sections. The pre-coded questionnaire will be collected, ordered and data entered into Epidata software, then exported to STATA version 14.0 for analysis. For qualitative data, face to face interviews will be conducted after giving oral and written informed consent, Data will be classified and presented using tables, charts, graphs.

Expected benefit: This study will assess the palliative care knowledge, attitudes and perceptions of HIV patients toward advanced care planning and the gaps therein because it is directly a determinant of health service delivery.



15:00-15:10

168: Improving access to cancer diagnosis and treatment among children in Southwestern Uganda: The experience of Kitagata Hospital.

Authors: Catherine Nakasita¹, Ethan Harned², Christine Akatukunda³, Angella Namatovu⁴, Mark Donald Mwesiga⁴

Affiliation; ¹Kitagata Hospital, ²Global Partners in Care/University of Notre Dame, ³Mbarara University of Science and Technology ⁴Palliative Care Association of Uganda

Background: Nearly 3,000 children are diagnosed every year with cancer in Uganda. The global paediatric cancer survival rate is 80%, while Uganda sits closer to 50%. There are many barriers that prevent children from completing their cancer treatment with one of the largest being the cost of transport to and from cancer centres. Kitagata Hospital with support from PCAU started a project to follow up with and support children facing cancer with transport, meals, etc. during the Covid-19 lockdown to access cancer treatment called the Special Hearts to Nurture Every Child SHINE programme.

Aim: To provide transport, meals and psychosocial support for children and their families so that cancer treatment is completed.

Methods: Kitagata Hospital identified twenty-seven children across five districts in western Uganda who could benefit from these services. Funding was provided to these families for their transport to Mbarara Regional Referral Hospital and for their upkeep during their time at the hospital. Bimonthly home visits were conducted by the palliative care team at Kitagata Hospital to evaluate the needs of each patient and their family, provide psychosocial support and monitor adherence to treatment.

Results: Out of the twenty-seven children supported by the SHINE programme, four have completed treatment. Two children died, and bereavement services were provided to their families. The rest have remained on treatment.

Lessons learned: The SHINE programme was successful in allowing paediatric cancer patients to continue treatment despite financial barriers. Support services offered to families reduced the burden of caregivers throughout their child's treatment. Further challenges were identified through discussions with caregivers such as the inability to continue a child's education, provide nutritious meals after a child has returned home, and reduce the stigma surrounding a cancer diagnosis within their communities. Future partnerships will need to be formed to sustain and grow this programme and address these needs.



15:10-15:20

78: Correlates of Late Stage Esophageal Cancer at Diagnosis Among Patients Attending Mbarara Regional Referral Hospital-Oncology Unit and Mobile Hospice Mbarara

Authors: *Nagujja Francisca¹, Imelda Tamwesigire²*

Affiliation: *¹Hospice Africa Uganda, Mobile Hospice Mbarara, ²Mbarara University of Science and Technology*

Background: Esophageal cancer is on the rise with a burden of late stage presentation among these patients creating a burden in survival of these patients globally. In sub-Saharan Africa, over 59.9% patients are reporting with inoperable tumors.

Objective: To determine the stage at diagnosis and factors associated with late stage esophageal cancer at diagnosis among patients attending Mbarara Regional Referral Hospital-Oncology unit and Mobile Hospice Mbarara

Methods: A cross sectional review of 150 esophageal cancer patients records for period of 2016-2020 and 13 key informants interviews and 4 case studies were conducted. In analysis, percentages, chi square and a multivariate Poisson regression were used. Thematic analysis was done on transcribed data.

Results: 79% of patients presented in late stage. With proportions in tribe and patients who smoke significantly being more with late stage [χ^2 (3, N=150) =11.1309, pvalue=0.011], [χ^2 (1, N=150) pvalue=5.6502, p=0.017] respectively. Major correlates at multivariate included age ranges 40-49 (IRR 0.511 95%CI 0.28-0.95 pvalue=0.032) 50-59 (IRR 0.597 95% CI 0.39-0.91) pvalue 0.016) and 70-79 (IRR 0.602 95%CI 0.39-0.92 pvalue=0.02), ethnicity (IRR 4.91 95%CI 5 5.4-4.44 pvalue= 0.000), time spent with between onset chest pain and diagnosis for 7-12 months and 13-18 months were associated with late stage (IRR 1.482 95%CI 1.030-2.13 pvalue=0.034 & IRR 1.42 95%CI 1.05-1.92 pvalue= 0.02) and time spent between onset dysphagia and diagnosis for 13 months and above (IRR 2.71 95%CI 2.08-3.5 pvalue=0.000). The themes that merged included knowledge about esophageal cancer, health seeking behaviors of patients, impact of preceding symptom, attitude of stake holders, referring network challenges, availability of esophageal cancer service provider and patient related factors.

Conclusion and Recommendations: The age, ethnicity and time spent with presenting symptoms chest pain and dysphagia had an association with late-stage presentation at diagnosis. Therefore, a need for improved service from screening throughout the course.



Track 3: Clinical Care and Symptom Management

14:00-14:10

132: Implementation of In vivo Dosimetry as part of Radiotherapy Quality Assurance Program

Authors: *Komakech Ignatius¹, Kavuma Awusi¹, Abal Bonny¹,*

Affiliation: *¹Uganda Cancer Institute*

Background: The primary objective of radiotherapy is to deliver a uniform dose of radiation to the cancer within $\pm 5.0\%$ of prescription and with minimal side effects. However, radiotherapy is recognized as a high-risk procedure. Although rare, there are reported instances of radiation errors with fatal injuries. The quality of radiotherapy treatments is known to directly impact the outcome of the treatments delivered.

Aims: The aim of this study was to ensure that patients receive the correct doses during radiotherapy treatments.

Methods: In-vivo dose measurements were performed for 593 treatment fields from 493 patients receiving 2DRT and 3DCRT treatments (radical: 70% & palliative 30%) between July 2021 and March 2023. For each patient, a calibrated diode detector was placed on the patient's skin at the point of radiation entry. The patient was treated, and the dose delivered was determined from the diode reading recorded. The measured and prescribed doses were compared to determined percentage deviations. Factors attributing to the observed deviation in delivered doses were identified, presented and discussed with the different professionals for action and learning purposes.

Results: Most common sources of errors were wrong calculations, change in technology, omission of tray and bolus in treatment time calculations contributing respectively 39.6%, 25.0% and 8.0% to the 48 observed sources of errors. Comparison of the measured and prescribed doses showed that in 501 (84.5%) of the 593 measurements, delivered doses were within $\pm 5.0\%$ of the prescribed doses. The most affected treated sites include cervix, breast, head and neck and esophagus each contributing 28.3%, 27.2%, 14.1% and 8.7% respectively to the recorded 95 dose deviations greater than $\pm 5.0\%$.

Conclusions: Opportunities for improvement of quality of radiotherapy treatments were identified. Learning from these present errors should raise awareness in the team of current quality concerns leading to quality patients' treatments.



14:10-14:20

80: How Low Can You Go: What Is the Safe Threshold for Platelet Transfusions in Patients with Hematologic Malignancy in Sub-Saharan Africa

Authors: Henry Ddungu¹, Warren Phipps², Jackson Orem¹

Affiliation: ¹Uganda Cancer Institute, ²Hutchinson Center Research Institute – Uganda, Kampala, Uganda

Background: The optimal threshold for prophylactic platelet transfusion is unknown in sub-Saharan Africa. The objective was to determine a safe threshold for platelet transfusion.

Methods: We observed patients admitted with a hematological malignancy in 3 sequential 4-month time-periods using incrementally lower thresholds for prophylactic platelet transfusion: platelet counts $30 \times 10^9/L$ in period 1, $20 \times 10^9/L$ in period 2, and $10 \times 10^9/L$ in period 3. primary outcome was clinically significant bleeding (WHO grade 2 bleeding). We used generalized estimating equations (GEE) to compare the frequency of clinically significant bleeding and platelet transfusions by study period, adjusting for age, sex, cancer type, chemotherapy, baseline platelet count, and baseline hemoglobin.

Results: 188 patients were enrolled; median 22 years. Platelet transfusions were given to 42% of patients in period 1, 55% in period 2, and 45% in period 3. In adjusted models, period 3 had significantly fewer transfusions than period 1 (RR = 0.6, 95% CI 0.4; $p = 0.01$) and period 2 (RR = 0.5, 95% CI 0.4; $p < 0.001$). Eighteen patients (30%) had clinically significant bleeding on at least one day in period 1, 23 (30%) in period 2, and 15 (23%) in period 3. Clinically significant bleeding occurred on 8% of patient days in period 1, 9% in period 2, and 5% in period 3 (adjusted $p = 0.41$). Thirteen (21%) patients died in period 1, 15 (22%) in period 2, and 11 (19%) in period 3 (adjusted $p = 0.96$).

Conclusion: Lowering the threshold for platelet transfusion led to fewer transfusions without changing the incidence of clinically significant bleeding or mortality among cancer patients, suggesting that a threshold of $10 \times 10^9/L$ platelets, used in resource-rich countries, may be implemented as a safe level for transfusions in sub-Saharan Africa.



14:20-14:30

145: Influence of Social Cultural Factors on Palliative Care Services

Authors: Atuhaire Auleria Kakwara¹

Affiliation: ¹kawempe Home Care

Background: Although palliative care has been shown to improve the quality of life of people with life limiting illness as well as their families, culture shapes preferences about care which then results in people from different ethnic groups selecting palliative care at different rates due to different perception with the current system of palliative care.

Aim: To explore the influence of social cultural factors on palliative care services for children with cancer.

Method: A focused group discussion, qualitative study design was used to collect data. 6 carers (2 male and 4 females) were purposively sampled at New Hope Childrens Hostel and a semi-structured interview guide was used to collect data following participants informed consent.

Results: Six main themes were identified : 1) Traditional customs and beliefs, they believe that cancer is due to a cultural ailment.2)The influence of elders and traditional healers in the community who believe they know everything.3) Issues of gender roles that affect decision making.4) Issues of language and communication barriers.5) Religion where some pastors/preachers say that cancer does not exist and that their children are possessed by demons. 6) Financial challenge was the most underlying issue.

Conclusion: Social cultural issues have a big influence on the provision of palliative care and as palliative care professions we need to anticipate cultural barriers to care, involve patient and family in decision making and above all to be respectful of people's cultural norms, beliefs and practices to develop appropriate palliative care services to all in need in Uganda and Africa as a whole.



14:30-14:40

112: Implementation of Rwanda pain-free hospital initiative (PFHI): An observational prospective descriptive study of short-term achievements since 2018

Authors: *Vedaste Hategekimana¹, Raphael Ndahimana²*

Affiliation: *¹Rwanda Biomedical Centre (RBC), Non Communicable Disease Division, Kigali, Rwanda. ² Africa Quantitative science (AQS), Norrsken Kigali/Rwanda*

Background: Studies showed that in hospitals, especially in low middle income countries there is under-prescription of pain medicine, mainly opioids among cancer patients reporting moderate to severe pain leading to patient discomfort. Rwanda biomedical centre initiated the pain free hospital initiative (PFHI) in collaboration with American cancer society (ACS) in 2018.

Aims: However, the purpose of the PFHI was to motivate clinicians to evaluate and treat pain, supply appropriate drugs to treat pain, equip clinicians with the skills and tools to effectively treat pain, and measure the impact of the program.

Methods: This was an observational prospective descriptive study design whereby pain score and opioid consumption baseline information before the project starts and subsequent periods were recorded. Hospital staff champions were trained by RBC on data recording to help the project in evaluation. Tools for data extraction were designed and validated. We combined data from hospitals in Rwanda where the program is being implemented.

Results: Pain assessment is now considered a 5th vital sign, pain score improved from 6 to 2 over ten, pain assessment and appropriate pain management is now among MOH accreditation policies. Oral morphine production improved from 0.03Kg in 2013 to the estimate of 12 Kgs in 2022 due to the raised awareness and hospital demands, 75% public hospital staffs are trained on PFHI and 2026 HCPs (Nurses and physicians) were trained by staff champions via onsite training and all have access to oral morphine solution for free of charge.

Conclusion/Recommendation: Basing on the available study results, there is observable positive change in the implementation of the project but to scale up the project there is also a need to train health professionals at primary health care facilities and sustainable training to prevent turnover of trained staff and ensure the availability of pain medicine.



14:40-14:50

104: Building a care model to address the barriers of access to palliative care in rural Uganda: The case of Rays of Hope Hospice Jinja

Authors: *Sylvia Nakami¹, Joanita Mbabazi¹, Josephine Namugambe¹, Margrethe Juncker¹*

Affiliation: *¹Rays of Hope Hospice Jinja*

Background: Rays of Hope Hospice Jinja (RHHJ) has since 2005 provided palliative in Busoga region and the neighboring districts. During the past seven years RHHJ has worked in line with the UN Sustainable Development Goal for 2030 to overcome barriers to the access of palliative care services for the poor rural people.

Aims and goal of RHHJ Programmes: RHHJ aims to provide palliative care and improve quality of life to all people with life threatening and life limiting illnesses and their families in the Busoga region.

Methods: Main barriers to access to care in Busoga Region were identified as long distances to health centers, long distances to specialized units, limited drug supply, limited knowledge among health workers, limited knowledge in the community and Poverty.

A holistic programme of care was set up to address these barriers including free homebased care, early detection of cervical and breast cancer, full diagnostic and treatment support for the poor, training of health workers, awareness raising in community, and emotional and material support.

RESULTS: Since 2017 the number of enrolled patients per year increased 200% to 1244 patients in 2022; new patients enrolled per year increased 230% to 644. 6000 women have been screened for cervical cancer and provided treatment as needed. 400 health workers from 100 health centers have been trained in introduction to palliative care. Emotional and material support is provided for the very poor. Awareness creation is implemented through a wide range of approaches.

Conclusions and Lessons Learnt: Significant progress has been made in making palliative care services accessible in peripheral districts of Busoga region. An enormous and urgent need remains to further develop and improve palliative care services, and also to make programmes sustainable and less dependent on donations.



14:50-15:00

141: The Reality of Nurses Multitasking Versus a Multidisciplinary Team: A Case Study of Mobile Hospice Mbarara

Authors: Antonia Kamate Tukundane¹

Affiliation: ¹Hospice Africa Uganda

Background: Palliative care is a nurse-led service, in Mobile Hospice Mbarara (MHM) covering a semi urban and rural setting. The nurses multitask, doing some roles for a doctor, social worker, counselor, spiritual leader in addition to traditional nursing roles.

Aim: To demonstrate the multiple roles of a palliative care nurse in MHM and the time spent doing these roles. Best practices that proved to be very effective in semi urban and rural settings.

Design, Methods, And Approach: A descriptive design was used where the patients' charts were reviewed, the nurses were given a questionnaire and observations of the nurses about the experience they had when a social worker was part of the team in Mobile Hospice Mbarara was also explored. Monthly reports were also used.

Results: The nurses at MHM do a number of non-nursing interventions as part of their daily routine. For example, social work, spiritual support, counseling, day care activities, making diagnosis and treating common ailments of the patients, data entry, procurement of drugs and sundries, dispensing medicines and clerking new patients. Non-nursing interventions may take half the time spent with an individual patient (15mins 1 hour).

Conclusion: Multitasking is a reality for palliative care nurses, A significant amount of time is spent on non-nursing interventions, The presence of other disciplines on the palliative care team enables the nurses to focus on nursing interventions, continuous nursing education and self-care.

It is recommended that every palliative care team strives to have the minimum of a part time doctor, a social worker and spiritual leader in order for the nurses to focus on nursing interventions, self-care and continuous nursing education. This will ultimately result in improved quality of care.



15:00-15:10

155: Strengthening the availability of palliative care for persons living with disabilities "the Palliative Care Association of Uganda's experience in becoming disability inclusive

Authors: *Esther Namara¹, Ethan Harned², Lisa Irumba¹, Mark Donald Mwesiga¹*

Affiliation: *¹Palliative Care Association of Uganda, ²Global Partners in Care, University of Notre Dame*

Background: Over 3.9 million Ugandans live with a disability, with the majority of these being children under 15 years old. This number is expected to rise significantly by 2050. Currently, there is no framework to ensure accessibility of health services especially palliative care services for persons living with disabilities (PWDs). The Palliative Care Association of Uganda (PCAU) audited its programmes to ensure inclusivity for PWDs.

Aims: To identify and address the challenges PWDs face when accessing palliative care services and make PCAU's programming disability inclusive.

Approach Taken: PCAU collaborated with multiple Civil Society Organizations (CSOs) focusing on disability advocacy and programming. The CSO then conducted training for all staff at PCAU. PCAU selected eleven representatives from six member organizations to be trained in disability inclusion. A survey with focus group discussions was then conducted with CSO representatives and PWDs to identify barriers to accessing palliative care and how those could be addressed.

Results: PCAU altered existing programmes to be disability inclusive. Champions who received training in disability inclusion created action plans for their organizations to become disability inclusive. The survey discussions revealed that palliative care was being offered to PWDs, but significant physical, economic, socio-cultural, and health facility challenges prevented PWDs from accessing palliative care.

Conclusion: Few PWDs had extensive knowledge on palliative care services or who qualified for them. Outreach programs have rarely been conducted to sensitize the public to palliative care, especially PWDs. This lack of knowledge of palliative care services by the public is exacerbated in PWDs, as these sensitization efforts have not accounted for the communication barriers facing PWDs.

Recommendations: Future efforts can be made to sensitize more palliative care organizations to the unique needs of PWDs and how to reach out to those in their communities.



15:10-15:20

Rural Palliative Care Outreach Team Confronts Barriers to Cancer Care: Clinical care and symptom management.

Authors: Prossy Nafula¹, Lauren Wagner², Benjamin Schwarz², Navendra Singuh², Randi Diamond².

Affiliation: ¹ Saint Francis Naggalama Hospital, ²Weill Cornell Medicine.

The Palliative Care Outreach Team of Naggalama Hospital cares for rural patients in the Mukono District. The team is composed of a nurse with a diploma in palliative care and two nurse assistants who have completed short courses in palliative care, one of whom is also a spiritual counselor. Over the past 10 years, they have seen over 900 patients; roughly 80% have cancer diagnoses. Most of these patients have been referred to the team by surrounding village health workers, family members, neighbors, or the Makerere/Mulago PC Unit. They are seen monthly or biweekly for pain and symptom management as well as for psychosocial and spiritual support. Our on-the-ground experience in the rural villages corroborates the findings reported by the Uganda Cancer Institute that cancer patients in Uganda face significant challenges which result in delays in initiation and continuation of cancer treatment. Aside from reduced access to cancer treatments related to financial hardship, our team has observed widespread limited understanding among our patients regarding cancer diagnosis, the expectations of the disease's progression and treatment, and the importance of adherence to prescribed treatment regimens. In addition to providing support and symptom management for those patients with limited access to healthcare, the team reinforces proper use of pain medications and provides teaching regarding cancer diagnosis, expectations including prognosis and side effects, as well as about the importance of adherence to prescribed chemotherapy schedules and follow up visits. The team encourages patients to seek appropriate, timely medical care. While the presence of a rural-based team helps to provide broader access to palliative care, the team also strives to develop and utilize innovative strategies to address the gaps in understanding among patients and families to help encourage improved comprehensive cancer care.



Track 4: Family and Community Involvement and Empowerment

14:00-14:10

93: Experience of Training Home Caregivers at The Institute of Hospice And Palliative Care In Africa (IHPCA)

Authors: *Harriet Nakiganda Muganga¹, Dorothy Olet¹, Wilson Acuda¹*

Affiliation: *¹Institute of Hospice and Palliative Care in Uganda*

Introduction: The growing burden of Non-Communicable Diseases contributes to increased need for palliative care services. Palliative care can be provided through various models, the commonest being the home care model. In this model, the greatest weight of caring for a patient with a life-threatening illness lies with the family members who are not trained in patient care. Lack of training compounds caregiver distress in care and negatively impacts patients' quality of life. Studies in Uganda and elsewhere have shown a high prevalence of distress and depression among family caregivers of cancer patients.

Aim: To equip home caregivers with knowledge of chronic conditions and their management, home care skills, and confidence so they can work together with health professionals to improve patient outcomes and quality of life.

Design: Following a home caregiver needs assessment, IHPCA designed a curriculum to address these needs and conducted a 3 weeks training. Various teaching methods were used to enhance learning which included physical classroom teaching, hand-outs/booklets, videos, audiotapes, all interactive between facilitator and caregivers. Over 26 students have completed the Homecare in the Community training.

Results: Based on test scores and self-report, trainings have empowered home caregivers of chronically ill patients with basic knowledge and skills in patient and self-care, thus improving the quality of life of patients and families.

Conclusion/Lessons Learned: Many home caregivers suffer the burden of care with little or no information on how best they can support their loved ones. Oftentimes they stumble into the different supportive measures and coping strategies, although the weight of care can be shouldered through deliberate focused training. It's evident that training can significantly improve the quality of patient care and reduce caregiver/family distress.

Finally, all palliative care providers should incorporate home caregiver training in their routine practice to support home caregivers of patients/families faced with life-threatening illnesses.



14:10-14:20

117: Leveraging Trained Village Health Teams and Community Volunteer Workers to Improve Access to Cancer Care and Palliative Care in Rural Uganda

Authors: *Germans Natuhwera¹*

Affiliation: *'Little Hospice Hoima, Hospice Africa Uganda*

Introduction; In Uganda, late presentation for healthcare, and linkage of referrals from the community is still a major challenge. Consequently, many patients, in particular those with cancer reach the health facility late and with advanced, incurable disease (over 80%). Majority are unable to receive palliative care (PC) for their symptoms. Empowered Village Health Teams (VHTs) and Community Volunteer Workers (CVWs) play a big role in mitigating this gap.

Objective of the project: To empower 13 VHT/CVWs in Bunyoro region with knowledge of cancer and palliative care needs in the community. The overall aim is to improve community awareness, early health-care seeking behaviors, and appropriate linkage and follow up of patients in the community for improved access to healthcare.

Approach used: This mini-pilot project was conducted at Little Hospice Hoima in Bunyoro sub region Mid-western Uganda. 13 VHTs/CVWs were purposively selected from five districts of Hoima, Kikuube, Kakumiro, Masindi, and Kyankwanzi in Bunyoro region for a 5-day intensive training in June 2022. A total of 11 course units were covered:- Introduction to Hospice and Palliative Care, Basic Information on Terminal/Chronic Illnesses (Cancer and HIV/AIDS), Pain, Symptoms, and Opportunistic Infections, Basic Communication and Counseling Skills, Practical Aspects of Nursing Care at home, Referral and Networking etc. A one-day update meeting was conducted in March 2023.

Results: In the July-September 2022 quarter, a review of the project found that the CVWs/VHTs had identified 325 patients for care and support, of whom 20 new patients were referred to Little Hospice Hoima and 10 (50%) of these had cancer and other Palliative Care needs, had identified and were following up 212 patients in the community, made 110 referrals to other facilities other than Hospice, and conducted 88 health education talks in the community. Challenges reported included:- transport and communication, identification within the community. At the update meeting, each CVW was given a hospice branded t-shirt for identification, branded umbrella, a pair of gumboots, airtime for six months, stationery for reports, and a kit with basic supplies (gloves, chlorhexidine, gauze, and cotton) for basic wound care to ease their work. In the next phase of the project, the CVWs will each receive a bicycle and a name tag.



Lessons learnt and recommendations: Due to their close link with the community, the CVWs/VHTs play a number of roles including; health education to increase awareness and improve health-seeking behaviors (such as early screening and testing for cancer), basic health care (e.g. wound care), identification, linking referrals and follow-up of patients within the communities. Motivation, and periodic monitoring and refresher trainings are key to the success of the project

14:20-14:30

162: Depression in Ugandan caregivers of cancer patients: The role of coping strategies and social support

Authors: *Simpson Nuwamanya¹, Rahel Nkola¹, Sarah Maria Najjuka², Harriet Nabulo³, Firoj Al-Mamun^{4,5,6}, Mohammed A. Mamun^{4,5} Mark Mohan Kaggwa^{1,7,8}*

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Background: Palliative care services involve the psychological care of the caregivers of cancer patients. Psychological conditions, especially depression among caregivers, distort caregiving roles; thus, it can increase a patient's psychological suffering.

Objective: To determine the prevalence of depression and associated coping strategies among caregivers of cancer patients at a rural cancer care facility.

Methods: This cross-sectional study was among 366 caregivers of cancer patients. The data was collected using a pretested questionnaire, where the symptoms of depression were assessed using the Patient Health Questionnaire-9 at a cutoff of 10 out of 27. The coping strategies were assessed based on the Brief-coping orientation to problems experienced Inventory. Logistic regression was used to determine the factors associated with depression.

Results: The mean age of the participants was 39.01 (± 11.50) years; most were females (60.38%). The prevalence of depression was 8.2%. The identified factors



associated with increased likelihood of depression were coping strategies: active coping (aOR= 1.55, 95% Confidence Interval (CI) = 1.05â€“2.28, $p=0.026$), denial (aOR= 1.62, 95% CI = 1.20â€“2.19, $p=0.001$), and humor (aOR=1.43, 95% CI= 1.111.84, $p=0.005$). However, coping with positive reframing reduced the likelihood of depression (aOR = 0.70, 95% CI = 0.52â€“0.94, $p=0.019$). There was no significant association between depression and social support.

Conclusion: The lower prevalence of depression reported in this study than in the prior Ugandan studies reflects that depression severity among caregivers in rural settings is less prevalent because of the fewer care-associated burdens they experience. Therefore, establishing palliative care near the patients can be a protective factor for caregivers' depression. In addition, the role of social support and coping strategies in depression might be helpful in mental health strategies.

14:30-14:40

79: Insights into Advance Care Planning in Africa

Authors: *Dianah Basirika¹, Anne Merriman¹, Nelson Gumoyesige¹, Namisango Eve², Samuel Guma³*

Affiliation: *¹Hospice Africa Uganda, ²African Palliative Care Association, ³Kawempe Home Care*

Background: Advance Care Planning is an important element of palliative care whose relevance has over the years shifted from focusing on patients at end of life to being applicable at any stage of an individual's health. It is said to be beneficial not only to the patient but also to the general health care system. It may facilitate a peaceful death in addition to minimizing unnecessary costs and the use of resources yet its use among health care workers in Africa is not well researched.

Aim: This study therefore aimed to explore the use of Advance Care Planning among health care providers in sub-Saharan Africa. It was a survey that targeted health care professionals across Sub-Saharan Africa who were either current staff or alumni of Hospice Africa Uganda (HAU) between 2012 and 2023. These were conveniently sampled from the HAU database. An electronic survey was sent out, data was collected into an excel sheet and it was analysed descriptively.

Results: Responses to the survey came from nine out of 37 countries with PC services across Africa and there was a 14% response rate. 83% of the respondents had insight into Advance Care Planning and a surprise finding was that 40% had cared for patients with ACP. The majority (96%) would respect Advance Care



Plans of their patients. These findings gave some insights into the use of ACP although the results cannot be generalized to a wider demography of healthcare providers.

14: 40-14:50

Telling our story; experience of living with a chronic illness; community generated data using Photovoice in Adjumani and Obongi districts

Authors: *Mhoira Leng^{1,2,3,4}, Toko Friday Santiago², Simon Maku³, Vicky Opia⁵, Godfery Oziti⁵, Elizabeth Nabirye², Hannah Ikong², Elizabeth Namukwaya^{1,2},*

Affiliation: *¹ Makerere University, ²Palliative Care Education and Research Consortium, ³Cairdeas International Palliative Care Trust, ⁴Global Health Academy, ⁵Peace Hospice Adjumani,*

Background: Previous situational analysis, needs assessments and training interventions have revealed much about the palliative care (PC) provision in Adjumani and Obongi districts. Community generated data is essential in ensuring interventions match the priorities of those directly affected yet is often missing. Aims A novel approach to explore in depth the experience of living with a serious chronic illness for the host and refugee populations

Methods (design, data collection, analysis): Following methodological training and ethics approval we developed and implemented a pilot in 4 villages working with local implementers and 8 Village Health Team (VHT) mentors who had been previously trained in PC and mentorship. They had 3 days of training in taking narrative photographs using a smartphone. Participating patients were consented then photographs taken by the VHT. Researchers visited fortnightly holding a qualitative critical dialogue using the SHOWED criteria focusing on 2 selected pictures by the VHT All patients were visited at home. 32 critical dialogue interviews were recorded and analysed by 2 experienced researchers; then discussed with the VHT mentors and health leaders.

Results: Thematic analysis revealed 4 key themes and associated subthemes 1.living positively; community contribution, self-management, living not dying, hope, health literacy 2.challenges faced; access to healthcare, unrelieved symptoms, caregiver burden, health literacy, social issues such as poverty, food insecurity, isolation, stigma 3.VHT role; identification, advocate, holistic care, supporting health access, opinion leaders 4.messages for health leaders; collaborative working, health literacy, strengthened health systems, Abstract ID: 140 for UCI-PCAU Conference (Auto-Generated August 29, 2023 9:49 am)



Copyright 2023 UCI-PCAU Conference powered by WPAAbstracts Pro social welfare, research. All themes will be presented with quotes.

Conclusion: Engaging community members and those directly affected by serious chronic illness through Photovoice methodology is feasible and important. In addition VHTs and patients appreciated being seen, including down to their homes, and having their stories told. One VHT said 'do you mean this time we get to choose what story to tell' and 'now they can believe us'.

14:50-15:00

167: Assessment of The Impact of Business Centers on Patient's Wellbeing and Their Families in West Nile

Authors: *Ndemaru Patricia*^{1,2}

Affiliation: *'New Life Hospice Arua, Muni University*

Financial toxicity to a large extent affects the well-being and quality of life of patients. A number of coordinated efforts have been made by care providers, the health system, insurance and at the government level. When patients are diagnosed with life threatening illnesses, it often affects their business/work activities. The patients in the formal sector are often supported through the provisions in the Human resource manual of their institutions unlike the ones in the informal sector who are often left in the hands of their families and friends. The researcher intends to assess the impact of business centers on the wellbeing of the patients and their families through identification and clustering of patients based on their health conditions and abilities and background of their engagements. Because of their experiences, people who become entrepreneurs in their own disease may be more eager, more motivated, and more passionate about solving problems than regular entrepreneurs, and that indicates enormous impatience (Karin Hehenberger, 2021).

This research will employ both Qualitative and Quantitative research approaches such as secondary data reviews, Panel group discussions, interviews for the patient and acquaintances.

Establishment of Business centers ideally combines several qualities in one: a well-known address, a central space for connections and an ideal environment to develop business at a Reduced cost of space. With the Support system in a business center, patients will further get a sense of belonging, association, networking, make sales and Engagement upon incapacitation due to their illness. Further looking at (UBOS, 2021).74% of the households owned a mobile phone.



32% owned at least one set of a radio. 3% of the population aged 10 years and above had used a computer in the last 3 months, patients will derive entertainment from Business Centres.

15:00-15:10

119: Challenges Facing the Informal Caregivers and Lessons Learnt in Provision of Palliative Care - Experience at Rays of Hope Hospice Jinja.

Authors: *Mukiibi Henry Kikonyogo¹*

Affiliation: *¹Rays Of Hope Hospice Jinja*

Background: Globally caregivers face a heavy load due to their caregiving duties and this impacts their health, particularly for informal caregivers in families. Caregivers perform key tasks like cooking, cleaning, feeding, and providing emotional support to patients. Caregivers experience stress, depression, anxiety, and lower quality of life when caring for palliative care patients, resulting in physical, emotional, and spiritual discomfort.

Aims: To determine the daily challenges faced by informal palliative caregivers.

To relate challenges faced by palliative caregivers to cultural attitudes and stigma about death.

Strategy Used: To assist informal caregivers of chronically ill patients at Rays of Hope Hospice Jinja who are unemployed and care for patients needing palliative care.

Notes from informal caregivers' observations and conversations.

Key Results: Financial challenges are common for every carer. Caregivers are financially constrained leaving them with high health bills. These burdens affect patients' health because transport, food, and accommodation at UCI aren't affordable. Emotional burden; Watching a loved one suffer from a chronic illness is emotionally burdensome, especially in times of limited resources. Caregivers struggle with providing medication, hospital visits, and specific foods on demand. Ignorance and stigma towards HIV patients creates difficulties for their caregivers who often hide their illness due to fear in the community.

Conclusion And Lessons Learnt: The main challenge seems not to be caring for the patients, as most informal carers are strongly motivated to do so by compassion or a sense of responsibility.



The issues are: Obtaining the resources necessary to maintain their standard of living and provide adequate care as well as coping with the inherent emotional challenges of caregiving. Assistance must be threefold:

Adequate medical care must exist so that they can obtain it for their patients, caregivers need appropriate support structures to deal with the psychological burden of caring for chronically-ill persons.

15:10-15:20

74: Characterization of Human Papillomavirus genotypes and their correlates among women living with HIV attending antiretroviral therapy clinic in Mukono, Uganda

Authors: Nantale Prossy Nabatte¹

Affiliation: ¹Amref International University

Background: Human Papilloma Virus (HPV) is a prevalent sexually transmitted infection (STI) in the world. Studies have revealed that prevalence of HPV infection is higher among Women Living with Human Immunodeficiency Virus infection (WLHIV).

The broad aim of the research was to explore the types, occurrence and associated correlates of HPV infection by genotyping Human papillomavirus among a cohort of WLHIV attending antiretroviral therapy clinic in Mukono, Uganda.

Methods: A cross sectional study was used to collect data for socio demographic, sexual practices and medical history factors associated with HPV genotypes using a pretested interview guide subjected to 342 WLHIV. The respondents' results for HPV genotypes were obtained retrospectively from respective laboratory records. Data was entered in Epidata v4.6 and analysed using STATA V14. The prevalence of hr-HPV was estimated as proportion of the entire sample size. Analysis for the correlates of hr-HPV infection was done using modified poisson regression model.

Results: Slightly more than a half of respondents were aged below 35 years (56.7%), married (52.6%), and with a primary level of education (51.2%). The prevalence of hr-HPV was 39.8% at 95% confidence interval (CI: 34.40-44.78). The hr-HPV was higher among those between 30-34 years of age (n= 41, 30.2%) than those between the age of 45-49 years (n=16, 11.8%). In terms of associated correlates, age 45-49 years (aPR: 1.95, 95% CI: 1.41-2.69), being married (aPR: 1.30, 95% CI: 1.00, 1.69), use of condoms (aPR:



1.31, 95% CI: 1.00 -1.71) and age of sexual debut (aPR: 1.42, 95% CI: 1.08-1.87) were significantly associated with Human papillomavirus genotypes.

Conclusion: The prevalence of hr-HPV infection was high, indicative of a risk to the health of WLHIV in Mukono, Uganda and worldwide at large. The correlates are age 45-49 years, being married, use of condoms, age of sexual debut.

Track 5: Education, Advocacy, Policy, And The Law

14:00-14:10

Impact of Training on Breast Cancer Knowledge, Practice, and Confidence of Community Patient Navigators in Uganda

Authors: Solomon Kibudde¹, Asasira Judith¹

Affiliation: ¹Uganda Cancer Institute

Introduction: Cancer patient navigators (CPNs) play a vital role in coordinating care in the resource-limited cancer care continuum by providing support, education, and addressing barriers to care. However, there is currently no community navigation program in Uganda.

Objective: To assess the impact of training on the knowledge, practice, and confidence of community patient navigators in Uganda.

Methods: The data was collected from 300 navigators across four regions of Uganda using pre-test and post-test evaluations. The objectives were to evaluate changes in knowledge, identify improvements in practice, and measure the impact on confidence levels.

Results: Training resulted in a significant improvement in the knowledge of the community patient navigators. Significant increases were observed in correctly identifying the roles of a navigator ($p < 0.001$), understanding shared decision-making techniques ($p < 0.001$), recognizing factors associated with breast cancer development ($p = 0.006$), and identifying the characteristics of advanced breast cancer ($p < 0.001$). Furthermore, the training positively influenced the practice of the navigators, as seen in their ability to discuss breast cancer screening and awareness ($p < 0.001$), explain diagnostic tests ($p < 0.001$), discuss treatment options ($p < 0.001$), address follow-up care ($p < 0.001$), and provide support to women impacted by cancer diagnosis ($p < 0.001$). The navigators also displayed enhanced confidence in their interactions with women about breast cancer ($p < 0.001$).



Conclusion: The training program significantly improved the breast cancer knowledge, practice, and confidence of community patient navigators in Uganda. This study highlights the importance of targeted training initiatives to enhance the capacity of navigators in effectively addressing the needs of breast cancer patients throughout the care continuum. By empowering these navigators, the quality of breast cancer care can be improved, ultimately leading to better health outcomes for affected individuals in Uganda.

14:10-14:20

143: Uganda Children's Palliative Care Nurses Leadership Fellowship Programme

Authors: *Florence Nalutaaya¹, Elizabeth Nabirye¹, Julia Downing^{1,2}, Mhoira Leng¹*

Affiliation: *¹Palliative care Education and Research Consortium, Kampala, Uganda, International Children's Palliative Care Network*

Background: Globally 21.1 children need PC, 98 % are from low- and middle-income countries such as Uganda and 90-95% of these cannot access such care. The Uganda Children's Palliative Care (CPC) nurse leadership fellowship programme was developed following previous successful leadership programmes and training on CPC, funded by the Burdett Trust.

Aim: To empower nurses to lead services which will improve access to and the provision of CPC in Uganda.

Methodology: Registers from Mulago Hospital and the Uganda Cancer Institute were reviewed to identify districts from which referrals were received. 16 nurses from 8 districts (Adjumani, Kiboga, Koboga, Luwero, Masaka, Mbarara, Moyo, Yumbe) along with Kampala, were identified to undertake the fellowship programme. Another 4 nurses are undertaking the nurse prescribing course. To date they have undertaken a five-day virtual workshop involving lectures, problem-based learning, case-based discussions, pre and post-test evaluations, followed by ongoing clinical mentorship. Leadership training will commence in September. Results: 16 nurses (10 female, 6 male) commenced the programme. 12 work in hospitals, 2 the community and 2 are trainers. The mean pretest score was 76% and post-test score was 84% with the highest improvement being 30%. Pre-training the mean competency score to provide CPC was 2.0, and post 3.5. The six-months post-training competency score was 3.8. Mentorship is ongoing and the majority of participants talk about change in practice and attitude.

Conclusion: It is important that children can access PC services close to their home and this training is building the competency of nurses from a range of



districts. It is also hoped that the next stage of the training will build their leadership skills to enable them to further develop CPC services. A combination of virtual training and mentorship has been successful in empowering and building CPC capacity in nurses.

14:20-14:30

108: Pulmonary KS at Presentation in Sub Saharan Africa

Authors: *Herriethsiah Noah¹, Ernesti Zakayo¹, Salum Lidenge¹, Felister Tupa¹, Owen Ngalamika³, Julius Mwaiselage^{1,2}, Charles Wood^{4,5}*

Affiliation: *¹Ocean Road Cancer Institute, Dar es Salaam, Tanzania. ²Muhimbili University of Health and Allied Sciences, Dar es Salaam, Tanzania. ³Dermatology and Venereology Section, Adult Hospital of the University Teaching Hospitals. ⁴University of Zambia School of Medicine, Lusaka, Zambia. ⁵Department of Interdisciplinary Oncology, Louisiana State University Health Sciences Center, New Orleans, LA, USA.*

Background: Cutaneous Kaposi Sarcoma (KS) is the most common presentation in both endemic (EnKS) and epidemic (EpKS) KS. Involvement of visceral organs occurs in up to 50% of cases and pulmonary KS can lead to rapidly progressive respiratory failure. Pulmonary KS mostly occurs in the EPKS group and can mimic other opportunistic infections like pulmonary TB, PCP, etc. Therefore, this study investigated the prevalence of pulmonary KS and its outcome among patients presenting at Ocean Road Cancer Institute (ORCI).

Methods: In this retrospective study, we have analyzed radiographic findings of patients with KS as they presented for treatment at ORCI between 2021 and 2022.

Results: The analyzed cohort consisted of 110 patients with KS (27 EnKS and 77 EpKS). At presentation EnKS (HIV neg) patients were significantly older than EpKS patients ($p=0.04$). In both groups there were male predominance ($p=0.04$). While all KS patients presented with cutaneous lesions, 9 (8.2%) had chest x-ray findings consistent with pulmonary KS. It was however not significant between EnKS and EpKS patients ($p=0.06$). An additional 14(12.7%) patients had findings consistent with other infectious conditions. Within 6 months of presentation almost 50% of the population diagnosed with Pulmonary KS had died.

Conclusion: Pulmonary KS that normally associates with poor outcomes, contributes at least 8.2% of the cases at presentation.



14:30-14:40

166: Factors Affecting the Turn Up of Patients for Palliative Care in Arua Regional Referral Hospital In Arua Central Division, Arua City

Authors: Osoru Caroline¹

Affiliation: ¹Arua Regional Referral Hospital

Introduction: Globally, Palliative care has attracted interest looking at its offerings. The purpose of this study was to determine the socio-economic and cultural factors that affect the turn up of patients for palliative care in Arua Regional Referral Hospital in order to make recommendations for policy adjustment so as to improve on the coverage.

Methodology: The study used a cross sectional survey research design mainly descriptive in nature to give a picture of real facts on ground. Data was collected from a total of 60 respondents from in and outpatient wings, using structured and semi-structured questions/ interview guides.

Results: All the respondents (23%) reported transport and financial support to be their major hindrance, (20%) as lack of information, (17.6%) religious and spiritual beliefs, (16.7%) lack of education and cultural beliefs (13%) and myths about palliative (10%).

Conclusion: Researchers concluded that factors affecting the turn up of patients for palliative care include lack of transport, religious and spiritual beliefs, cultural beliefs, lack of knowledge and education, myths and misconceptions about palliative care.

The researcher recommends education and sensitization of the staff and community about palliative care, changing the perception of the community, improving government policies, continuous awareness, timely referral of terminally ill patients from communities and wards, implementing the palliative care models.

Nursing implication: The nursing profession has a responsibility to provide a palliative care approach to patients, no matter where they are deployed there's an endless need to seek the necessary knowledge and support to provide this. It also has a mandate to undertake initiatives like establishment of good communication networks which allow health professionals to advocate for their patients and access specialized palliative care advice promptly.



14:40-14:50

61: Clinical commitment without political commitment is meaningless: Perceived policy-related barriers to the implementation of palliative care in the rural and regional healthcare facilities.

Authors: *Atsede Aregay¹, Margaret O'Connor², Jill Stow³, Nicola Ayers⁴, Susan Lee^{5,6}.*

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Background: In Ethiopia, palliative care is included in different national health care plans and policies including into the national cancer control plan. However, despite these plans and guidelines, there are limited governmental health care facilities and a few non-governmental organizations that deliver services, which are mostly found in the capital city.

Aim: This study aimed to identify perceived policy barriers for the implementation of palliative care in the rural and regional health care facilities.

Methodology: Face-to-face interviews were conducted between October 2018 and January 2019 in rural and regional health care facilities. Interviews were conducted with 38 targeted professionals working in primary, secondary, and tertiary health care levels and policymakers from the regional health bureau. Additionally, academics from the university and regional health college and health extension workers (HEWs) deployed in health posts located in rural areas were interviewed. The data was analyzed using thematic analysis technique and NVivo 12 software was used for coding in addition to manual coding and analyzing of the qualitative data.

Results: Participants described several policy-related barriers for palliative care implementation including lack of government priority and focus on palliative care; lack of health professionals' awareness of the national palliative care plans and guidelines; and lack of palliative care integration into the existing healthcare system and the national budget. Participants said that the available palliative care services were mainly limited to patients with HIV and because the services were often managed with external support, were hence unsustainable.



Conclusion/Discussion: Having a focus and policy priority is a key component for the implementation of palliative care. And subsequent to that, as participants suggested, palliative care should be integrated into the existing health care system, particularly into the primary health care units and the health extension program, to support millions living in rural areas.

14:50-15:00

137: Examining the Impact of Diploma in Paediatric Palliative Care Academic Programme on access for Children's Palliative Care services in selected Public Health Facilities of Uganda

Authors: David Kavuma¹

Affiliation: *Mildmay Institute of Health Sciences*

Background: The World Health Organization, World Hospice Palliative Care Association and Palliative Care Association of Uganda, recognises that capacity building is one of the key strategies that can significantly contribute to improved access to palliative care services. In Uganda, about 60,000 cancer cases are registered each year of which 7,000 are paediatric. About 80% of people with cancer in Uganda not only report late but also are diagnosed late hence making cure almost impossible, especially in children. Inadequate competent professionals in paediatric palliative care (PPC) has been identified one of the critical barriers to paediatric palliative care services access in Uganda.

Goal of the intervention: To contribute to the improvement of access to quality palliative care services for children with palliative care needs as well as their families, in Uganda.

Methods and approach taken: Between 2014 and 2021, Mildmay trained over 48 health workers from various public health facilities on a one-year, work-based, modular Higher Diploma in Paediatric Palliative Care academic programme to offer palliative care to children that need it. Learners were in-service health care providers who needed specialized training in PPC.

Results: There is an increase in the number of children accessing palliative care services and improvement in the quality of PPC services provided by the graduates. Morphine prescription is available in most facilities with clinicians who were trained in morphine prescription. Play therapy, documentation, referral, and follow-up of children with palliative care needs also improved as a result capacity building.



Lessons learnt: Training of health workers greatly contributes to the improvement of access and quality of PPC services. There is still a great need for investing in capacity building. Consequently, this can significantly contribute to universal health coverage through reduction of premature mortality from non-communicable diseases especially among children by the year 2030 as emphasized in SDG 3.4 – reducing premature mortality from non-communicable diseases.

15:00-15:10

97: Oncology Nursing Training at Uganda Cancer Institute

Authors: *Kemigisha Misk¹, Mayanja Namaala¹, Kaggwa Doreen Agnes², Nankinga Rose², Nabakooza Susan², Ndagire Mariam², Naluyima Leila², Namutebi Jaliah², Bafumba Ritah². Dr. Jackson Orem³*

Affiliation: *¹Uganda Cancer Institute*

Background: Increasing incidence of cancer in Uganda coupled with the identified training gap has created an urgent need for training of specialized oncology nurses. Therefore, an effective, skilled oncology-nursing workforce is needed not only to build capacity to meet specialized training gap but also to contribute to the workforce to operationalize regional satellite cancer centers.

Methods: Through corroboration with UCI partner, (Fred Hutchinson Cancer Research, St. Jude's Cancer Center guidance, NHS trust together with Uganda health alliance and guidance of oncologists at UCI and senior nurses, nursing directorate designed a program of study with aim of developing relevant oncology clinical skills, knowledge, and competencies. A multi-disciplinary team of local and international experts in the fields of Clinical and Nursing Oncology, Medical Oncology, Pediatric Oncology, Surgical Oncology, Gynecological Oncology, and Palliative care and radiation Oncology will offer training staff

Results: Trainers of trainees have been trained in foundations of oncology nursing. All nurses, who have successfully completed a bachelor's degree in nursing education program from a recognized institution, with a minimum of two years of post-qualification experience and registered with Uganda Nurses and Midwifery Council to be enrolled. Ongoing evaluations to be conducted to assess for success in competency building in oncology knowledge and clinical skills.

Recommendations: The oncology curriculum is building capacity for oncology care of patients at UCI. Skill and knowledge competency assessments will be conducted per semester. Thereafter, services will be decentralized to satellite oncology units so as to decrease the late-stage diagnoses and improve patient survival with early diagnosis and treatment.



15:10-15:20

88: Impact of Stigma in Accessing Palliative Care Services in West Nile.

Authors: *Daniel Drileba Dratibi*¹

Affiliation: *'voice Of Restoration International*

Background: In Africa, terminal illnesses like cancer, HIV AIDS, heart failures attract a lot of stigma in many community settings, be it at church, mosque, schools, or village meetings. This mentality has fueled stigma and discrimination in various forms in homes, schools, churches, mosques, and places of work. Having lived through this as a person, I am aware that the consequences of stigma can be serious and devastating. With stigma due to mental ill-health and associated attitudes comes reluctance to seek out help and treatment. Delayed treatment increases social rejection, isolation, worse psychological well being, poor understanding among friends and family, poor quality of life, disability, increased socio-economic burden, increased feelings of shame and self-doubt, and may lead to death.

Aims: This qualitative study examined public and self-stigma, and attitudes amongst local residents in accessing palliative care services before and after introduction of community-based palliative care services in West Nile.

Method: Awareness and support programs were carried out on radios and there after, community-based palliative care awareness campaigns were introduced in churches, mosques and schools. We then conducted focus group discussions to determine public and self-stigma, and attitudes among residents accessing palliative care services.

Results: Public and self-stigma were significantly lower, and attitudes towards seeking professional help significantly more positive, after community-based palliative care services had been introduced in each community.

Challenges: Being that we had limited resources due to lack of funding for mass awareness campaigns, the target groups could not be adequately reached as desired.

Recommendations: Need for more awareness campaigns to break stigma

Conclusions: Community based awareness and accessible palliative care services can positively impact help-seeking behavior by reducing stigma and changing norms and attitudes.



POSTER PRESENTATIONS

TRACK 1: Clinical Care and Symptom Management

69: Human Herpesvirus-8 Replication and Kaposi Sarcoma Response to Treatment at Uganda Cancer Institute (UCI).

Authors: Phipps Warren¹, Dennis Mubiru¹, Semei Sekitene¹, Peter Mooka¹, Janet Nankoma¹, James Kafeero¹

Affiliation: ¹Fredhutch Cancer Research Institute Uganda.

Objective: Improved understanding of the effect of HIV infection on Kaposi sarcoma (KS) presentation and outcomes will guide development of more effective KS staging and therapeutic approaches. We enrolled a prospective cohort of epidemic (HIV-positive; HIV+KS) and endemic (HIV-negative; HIV-KS) KS patients in Uganda to identify factors associated with survival and response.

Methods: Adults with newly diagnosed KS presenting for care at the Uganda Cancer Institute (UCI) in Kampala, Uganda, between October 2012 and December 2019 were evaluated. Participants received chemotherapy per standard guidelines and were followed over one year to assess overall survival (OS) and treatment response.

Results: 200 participants were enrolled; 166 (83%) had HIV+KS, and 176 (88%) were poor-risk tumor (T1) stage. 1-year OS was 64% (95%CI 57%-71%), with the hazard of death nearly three-fold higher for HIV+KS (HR=2.93; p=0.023). Among HIV+KS, abnormal chest x-ray (HR=2.81; p=0.007), lower CD4 T-cell count (HR =0.68 per 100 cells/ μ L; p=0.027), higher HIV viral load (HR=2.22 per log₁₀ copies/mL; p=0.026), and higher plasma KSHV copy number (HR =1.79 per log₁₀ copies/mL; p=0.028) were associated with increased mortality. Among HIV-KS, factors associated with mortality included Karnofsky score <70 (HR =9.17; p=0.045), abnormal chest x-ray (HR=8.41; p=0.025), and higher plasma KSHV copy number (HR =6.21 per log₁₀ copies/mL; p<0.001).

Conclusions: Although survival rates were better for HIV-KS than HIV+KS, the high mortality rate seen in both groups underscores the urgent need to identify new staging and therapeutic approaches. Factors associated with mortality, including high plasma KSHV, may serve as important targets of therapy.



128: Barriers in the Use of Oral Liquid Morphine for Pain Treatment in Palliative Care for Hospice Africa Uganda - Health Professionals Perspective

Authors: E.M. Pronk¹, N.W. Olde Engberink¹, G.A.M.M. van Osch¹, B.J. Wiegers¹, Harriet Nakiganda Muganga²

Affiliation: ¹HAN University of Applied Science, ²Institute of Hospice and Palliative Care in Uganda

Introduction: Access to controlled medications (oral liquid Morphine inclusive) is still a challenge in Uganda. Only about 2.3% of the population that needs oral liquid morphine access it. It has been observed over time that patients suffer uncontrolled pain despite the availability of oral liquid morphine. Hospice Africa Uganda (HAU) was interested in the barriers to the use of oral liquid morphine so they can reduce them and improve their care.

Aim: To determine the barriers to the use of oral liquid morphine for palliative patients attending at Hospice Africa Uganda (HAU) Healthcare professionals' perspective.

Design: A qualitative, descriptive, cross-sectional research design was chosen. Data was collected through semi-structured interviews using topic guides. The interviews were transcribed, coded thematically, and analyzed.

Results: 14 respondents participated. The results were organized into themes. In the cultural theme, with subthemes beliefs, religion, traditional healers, and herbal medicine. Financial the subthemes, lack of funds, voluntary contribution, and transport costs. -Individual the subthemes side effects; knowledge of the healthcare professionals and patients. Logisticâl the subthemes availability raw materials; lack of oral liquid morphine; patient's location; facilities offering morphine; amount of prescribers; partnership HAU and government, and transport of morphine powder. Social the sub themes availability of training palliative care nurses; patient's environment; partnership HAU and hospitals; recognition palliative care professionals by the government, and patient's social status.

Conclusion: It can be concluded that there are barriers to the use of oral liquid morphine inside HAU. Within the themes financial and cultural, all barriers apply to HAU. Within the individual theme, the lack of knowledge of the patients about morphine and the fear of the side effects are barriers for HAU. In the theme logistical: limited prescribers and patients living outside catchment areas of HAU. In social themes: influence of the environment and social status of the patients.



70: A Phase 1 Study of Subcutaneous Rituximab Hyaluronidase Combined with Local Standard-of-Care Chemotherapy for the Treatment of Burkitt Lymphoma, Diffuse Large B-Cell Lymphoma or as Monotherapy for Kaposi Sarcoma Herpesvirus Associated Multicentric Castleman Disease, in Pediatrics and Adults in Uganda.

Authors: *Manoj Menon¹, Joyce Kambugu², Jacqueline Asea¹, Rosemary Namagembe², Prossy Ethel Namuli², Henry Ddungu²*

Affiliation: *¹Fredhutch Cancer Research Institute Uganda, ²Uganda Cancer Institute*

Introduction: Patients with Burkitt Lymphoma (BL), Diffuse Large B-Cell Lymphoma (DLBCL), or Kaposi Sarcoma Herpesvirus Associated Multicentric Castleman Disease (KSHV-MCD) treated in low resource settings have inferior outcomes compared to those in high resource settings. Rituximab, a monoclonal antibody which targets CD-20, substantially improves overall survival for these diseases but is not routinely used in sub-Saharan Africa (SSA) because of cost and administrative challenges. Although approved by FDA, the safety of subcutaneous rituximab hyaluronidase (sqR) is not established in this setting but may be greater than that of intravenous (IV) rituximab.

Aim: The primary aims of this study are to evaluate the safety and tolerability of administering sqR) in combination with standard-of-care chemotherapy in pediatrics and adults with BL, DLBCL, or KSHV-MCD, in Uganda; and to evaluate weight-based dosing of sqR in pediatrics to minimize extreme dose levels, defined as a rituximab ctrough level less than 25µg/ml or greater than 400µg/ml after the first subcutaneous dose.

Methods: This is an open-label phase I study in 2 age-based cohorts of patients; cohort 1: age ≥ 18 and cohort 2: age 2-17 years. Our enrollment target is 36-40 study participants. Patients that met study inclusion criteria are enrolled onto the study, staged, and started on treatment.

Cohort 1 group 1 (6 patients): received intravenous rituximab, 375mg/m² plus standard of care chemotherapy for the first cycle followed by 1400mg SqR plus the standard of care chemotherapy for the subsequent 5 cycles. Cohort 1 therapy group 2 (12 patients) received flat-dose SqR plus CHOP for all 6 cycles.

Cohort 2 group 1(6 patients): 375mg/m² of Intravenous Rituximab plus standard of care chemotherapy for the first cycle then 700mg (for those below 35kgs) or 1400mg (participants above 35kgs) SqR plus the standard of care chemotherapy for the next 05 cycles.



10 mls of blood is drawn from cycle 1 to cycle 5 for evaluation of rituximab pharmacokinetic (PK) activity.

Adverse events are monitored through weekly phone calls with the participants, participant self-reports, and laboratory results.

All participants' responses to therapy are evaluated based on CT scans done at baseline and at the end of therapy.

Participants are followed up for 12 months from time of treatment initiation to assess survival outcomes.

Results: To date, 18 participants have received treatment under cohort 1, therapy groups 1 and 2. Three participants (03/18) died before treatment completion; 15 completed treatments (One (01) achieved partial response and fourteen (14) achieved complete response (CR) as defined by the protocol). We currently have two (02) study participants that are active in study and are in the process of activating the second cohort. The Team is in the process of analyzing the PK samples. Results are pending.

Conclusion: There is an urgent need to improve outcomes of patients with BL, DLBCL, and KSHV-MCD in SSA. We believe that sqR will be safe, well-tolerated, and efficacious as has been demonstrated in other parts of the world. As such, we expect that this research will improve care not only in Uganda but in other resource limited settings in SSA with high CR rates, reduced costs of administration, and less infusion adverse events.

71: Sepsis in Post Chemotherapy Infection, 30-Day Case Fatality Rate and Optimal Mortality Risk Score for Sepsis in Cancer Patients Admitted at Oncology Ward Mbarara Regional Referral Hospital.

Authors: Ambaru Jacinta Ojia², Semei Sekitene², Edwin Nuwagira¹, Christopher C. Moore³, Sophia Lyon⁴, Rose Muhindo⁵

Affiliation: ¹Internal medicine resident – Mbarara University of Science and Technology, ²Medical Oncologist – Uganda Cancer Institute, ³Infectious disease Physician – Mbarara University of Science and Technology, ⁴Associate Professor of Infectious disease – UVA, ⁵Pharmacy Student at University of Virginia, Renal Physician - Mbarara University of Science and Technology

Background: Sepsis is the leading cause of death among patients receiving cancer-chemotherapy. Sepsis is currently defined as, quick Sequential Organ Function



Assessment (qSOFA) by Sepsis 3 to clinically identify patients with sepsis, no one biochemical test for sepsis. Other definitions also mortality risk scores (MRS) include Universal Vital Assessment (UVA) and Systemic Inflammatory Response Syndrome (SIRS). In our setting fever is almost always the only indicator of sepsis. Hence it is imperative to define sepsis in cancer patients. Aim was to determine the Case fatality rate (CFR) and optimal MRS to define sepsis. We evaluated the performance of qSOFA, UVA, SIRS in predicting 30-day CFR.

Methodology: Prospective cohort of 18 years or older cancer patients, received chemotherapy within 30-days and admitted with confirmed or suspected infection requiring intravenous antibiotics. We prospectively measured vital signs in 12-hours before intravenous antibiotics and laboratory results in 24-hours as of the MRS. Follow-up on day 30 physically or phone-call for outcome and enrollment was for 9 months.

Castor database and Stata16 for analysis. Case fatality rate was determined by simple proportions. For optimal MRS, predictive analysis - Sensitivity, Specificity, Negative predictive value (NPV) and Positive predictive value (PPV). Receiver Operating Characteristics (ROC) curve and Area Under the Curve (AUC), by non-parametric DeLong.

Results: Case fatality rate was 42.7%. SIRS (sensitivity 81%, Specificity 22%, PPV 44%, NPV 61%), qSOFA (Sensitivity 63%, Specificity 72%, PPV 63%, NPV 72%) and UVA (sensitivity 45%, specificity 91%, PPV 78%, NPV 69%). UVA AUROC 0.763 (CI 0.69-0.84) and qSOFA AUROC 0.714 (0.63-0.80) P-value <0.001 for both.

The UVA had higher specificity a higher AUROC than qSOFA, which may not be sufficient to screen for sepsis in this cohort. We recommend qSOFA with UVA or UVA alone in post cancer chemotherapy infection to screen for sepsis which predicts 30-day case fatality rate.

85: Independent Calculation of Monitor Units and Doses as Part of the Radiotherapy Patient-Specific Quality Assurance Program

Authors: Komakech Ignatius¹, Dr. Okello Denis², Dr. Awusi Kavuma², Mr. Abal Bonny¹, Dr. Annette Wygoda³

Affiliation: ¹Uganda Cancer Institute, ²Makerere University ³Ministry of Health.

Background: Radiotherapy is a highly effective modality for cancer treatment but could as well harm if not properly used. Therefore, a thorough quality assurance (QA) program is required in order to ensure safe and accurate delivery of dose to



patients. An independent calculation of monitor units (MUs) for validating the results of the treatment planning system (TPS) is an important element of such a program.

Aim: The primary aim of this study was therefore to validate through dose measurements, a commercial software: ClearCalc (CLC) for clinical workflow use.

Materials and methods: ClearCalc was validated by creating several phantom test plans for square, rectangular and irregular fields for open and wedged beams, then comparing doses calculated by CLC and TPS at each reference point with the measured. Upon satisfactory results, CLC was implemented for 505 treatment plans (3DCRT & IMRT) related to 330 patients. Additionally, for each IMRT treatment, a phantom verification treatment plan was created and a gamma analysis utilizing 3 mm, 3% agreement criteria was used to compare the TPS calculated doses and measured.

Results: Results from the different test plans show good agreement between measured and TPS ($-0.9 \pm 1.6\%$), measured and CLC ($-0.1 \pm 1.4\%$) and for TPS versus CLC calculated doses ($0.7 \pm 1.2\%$). Similar agreement ($-0.8 \pm 1.0\%$) was seen when CLC and TPS calculated MUs were compared. For patients' treatments, good agreements between TPS and CLC calculated MUs ($0.2 \pm 1.8\%$) and PTV doses ($0.2 \pm 1.2\%$) were demonstrated. Large deviations in MUs and doses were noted with treatments utilizing small fields. This phenomenon was also observed with IMRT pre-treatments QA measurements where lower gamma pass rate of 92.2% was detected.

Conclusions: ClearCalc was extensively validated and implemented for clinical use upon satisfactory results. The independent verification and phantom measurements are important and reliable QA tools that ensure accurate radiotherapy dosimetry.

157: Costing of Breast Cancer Treatment Based on Stage at Diagnosis at Mbarara Regional Referral Hospital Cancer Unit

Authors: Deo Kyambadde¹, Esther Cathryn Atukunda², Juliet Sanyu Namugambe², Henry Ddungu¹

Affiliation: ¹Uganda Cancer Institute, ²Mbarara Regional Referral Hospital Mbarara

Introduction: Better treatment and survival outcomes for breast cancer are achieved if the cancer is diagnosed early. Although breast cancer is a growing health problem in Uganda, the costing of its treatment, for different stages of diagnosis still remains undocumented.



Purpose: The study aimed at costing breast cancer treatment at Mbarara Regional Referral Hospital (MRRH) Cancer Unit based on the different stages of the cancer diagnosis.

Methodology: A retrospective descriptive cost analysis method was adopted for this study and involved reviewing patient charts for all patients aged 18-65 years diagnosed with breast cancer in the year 2018. A micro-costing approach was used to cost the investigations done, major stage specific treatment options (Surgery, Radiation therapy, Chemotherapy, Hormone therapy), other supportive medication, and human resource used to offer the treatment.

Results: There was 100% compliance to the documented treatment guidelines for stage II and stage IV breast cancer patients over the period of review. The average treatment costs (in US dollars) for stage I,II, III, and IV, were \$537.5, \$609.6, \$994.4, and \$1403.2 respectively indicating a positive relationship between cost of treatment and stage of disease at diagnosis.

Conclusion: The cost of breast cancer treatment increased with tumor stage of diagnosis and there was 89.2% compliance to the Uganda Cancer Institute Treatment guidelines of 2017, and National Comprehensive cancer Network guidelines in the management of breast cancer at MRRH Cancer unit.

98: Uptake and Integration of The NCCN Harmonized Guidelines for Sub-Saharan Africa: A Survey

Authors: *Racheal Angom¹, Henry Ddungu¹*

Affiliation: *¹Uganda Cancer Institute*

Background: Standard treatment guidelines improve cancer care practices, patient outcomes and reduce the cost of cancer care. The National Comprehensive Cancer Network (NCCN) guidelines are a cancer treatment resource used by clinicians around the world to make decisions pertaining to treatment for cancer patients. The NCCN Harmonized Guidelines (NCCN-HG) are collaboratively developed in consideration of the unique circumstances of cancer care world-wide to help cancer treatment centers in resource-constrained areas attain the optimal quality of cancer care they aspire to. The NCCN-HG for sub-Saharan Africa (SSA) were developed in a joint effort by the African Cancer Coalition, American Cancer Society, the Clinton Health Access Initiative, and International Business Machines (IBM) Corporation and they incorporate guidelines for early detection, prevention, risk reduction, treatment, and supportive care for specific cancers. The guidelines have been endorsed by various countries including Ethiopia, Malawi, Nigeria, Tanzania, Uganda, and Zambia.



Aim: To determine what proportion of doctors at UCI knows about the NCCN-HG for SSA, whether they use them, their attitudes about cancer treatment guidelines in general and NCCN-HG for SSA in particular.

Methods: Online survey administered to all doctors at UCI. We will report; proportion of doctors who know about the NCCN-HG for SSA, proportion of doctors who use NCCN-HG for SSA and doctors' attitudes about cancer treatment guidelines in general and NCCN-HG for SSA in particular.

Results: Our findings will be presented during the 4th Uganda Conference on Cancer and Palliative Care

125: Unearthing and Addressing Barriers to Cancer and Palliative Care Access Through Collaboration: An Experience of a Hospice and a Regional Cancer Center in Southwestern Uganda

Authors: *Martha Rabwoni¹*

Affiliation: *¹Hospice Africa Uganda*

Background: Access to cancer care and palliative care can be hampered by a number of factors, including patient, societal and health care system barriers. These, oftentimes make patients decline medical advice or even referral for further specialist management of joint care.

Aim: To highlight the role of collaboration in addressing barriers and improving access to palliative care and cancer care.

Approach taken: This case study was conducted at two facilities; Mobile Hospice Mbarara (MHM) and Mbarara Regional Referral Hospital (MRRH) Cancer unit in southwestern Uganda. Three patients with cancer of the; breast, prostate, and esophagus who sought palliative care at MHM were studied. The patients needed to be investigated prior to initiation of active cancer treatment. However, they each declined referral to MRRH cancer unit. A palliative care nurse at MHM explored the reasons for declining the referral. Common reasons were: financial constraints and fear of treatment costs, negative Perception about their cancer diagnosis, ignorance (lack of information), patients' autonomy, influence (from relatives/caregiver, friends, or community) fear of side effects of medications, unfriendly health care providers.

The patients were then counselled, given a referral letter, and a prior phone call made to the team at MRRH cancer unit to allay patients' anxiety due to anticipated navigation challenges. They were supported through comfort fund for needy patients at MHM to do basic investigations.



Results: The patients were able to get individualized cancer treatment (chemotherapy) specific to their disease diagnosis at MRRH cancer unit. The MHM team continued to provide holistic palliative care. Their quality of life improved.

Lessons learn and Conclusion: Health professionals need to be empathic listeners to be able to understand the multiple patient, community, and healthcare system related barriers to care access for patients. Effective communication skills, multi-professional team working, and collaboration are great facilitators to health care access for patients.

183: Total Pain and Making a Nursing Diagnosis Plan: Experience at St. Francis Hospital Nsambya

Author: *Elizabeth Babirye¹*

Affiliation: *¹St. Francis Hospital Nsambya*

Background: Palliative Care Nursing: Caring for Suffering Patients continues to explore the concept of suffering as it relates to nursing practice in an updated new edition. Palliative care are actions that enhance the quality of life of patients and their families in coping with a progressive and incurable disease. In this context, the role of Nursing stands out, which has contributed to the development of various terminologies related to the stages of the nursing process. Understanding the concept of total pain and its dimensions should be a priority for clinicians who care for patients facing a life-limiting illness. This abstract discusses the concept of total pain along with, evaluation and management strategies using Nursing diagnosis care plan.

Objective: To identify in the literature on best practices in nursing patients with palliative care needs a framework of Basic Human Needs of chronic illnesses in holistic pain assessment and management.

Methodology: We mapped the common needs of palliative care patients in St Francis Nsambya palliative care unit and then literature review on best practices from three key medical databases PubMed, MedlinePalliative care” and “Nursing diagnoses” we then identified literature and resources on practical aspects to match with each of our common nursing needs for the patients under our care (case scenarios).

Results: We found that the most used classification system for formulating diagnoses was NANDA. Approximately 12 diagnoses were identified according to patients needs and were met through holistic care. We also used the best nursing practices as guidance in meeting the dimensional needs of three case examples in our nursing and the patients reported positive experiences from home nursing.



Conclusion: This study contributes to the realization of nursing care, subsidizing nursing interventions that aim to address the needs of patients under palliative care. Practical performance, diagnoses classified in these case scenarios serve as evidence for clinical nursing practice during home visits, clinical decision in Nursing, allowing nurses to make a diagnostic judgment supported by scientific evidence, continuous capacity building to the committed team through sensitization mass media, churches, schools, continuous medical education, coaching, and mentorships is recommended to improve quality of life of patients in the community.

139: The Practice of Health Workers in Physical Pain Assessment Among Children at Mobile Hospice Mbarara

Authors: *Kabigarire Miriel'*

Affiliation: *'Hospice Africa Uganda*

Background: Pain experienced by children is often poorly assessed and managed, yet it can be a major intrusion into the lives of children and their families. They are left stunned by the situation and it has a great influence on the quality of life.

Aim: To assess the health workers practice in physical pain assessment among children at Mobile Hospice Mbarara.

Method: This was a retrospective quantitative approach to establish the practice of how health workers assess physical pain among children at Mobile Hospice Mbarara in southwestern Uganda. A sample of forty patient records was reviewed using Krejcie and Morgan table of sample selection from a population of forty-five children. These were active children enrolled 2013 to 2018 and meeting appointments as scheduled up to their three subsequent visits. Secondary data was collected from selected files using a formatted checklist. Data was compiled, sorted, classified and entered into a computer, analyzed using the statistical package for social sciences.

Results: 40 children's files were reviewed; all children had their physical pain assessed on the first contact using only two pain score tools. 24(60%) had physical pain scored and documented on the second visit and 17(42.5%) had their physical pain scored and documented on the third visit.

Conclusion: Health workers assess every child's physical pain on the first contact. When it comes to the subsequent visits, there was inconsistency in re-assessment of children's physical pain; health workers are not systematic in continual physical pain assessment and documentation. The best practice is to have regular pain assessment and documentation of the children's pain on every visit for improved quality of life.



159: Thyroid Cancer in Uganda: Clinico-Pathological Patterns and Management Disparities at a Major Tertiary Centre.

Author: Kintu Luwaga¹

Affiliation: ¹Mulago Hospital

Background: Thyroid cancer is the commonest endocrine cancer. Its incidence is rising fast globally. In low-income countries including Uganda, the disease burden is increasing but care is sub-optimal, and it remains understudied.

Aim: To review the clinical and histo-pathological characteristics of thyroid cancer in Uganda, as well as the available treatment options.

Methods. We conducted a retrospective chart review for all patients with thyroid disease who presented on the endocrine surgery unit of Mulago National Referral Hospital, from 2008 to 2018. All histologically confirmed cases of thyroid cancer were included in the study. The demographic, clinical and histo-pathological data was captured into a study proforma, as well as the treatment interventions and patient status at the time of the study. Descriptive data analysis was used to determine frequencies and proportions of the patient variables.

Results: 568 accessible charts of patients with thyroid disease were assessed and 87(15.3%) confirmed cases of Thyroid cancer were analysed. The majority were female (78.2%). Neck swelling (62.8%) and pressure symptoms (40%) were the main symptoms. Almost half (48%) presented with cervical lymph node involvement and 32.2% had inoperable disease. The majority, 67.8% (n = 59) patients underwent thyroidectomy. Adjuvant treatments included radiation, palliative medical care and radioactive iodine ablation (2.3 %). The most common sub-type was Papillary Thyroid Cancer (70%), followed by Follicular Thyroid Cancer (23.4%). The absolute 5 year survival rate was 65.2%.

Conclusion: In Uganda, as seen at this centre, the prevalence of thyroid cancer is high and advanced at presentation. The Papillary sub-type is dominant. Thyroidectomy is the main treatment intervention, but operation rates are low, with extremely low utilisation of radioactive iodine and a poor survival rate.



116: Strengthening Medical Teams for Improved Palliative Delivery In A Refugee Hosting Community

Authors: *Natuhwera Germans¹*

Affiliation: *Little Hospice Hoima, Hospice Africa Uganda*

Background: Established in 1960, Kyangwali settlement camp in Kikuube district, Midwestern Uganda is home to about 130,000 refugees from South Sudan, Burundi, DRC and Rwanda. According to the new inter-agency Feedback, Referral and Resolution Mechanism (FRRM), Medical Teams International (MTI) estimates at least 10% of cold cases from the camp to Hoima regional referral and Mulago require palliation. This gaps exists mainly because most of the health workers lack knowledge of palliative, resulting in constant patients' health complaints and unnecessary referrals.

Main Objective: To equip health workers from across 10 health facilities in the camp with basic skills and knowledge of palliative care service delivery.

Methods: 16 health workers from 10 health facilities (medical teams) in the camp (one health centre IV, two health centre III, and seven health centre II) participated in a 3-day residential training in Hoima city. Participants included nurses, clinical officers, reproductive health officer, emergency officers, as well as the camp's medical coordinator, programs manager, and public health officer). The selected participants are palliative care focal persons at their stations of work. Training was conducted from 27th to 29th July 2022 and was led by a palliative care clinician at Little Hospice Hoima supported by the District Health Officer, and the camp's medical coordinator and public health officer. A pre-test and post-test were conducted. Medical Teams International organized and coordinated the training with Funding from UNHCR.

Results: The results of the pre-test and post-test demonstrated an exponential increase in participants' knowledge of palliative care and improved perception of and attitude towards palliative care. This was further demonstrated by an increase in the number of patients attending Kyangwali HCIV monthly outreach conducted by Little Hospice Hoima. The number of patients who need palliative care at the outreach increased from 20-25 patients before the training to 32-40 patients every month post training. One of the trainees got inspired to undertake a BSc degree in palliative care.

Lessons learnt: The increase in the number of referrals from medical teams across the camp to Kyangwali HCIV, an outreach site post training is due to health workers' increased awareness and knowledge of palliative care and its roles and improved attitude and capacity to identify and provide basic palliative



care to patients who need it, identify and refer patients for care continuity and further management (complex cases) by the Little Hospice Hoima team. This has also reduced/avoided unnecessary referrals to the regional referral and Mulago. Training more health workers and maintaining the existing networking and collaboration would improve access to palliative care even further.

100: Does concurrent prescription of morphine with laxatives happen at Joy Hospice Mbale?

Author: John Mawogole¹

Affiliation: ¹Kaberaido Genertal Hospital

Introduction: opioids are prescribed in over 40% of patients with advanced cancer, but side effects occur frequently. Inevitably codeine and morphine cause constipation and a laxative should always be prescribed as a prophylactic (Care in AIDS patients who are susceptible to diarrhea). The audit project was focused on assessing the practice of documentation of prescription of laxatives in patients taking oral morphine for chronic pain control amongst cancer patients enrolled at Joy hospice Mbale.

Method: 74 patients files were included in this study and the audit data was collected from patient files using an observation checklist and then entered into a Microsoft excel template and manually analysed.

Results: result revealed that most of the patients received concurrent prescription of oral morphine and a laxative as recommended in the standard of this audit; 73 (99%) and 74 (100%) were scored for pain before pain medicine prescription. Bisacodyl 70 (96%) and lactulose 03 (04%) were the prescribed laxatives. The patients involved presented with different cancer types like breast cancer 03 (4%), cervical cancer 21 (28%), cancer of oesophagus 05 (7%), prostate cancer 22 (30%), and others 23 (31%).

Discussion: all age groups were affected by cancers with progressive increase with age. almost an equal distribution by sex was reflected with female 38 (51%), male 36 (49%). OPD care model was twice more than of IPD, OPD 53 (72%), IPD 21 (28%).

Conclusion: continuous re-audit is recommended to monitor sustainability of these good standards, continuous capacity building to the committed team through sensitization, continuous medical education,

coaching and mentorships: Other sites that offer similar services should replicate these good practices to ensure universal quality palliative care services.



114: Knowledge and Practices Among Caregivers of Children Receiving Radiation Therapy Regarding Skin Care at Parirenyatwa Radiotherapy Centre

Authors: *Tendai Chisamba¹*

Affiliation: *'Parirenyatwa School of Nursing*

Background: Radiation therapy is one of the most used cancer treatment modalities worldwide, although it is associated with skin injuries. Skin injuries occur in about ninety-five percent of patients who receive radiation therapy, including pediatric patients. Any body part site treated with radiation is susceptible to cutaneous injury. Most caregivers of pediatric patients receiving radiation therapy at Parirenyatwa Radiotherapy Centre report different skin injuries on the irradiated area(s) after first dose of radiation.

Aim: Assess level of knowledge and practices among caregivers of children receiving radiation therapy regarding skin care at home.

Methods: A cross-sectional study was conducted with caregivers of children receiving radiation therapy at Radiotherapy Centre Parirenyatwa Hospital, regarding skin care of irradiated area at home. Eligibility criteria: All caregivers with children twelve years old and below, receiving radiation treatment at Parirenyatwa Radiotherapy Centre, speaking English, Shona, Ndebele and willing to participate. A self-developed questionnaire based on topical literature was developed in collaboration with specialists in the field of radiation oncology. The questionnaire included four items each scored on a Likert type scale (one to five) and was distributed to caregivers to complete anonymously.

Results: A total of fifty caregivers (participants) participated (forty females, ten males). More than half of the participants, eighty percent, forty participants had no knowledge and were not practicing any skin care precautions at home. Ten participants, twenty percent, indicated knowledge on skin care post radiation at home and were practicing skin care precautions.

Conclusion: The study provided evidence that the majority of caregivers (eighty percent) did not have knowledge and lacked practices of skin care precautions on irradiated area(s) of their children after receiving radiation treatment. Health care providers must empower the caregivers with comprehensive information regarding skin care of irradiated area(s) before and during treatment to minimize further skin damage



105: Patients' Satisfaction with Nursing Care Among Pediatric Cancer Patients Attending Uganda Cancer Institute-Mulago, Kampala Uganda

Authors: Beatrice Rukundo¹

Affiliation: ¹Uganda Cancer Institute

Purpose: To assess the level of patient satisfaction with nursing care among pediatric cancer patients attending Uganda Cancer Institute in order to improve the quality of oncology services provided by the nurses to the pediatric patients at UCI.

Methods: The study was done among a sample size of fifty-six (56) respondents who were caregivers of children between 0-17 years getting treatment at UCI. A cross-sectional study design was used for this research, and a quantitative method of data collection using a questionnaire was used.

Results: The study findings showed the respondents were satisfied with availability of drugs (78.6%), punctuality of nurses (71.4%), listening skills (64.3%), procedure competences (67.9%) but with dissatisfaction with accessing clean water for drinking 60.7%), failure to give diagnostic talk (67.9%), no comfortable rooms for privacy (52%), nurse-patient ratio at (62.5%) and nurses' failure to give follow up calls (83.9%) were among the dissatisfactions.

Conclusion: The researcher concluded majority of respondents were satisfied with nursing care at UCI pediatrics nursing care. However, they expressed dissatisfaction in some crucial areas that need immediate attention from the hospital management.

Recommendation: The UCI management should support the nurses with equipment to aid their work in their areas of operation especially setting up clean safe drinking water for the patient and loading airtime on the already existing landline phones for follow-up calls. The nursing team at UCI should always create time to give diagnostic talk to the patients and finally, the Ministry of Public Service/Health should support the recruitment process of oncology nurses to increase their numbers of pediatric nurses to bridge the gap between the nurse-patient ratio.



179: Clinico-Pathologic Features Associated with Disease Recurrence Beyond 6 Months of Post Mastectomy: A Study from Addis Ababa Oncology Center

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Background: Due to high cancer patients' burden and long radiotherapy waiting time at Tikur Anbessa Specialized Hospital (TASH) oncology center, majority of high-risk post mastectomy patients, do not get the recommended post mastectomy adjuvant radiotherapy (PMRT). Beyond the recommended post operative period, there are no known clinic-pathologic prognostic factors used to identify high risk patients and the benefits of delayed adjuvant chest wall irradiation beyond 7 months after mastectomy were unknown.

Methodology: A retrospective cross-sectional study done among 185 high risk post mastectomy patients registered for adjuvant PMRT in 2016. After identifying the patients' medical recording, Patients' socio demographic data, date of RT registry including date of RT initiation were collected. data were analyzed using SPSS version 24 and Binary logistic regression was applied to see any difference among the group.

Result: Among all high risk patients, only 28.8% (79) patients took the PMRT and nearly 38.2%(106) patients were omitted. The median RT waiting time at TASH was 8.8 ± 1.4 months and the median PMRT delivery time was 10.4 ± 1.9 months. At 4 years follow up, PMRT did not improved an overall tumor control rate (COR=1.5, 95% CI=0.83-3.03,P=0.16) and tumor recurrences were associated with age less than 55 years, stage (D⁺) tumor and advanced nodal metastasis at presentation. On multivariate, only advanced nodal metastasis (N2&N3) was associated with increased risk of recurrences. (AOR, 3.86,CI 1.72-8.65, AOR, 4.34,CI 1.54-12.26)respectively.

Conclusion: PMRT did not associate with neither improved overall tumor control rate nor prolonging disease progression time. Delayed RT showed a non-significant improvement in loco-regional tumor control among certain groups of patients with poor prognostic factors through shifting the site of tumor recurrence from loco regional to distant site (8.8% vs13.2%).



129: Prevalence of Anxiety and Depression Among Patients in Palliative Care Setting During Covid-19 Pandemic: A Mixed Methods Cross-Sectional Study

Authors: Doreen Agasha Birungi¹, Germans Natuhwera¹, Eve Namisango², Wilson Acuda³, Ekiria Kikule³

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Introduction: Depression and anxiety are known to compromise quality of life for patients and families living with life limiting and life-threatening conditions as well as of the general population. COVID-19 and its rapid transmission, high mortality rate and other disruptions could exacerbate emotional and psychological morbidity. Much of the research on COVID-19 is concentrated in high resourced regions of the world and more on the general public than on patient populations.

Aims: The study aimed to: (1) determine the prevalence of anxiety and anxiety, (2) explore palliative care patients' experiences, (3) identify factors associated with anxiety and depression among palliative care patients during the COVID-19 pandemic.

Design and methods: The study was conducted at three hospices; (1) Hospice Africa Kampala in central Uganda (2) Mobile Hospice Mbarara in southwest Uganda, and (3) Little Hospice in rural mid-Western Uganda. Participants were; aged 18 years and above, and received palliative and hospice care at hospice between March 2020 and 30th July 2021. The study was approved by Hospice Africa Uganda and Uganda National Council of Science and Technology. Simple random sampling and purposive sampling were used to select participants for quantitative part and in-depth interviews respectively. Data collection was conducted between April 2022 and June 2022. Quantitative data were collected using the adapted structured Hospital Anxiety and Depression Scale (HADS) and a bio data form. Qualitative data were analyzed using thematic analysis while quantitative data were analyzed using SPSS software.

Results: 96 patients of whom 71(74%) were female responded to the questionnaire. 50% had no source of income and 41% were peasants. 31% had a family member or relative who had acquired or died of COVID-19. 38% reported a positive personal/family history of depression, anxiety or mental illness. 47% reported a change in their sleeping patterns. 65% had missed their appointments while 58% respondents had missed their routine medicines in the same period. Reasons for missed clinic appointment and treatment included; lack of means of transport/lockdown (70%), lack of money (52%), fear of catching COVID-(28%). 40% and 26% had borderline and abnormal depression respectively, while 33% and 28%



had borderline and abnormal anxiety respectively on the HADS Scale. 27% and 14% had normal and abnormal levels of both depression and anxiety respectively. Younger age ($p=0.002$), history of mental health problems ($p=0.006$), poverty ($p=0.002$), loss of independence ($p=0.004$), missed appointments ($p=0.006$), missed medicines ($p=0.002$), history of catching COVID-19 or death due to COVID-19 in the family ($p=0.049$), and changes in sleep patterns ($p=0.005$) were significant predictors of depression. Younger age ($p=0.017$), history of mental health problems ($p=0.004$), missed medicines ($p=0.039$), changes in sleep patterns ($p=0.000$) were significant predictors of anxiety. 10 interviews were conducted. Thematic analysis yielded three broad themes: (1) psychosocial factors, (2) COVID-19 and its disruptions, (3) health care system factors, and (4) coping mechanisms.

Conclusion: Younger age and limitations in accessing care, including disruptions caused by the COVID-19 pandemic, poor socioeconomic status, history of psychological morbidity can cause or precipitate existing psychological morbidity. Strategies to ensure care continuity during emergencies, addressing health care system barriers and providing emotional and psychosocial support could help assuage the problem.

184: Effectiveness of low dose Immunotherapy in Triple negative Breast cancer treatment

Authors: Benjamin Mwesige¹, Najib Bogere¹, Deo Kyambadde¹

Affiliation: ¹Uganda Cancer Institute

In just a few years, immune checkpoint inhibitors have dramatically changed the landscape in oncology, offering durable responses and improved survival for many patients across several tumor types. Several clinical trials confirmed the fact that increasing the dose has no statistically significant effect on tumor response. Outside the industry-sponsored phase I studies we have discussed, there is little clinical data with lower doses of these agents.

Chemotherapy doses are arrived at basing on the concept of Maximum tolerated dose in phase 1 studies. In these studies, the investigator will titrate the drug dose upwards until a Dose limiting toxicity is reached which defines the MTD. The MTD or doses slightly below MTD is what is recommended for phase 2, 3, and phase 4 studies

While the MTD based concept helps determine the appropriate and safest dose for cytotoxic chemotherapy, it is not an applicable strategy for immunotherapy because DLT may not occur even at doses significantly higher than approved pharmacological doses. In such scenarios, the criteria to stop dose titration may



be unclear hence a higher than necessary dose may be used in phase 2,3 and 4 studies and then subsequently in routine clinical practice.

Recent reviews by FDA now employ a concept of Biologically effective dose which stresses the fact that immunotherapy drugs have dose levels, above which the dose–response curve plateaus, and it is frequently below the MTD. Thus the use of BED instead of MTD puts patients at lower risk of toxicity and is more cost-effective.

Data from phase 1 studies which used multiple dose levels suggest that response to immunotherapy does not decrease with a decrease in the dose. The dose–response curve does not seem to be linear for immunotherapy. Data for multiple tumors with multiple dose ranges for multiple immunotherapy agents suggests similar responses to different dose levels of immunotherapy. This again suggests that lower doses might have similar efficacy.

Taking into account the PK, mechanism of action, receptor occupancy, phase 1 clinical trial results, and the low dose Immuno-check point inhibitors analysis it can be concluded that low dose levels of immunotherapies may be adequate. The receptor occupancy (PD 1) required for effective action is 70%–90% for immunotherapies. This receptor occupancy is achieved at a very low dose of 0.1–0.3 mg/kg as in the case of Nivolumab.

A randomized prospective trial is now required to further investigate the role and cost-effectiveness of lower-fixed dosing of Immunotherapy at 100 mg 3-weekly or low doses to maximize the principle of Immunotherapy binding to receptors for better clinical outcomes.



TRACK 2: Education, advocacy, policy, and the law

118: Final-year Undergraduate Nursing and Medical Students' Knowledge and Perceptions of and Orientation towards Palliative Care: A multicenter Mixed Methods study in Uganda

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Introduction: In Uganda, at least 486,000 people need palliative care (PC), and only 11% are able to access the service. Close to a decade since the introduction of PC as a taught and examinable course in the curricula for undergraduate nursing and medical schools in Uganda, it remains unclear as to what extent the training impacts students' knowledge and perceptions of and orientation toward PC. Hence, this study sought to examine this understudied area.

Objectives: The study sought to:- (1) estimate the level of knowledge of PC among final-year undergraduate nursing and medical students, (2) identify final-year undergraduate nursing and medical students' perceptions of PC, (3) determine final-year undergraduate nursing and medical students' orientation toward PC.

Methods: This is a multicenter, mixed methods study on final-year undergraduate medical and nursing students in four public and private universities and four nursing training schools in central, southwestern and Midwestern Uganda. Convenience sampling was used. Pre-tested instruments i.e. a biographic data sheet, the validated Palliative Care Quiz for nursing questionnaire (to test knowledge), the validated 23-item self-assessment Self-Efficacy Palliative Care scale (SEPCs) to test students' perceptions of and orientation towards PC, and an open-ended topic guide via focus group discussions (FGDs) were used. Data collection took place between October 2022 and February 2023. Ethical approval was obtained from Hospice Africa Uganda Research Ethics Committee (number: HAU-2022-03-A). Descriptive statistical analysis for quantitative data and thematic analysis for qualitative data will be used.

Preliminary results: 466 participants responded to the questionnaire part. 10 focus group discussions were conducted for the qualitative part. 9 FGDs have been conducted with :- medicine (n=3), Bachelor of Science in Nursing (n=2), certificate nurses (n=4), and diploma nurses (=1) students. Preliminary emergent themes include:- (1) participants' conceptualization of palliative care, (2) perceived capabilities to provide PC, (3) Theory versus practice, (4) training gaps and needs. (Note: Data analysis is in final stages)



Conclusion: Preliminary qualitative findings show participants have low self-efficacy manifesting as a lack of and/or inadequate practical exposure, low confidence, and very readiness and willingness to provide PC. Findings highlight training gap, with teaching predominantly theoretical, and very minimal, and/or even lack of experiential and practical exposure.

83: Online Sickle cell Learning and Awareness

Authors: *Prosper Katugume¹*

Affiliation: *¹Mbarara University of Science and Technology*

Background: Sickle cell disease (SCD) is the most common inherited hemoglobin disorder globally. Surveillance in 2015 found 13.3% of Ugandans to be carrying the sickle cell trait. The United Nations 2009 recognized SCD as a global health problem; and urged global health systems to build the capacity to control the disease and do more research. WHO recommended that member-states have to implement SCD prevention and control programs like health education training, public awareness, and screening by 2020. Unfortunately, Uganda has not implemented these; mostly medical education thus increasing Sickle cell-related deaths from poor management, hence the need to establish educational training and learning Sickle cell Disease Infonet student-based initiative at MUST started in February 2022 designed an online program to conduct online training on different aspects of SCD and patients.

Purpose: To promote online educational learning, awareness and knowledge about sickle cell diseases among medical schools thus improving the healthcare quality for sickle cell patients.

Method: 6 online Zoom teaching sessions were done on, SCD and Mental health session basics of SCD, SCD and herbal medicine, nutrition and sickle cell, and student life and Sickle cell. from June 2022 to November 2022. Participating institutions were Gulu University, Kabale University, Makerere University, Busitema University, KIU, King Caesar University, Lira University, BSU, Lira University, IUIU, and MUST. Knowledge and awareness were assessed using self-administered questionnaires after every session.

Results: Average session attendance was 48 participants. From post-session surveys, moderate to high-level knowledge was acquired on a comprehensive understanding of SCD, multidisciplinary approach to management and care of Sickle cell patients, attitudes and practices about SCD, moderate awareness was created among medical schools on SCD burden in Uganda and Inter-institutional relations through online interaction was achieved.



Conclusions: There is a demanding need to increase awareness, knowledge and better practices on SCD in institutions through online medical training.

109: Providing Access to Cancer Treatment - Even for the Poorest Among Us.

Authors: *Susan Walusansa¹*

Affiliation: *'Rays of Hope Hospice Jinja*

At Rays of Hope Hospice Jinja, a number of the many patients seeking palliative care services have treatable conditions. However, due to obstacles such as poverty, high cost of treatment, late diagnosis, incorrect referrals, fear of treatment, getting lost in the system at the national hospital and hardships faced while at the hospital, they cannot access the treatment they need. RHHJ believes access to health care is a human right thus whenever possible we support these patients for treatment such as provision of transport, the cost of medical investigations, treatment and upkeep while in the hospital.

58: Education in Dealing with the Impact of Working in Palliative Care

Authors: *Mrs. Dorien van de Ven¹, Wout Linsen¹*

Affiliation: *'HAN University of Applied Sciences, The Netherlands*

Background: Healthcare professionals deal with difficult situations in patient contact and in interactions with colleagues and peers. Working routines in palliative care nursing can be associated with stress and anxiety. Reflective practice is a critical tool to process and learn from these stressful daily interactions. It can provide the opportunity to recognize and understand uncomfortable thoughts and feelings that may be triggered by encounters in giving end-of-life care. Developing self-awareness can help understand emotional reactions to difficult situations and recognize early signs of stress. Reflective practice is not only about looking back on past actions and events, but also taking a conscious look at emotions, experiences, actions, and responses.

Goal: The goal is to improve the quality of care and enhance job satisfaction.

Efficient and well taught self-reflection during training results in personal growth and fulfillment. In the new Bachelor Nursing curriculum at HAN University of Applied Sciences, the Netherlands, reflective practice is fully integrated in the four-year program. An evidence-based approach to self-reflection by Korthagen (2002) is used by students and educators. During bi-weekly reflection sessions with students from different internship settings and one facilitating teacher, students apply the method to share insights they have gained and help their peers to improve practice, avoid burnout, and find solutions.



Not all practitioners are familiar with the process of reflective practice as it may not have been part of their training. Therefore, it is important that this knowledge is obtained through ongoing professional development. Also, reflective practice is not necessarily a comfortable experience as it challenges and evaluates personal practice. Organizations have an important role in promoting staff resilience by offering supervision, reflective practice and opportunities for staff communication that promote team engagement (Gillman et al., 2015).

115: Assessing Knowledge, Attitudes, and Behaviors About Gender-Based Violence Through the Lens of Palliative Care Providers in Africa

Authors: *Emily Karalus¹*

Affiliation: *¹University of Notre Dame, African Palliative Care Association*

Background: Gender-based violence (GBV) is a prevalent issue worldwide; women and children are most affected. It can take many forms and have different levels of severity and perpetration. Palliative care providers could be witnessing potential GBV when they provide care in the homes of patients, hence giving them the potential to assist in identifying and combating GBV.

Objectives: 1. Explore knowledge, attitudes, and behaviors of palliative care providers in Africa regarding GBV. 2. Explore what role, if any, these providers may have in assessing GBV among their palliative care patients. 3. Determine if these providers feel well-prepared to identify or assess GBV within the home, or if there is a need or desire for training on GBV among these providers.

Methods: This research study includes phase 1 which assesses the knowledge, attitudes, and behaviors of palliative care providers regarding GBV across Africa through an online survey, and phase 2 which explores the perceptions of palliative care providers in Uganda through focus groups/in-depth interviews and expert interviews throughout Africa. Survey data will be quantitatively analyzed using linear regression models, means, percentages, and correlations. From in-depth interviews and focus groups, thematic analysis will determine salient themes and patterns.

Results: Data collection and findings are currently in progress as of June 2023. Preliminary results are to be presented at the conference as ongoing analysis occurs.

Conclusion/Discussion: From this study, future researchers can determine if palliative care providers can play a role in assessing GBV among their patients and then create applicable interventions, policies, or procedures that can eliminate/reduce GBV. Knowledge on the warning signs and manifestation of GBV will enable the development of tools and resources to be used within the community to prevent GBV.



153: The Experiences of Families with Terminally Ill Breastfeeding Mothers Receiving Palliative Care at Hospice Africa Uganda.

Authors: *Dorcus Aciro¹, Dr. Nasur Buyinza¹, Natuhwera Germans¹*

Affiliation: *¹Hospice Africa Uganda*

Introduction: The pain and agony that families with patients suffering from terminal illnesses navigate are immense, especially in settings where a woman is a pivot around which almost all the socioeconomics of the home revolve. Terminally ill breastfeeding mothers and their families who are socioeconomically constrained face multidimensional challenges that compromise their access to quality comprehensive palliative care.

Studies indicate that cancer patients and survivors within reproductive age have intentions of bearing children 3-7 years after diagnosis and that the desire to have children is mainly associated with the desire for parenting before cancer treatment.

Aim: To highlight the challenges experienced by families caring for a breastfeeding patient with a terminal illness.

Design, Methods, And Approach: The data collected was based on face-face interactions and unstructured interviews with families caring for terminally ill patients who are breastfeeding during routine home visits, nurses briefs, and case conference proceedings.

Results: Terminally ill breastfeeding mothers undergoing palliative care were seen to have an additional double challenge of poverty, and malnutrition among others. One of the families we visited had a breastfeeding mother with pancreatic cancer but the family went through immense distress and an unimaginable lack of essential basic needs mainly due to financial challenges worsened by frequent threats of eviction from their landlord for non-payment of rent. The mother's death worsened the problem even more for there was nobody to take care of the breastfeeding baby left behind.

Conclusion: It was demonstrated that families with terminally ill breastfeeding mothers experience financial, and psychosocial distresses and dilemmas on how to care for the child and their family. It is therefore recommended that an adequate family support system for babies of terminally ill mothers be put in place for proper care and their financial challenges addressed through the provision of comfort funds.



177: Strengthening the Availability and Accessibility to Essential Medicines and Supplies for Patients with Palliative Care Needs in Uganda, An Experience at the Palliative Care Association of Uganda

Authors: Joyce Zalwango¹, Mark Donald Mwesiga¹, Lisa Irumba¹

Affiliation: ¹Palliative Care Association of Uganda

Background: An estimated 75% of the world's population lacks access to pain relief medicines. The Lancet Commission report of 2018 notes that only 11% of those who need pain control and palliative care access it in Uganda. Access to essential medicines and supplies for use in palliative care remains limited. PCAU initiated integrated approaches to strengthening the availability and access to Essential Medicines and Supplies.

Aim: To enhance the availability and accessibility of essential medicines and supplies for patients with palliative care needs in Uganda.

Approach Taken: PCAU offered scholarships to support specialist palliative care education and training for health workers. PCAU coordinated morphine partner meetings aimed at strengthening the supply chain for essential palliative care medicines. Worked with the Ministry of Health to accredit health facilities to offer palliative care. Conducted support supervision visits to follow up on documentation practices and standards. Established the National Palliative Care Toll-free line to support reporting on issues impacting the Morphine Supply Chain.

Results: Achievements for the period 2018 to 2022. A total of 54 scholarships were offered to health workers enabling them to prescribe and dispense oral liquid morphine. The consumption of morphine powder increased from 33.4kg to 77kg with limited reported stock outs of oral morphine solution at the facilities. An increase from 97 to 107 districts with health facilities providing palliative care services. Supported 102 out of 226 accredited health facilities to improve documentation practices. 75 correspondences with the public and community on access to pain relief medicines were registered in 2021/22. A total of 240 patients were supported with essential medical supplies from Hospitals palliative care units and Hospices.

Conclusion: Integrated approaches greatly contribute to strengthening the Availability and Accessibility to Essential Medicines and Supplies for patients with palliative care needs.



TRACK 3: Innovations and new technologies

138: A Machine Learning Approach to Mortality Forecasting for Advanced Breast Cancer Patients to Enhance Referral to Palliative Treatment at the Uganda Cancer Institute

Authors: Gyezaho Collins¹

Affiliation: ¹Uganda Cancer Institute

Background: Breast cancer is a type of cancer that develops in the epithelial lining of glandular tissue's ducts (85%) or lobules (15%). It is the most common cancer among women worldwide, with roughly 23.6 million new cases and 10.0 million deaths per year as of 2019 (Global burden of disease cancer collaboration, 2021). All patients with advanced cancer should get palliative care treatment, according to the American Society of Clinical Oncology (Ferrell et al, 2017). A study at Uganda Cancer Institute (UCI) reported that not enough patients are referred to palliative care specialists because oncologists lack specific protocols for referral. (Low, Daniel et al, 2018). Yet, palliative care should be started at least 3 months before death to improve patient quality of life and decrease costly procedures and costs (Jordan, R.I., Allsop, M.J., ElMokhallalati, Y. et al, 2020).

Objective: To develop and validate a machine learning model at the UCI that predicts mortality of patients with advanced breast cancer during the next 3-12 months in order to facilitate prompt referral for palliative care.

Method: The study will be retrospective and it will use data from medical records of stage 3 and stage 4 breast cancer patients who enrolled for cancer care and later died at UCI between 2016 and 2021. After inclusion and exclusion criteria, patients' records will be randomly selected for model development (60%) and validation (40%). Python and R-software will be employed to test and apply Machine Learning (ML) methods. To assess performance of predictive models, evaluation metrics such as confusion matrix, accuracy, precision, recall, and F1 score will be employed.

Anticipated benefits: The study findings will be used by both patients and clinicians to hasten the commencement of palliative care, resulting in an enhanced quality of life. The created ML model may help improve the precision with which palliative care is initiated.



59: Minimizing the Cost of Palliative Parenteral Chemotherapy Through a Dose Rounding Strategy at Uganda Cancer Institute, Mbarara, Uganda

Authors: John Isiiko¹, Imelda Busingye², Idrine Kato², Semei Sekitene¹

Affiliation: ¹Uganda Cancer Institute, ²Mbarara Regional Referral Hospital

Background: Approximately 10 million cancer deaths occurred in 2020 worldwide. In Uganda, the majority of the patients present with advanced disease, where palliative care is usually the goal of treatment. The growth rate of anti-cancer medicines expenditure surpasses that of new cancer cases; with a global market of \$200 billion in 2022. The Uganda Cancer Institute saved over UGX 10 billion with direct negotiations with drug manufacturers in 2020 however, the resources are still scarce. The 10% dose rounding is another strategy that has been explored to minimize cost without compromising therapeutic effectiveness among patients with advanced cancer.

Aim: This study aimed at determining if dose-rounding of chemotherapy agents is a feasible cost-saving strategy at a limited-resource oncology center.

Methods: This study involved a chart review of body surface area-dosed parenteral chemotherapy prescribed with palliative intent for histologically confirmed cancer diagnoses for a period of January to June 2022. Chemotherapy doses were rounded down by 10% to the nearest vial and evaluated for a potential decrease in the number of vials needed to prepare the dose. The cost was represented as the shilling per vial of the drug and based on the Uganda market price.

Results: A total of 922 doses of chemotherapy were prescribed with palliative intent for 82 adult patients with advanced cancer during the study period. The doses were rounded down by 10%, and 169 (18.3%) doses qualified for a decrease in vial number (from 1305 to 1136 vials). The potential for cost savings was about UGX 17 million.

Conclusion: Dose rounding has the potential to be an effective cost-saving strategy that can lower the cost of palliative care and improve the availability of medicines in an oncology setting. A 10% dose rounding of palliative parenteral chemotherapy to the nearest vial strategy should be introduced in oncology centers.



102: Development, Implementation, And Evaluation Of Palliative Care Service In Uganda; Ankole Subregion

Authors: *Nduhukire Moses¹, Nakasita Catherine²*

Affiliation: *¹ Mobile Hospice Mbarara, Hospice Africa Uganda, ²Kitagata Hospital*

Introduction: PC is one of the national priorities in the health care system. There remains limited evidence regarding service provision and its evaluation. The MOH in partnership with PCAU developed a strategy to introduce PC HMIS tools to help collect data and ease reporting from different Health centers in Uganda.

Aim: To ensure that all health centers in southwestern Uganda Ankole subregion who take care of Palliative care patients collect data and submit to the District Health management Information system.

Method: The Ministry of Health in partnership with Palliative Care Association of Uganda identified and trained champions to help train different facilities. In the Ankole region, Nduhukire Moses Data officer at Hospice Mbarara and Catherine Nakasita SNO Kitagata Hospital were both trained. These helped in CME's at health centers like Ishaka Adventist, Kitagata , Holy Innocents Children Hospital, Kabuyanda , Nsiika H/c, Nakivale H/c and others. Clinicians were trained about PC, pain score, management and were oriented on use of the new Palliative care HMIS tools which included the Out-patient department register and Report book.

Results: Health workers from different health centers from Ankole region at least gave in ten health workers to be trained on palliative care service and how to use the newly developed palliative care HMIS tools. Since the training, there has been at least 60% of data about palliative care service reported to the Ministry of Health every month and this data appears on the dashboard of District Health Management System.

Conclusion: Many clinicians have shown interest in Palliative care service provision. Through the continuous reporting, this will provide enough evidence to the MOH the need for the service in different health care settings. We continue to do CME's at different health centers to enable collection of accurate and reliable data regarding palliative care patients.



120: More Than Defensive Driving the Multi-Faceted Role of Transport Officers in an Interdisciplinary Palliative Care Team

Authors: *Kazibwe Siragi¹*

Affiliation: *¹Hospice Africa Uganda*

Introduction: Working in a multidisciplinary team sometimes necessitates members of the team to multitask, especially in situations where human resources are constrained. Beyond defensive driving, transport officers are such a great resource and can support clinical teams.

Aim: To share transport officers' lived experiences of working in multidisciplinary palliative care teams in a hospice setting.

Approach taken: This paper outlines the lived experiences of transport officers as productive members of palliative care teams. It integrates insights and inspirations as well as challenges transport officers navigate while supporting palliative care clinical teams. The lived experiences include those of a head driver working with Hospice Africa Uganda for 10 years, and those of his fellow transport officers at the three sites of Hospice Africa Uganda i.e. Hospice Africa Kampala in central, Mobile Hospice Mbarara in the Southwest, and Little Hospice Hoima in Midwest Uganda. The drivers are exposed to short course training in palliative care for non-health professionals.

Results: Among supportive roles transport officers play:

- Home visits: When there is only one nurse (usually on home visit), the transport officers serve as 'nurse aides'; helping with basic patient care, such as washing and changing patient's bed sheets and clothes, changing position of bedridden patients, and handing nurses what's needed during wound care procedures.
- Outreach sites: Organize, load and unload supplies. Engaging with care and patients waiting to be seen, providing a listening ear and information as needed. Often gain valuable insights and information to share with the rest of the palliative care team for further assessment and management of the patient. Recording patients in the attendance register, giving comfort fund after clinicians'/nurses' assessment, giving refreshments to patients and caregivers.
- Health education in the community: Take photos and distribute training materials, give information appropriately when approached.
- Death and bereavement: Help nurses who are giving last rites; drive bodies to final resting places; join other team members in giving emotional support to grieving families.



Lessons learnt and Conclusion: Transport officers can do far more than defensive driving, especially in resource-constrained settings. To empower and motivate them, they need basic non-health professions training, coaching, mentoring, workshops on working with patients, emotional and psychosocial support and appreciation of their efforts are all important strategies.

TRACK 4: Health promotion, prevention, and early detection

106: Effective Mobilization Is Key to Ensure High Cervical Cancer Screening Uptake

Authors: *Naleba Irene¹*,

Affiliation: *'Rays of Hope Hospice Jinja*

Background: In Uganda, cervical cancer accounts for 20% of all new cancers and 35% of all female cancers – 80% of these women present with advanced disease. The 2030 WHO goals for elimination of cervical cancer are to reach 70% of all women to be screened at age 35 and 45. Several studies indicate persistently low uptake of cervical cancer screening services in low and middle income countries, Uganda inclusive (Catarino R, 2015). Presently < 10% of women in Uganda are screened pointing to an urgent need of increasing screening uptake among ladies in the reproductive age.

Purpose of the Initiative: Cervical cancer is the most common diagnosis among patients in Rays of Hope Hospice Jinja (RHHJ) with around 42% of all women with cancer suffering from this disease. RHHJ has since 2018 offered free screenings for cervical cancer in the community with > 6000 women screened - in 2022 alone RHHJ screened 2906 women with 4.7% of women VIA positive for precancerous cells and treated on site.

Aim: To highlight effective strategies that boost cancer cervix screening among women in reproductive age.

Approach: The major mobilization strategies include door-to-door sensitization done by Village Health Teams and sensitization drives in the community to create awareness. Use of mass gatherings in churches, mosques, and markets, use of community radios and megaphones to provide information in hard-to-reach areas.

Lesson learnt: Effective mobilization ensures high turn up. It dispels myths and empowers ladies to make guided decisions about their own health. Male involvement is important since they are responsible for decision making in families. To ensure maximum uptake of the service, strategies must be tailored to the target audience and environment.



73: A Survey of Attitudes Relative to Engagement in Cancer Screening and Prevention Practices in Uganda.

Authors: *Nantayi Martha¹, Arlyce Coumar¹, Briana Sanger¹, Kathleen Shannon Dorcy¹,*

Affiliation: *¹Uganda Cancer Institute*

Background: Accessibility to health promotion education is essential for equitable cancer prevention, screening, early detection, and intervention. Cervical cancer (Cacx) is one of the most common Human Papillomavirus (HPV) infection-related cancers and ranks as the most common cancer among women in Uganda. Data from the 2021 International Agency for Research on Cancer report 6959 new Cacx cases and 4607 deaths. Women in Uganda, both in urban and rural communities, do not seek regular health screening, which could help eliminate many cancers and associated suffering.

Aims: To identify barriers to awareness of the need for HPV and cancer screening for women. Provide accessible health education, screening, and prevention services for women.

Methods: In 2022 Hutchinson Cancer Research Institute Uganda (HCRI-U) community outreach team conducted 16 informational interviews of women ages 27-66 years old about their understanding of the HPV vaccine and obstacles to HPV regular annual screening. Analysis of the data from this empiric study demonstrated the existence of barriers in understanding sexual transmission of viruses and the relationship of HPV to Cacx.

Results: Women had perceptions of the vaccine as a form of family planning so discouraging parents from vaccinating their children. Implications of diagnosis of HPV, HIV, or cancer created a sense of mistrust between partners.

Conclusion: This study identified a need for greater accessibility to health education and services. Continued outreach work is critical for a comprehensive program of education and services availability and shared decision-making to vaccinate for HPV and decrease Cacx incidence and death rates in Uganda.



173: Cervical cancer screening among HIV-positive women in urban Uganda: a cross sectional study

Authors: *Najjuka Maria Sarah¹*

Affiliation: *¹Makerere University*

Background: Women living with Human Immunodeficiency Virus (HIV) are at a high risk for early development of cervical cancer. Adherence to cervical cancer prevention strategies in this population is vital for the early detection and treatment of cervical cancer. This study aimed to determine the prevalence and factors associated with cervical cancer screening among HIV-positive women attending an urban HIV care center in Uganda.

Methods: This cross-sectional study included 205 HIV-positive women receiving care at an urban HIV care center. An interviewer-administered questionnaire was used to capture sociodemographic information, history of screening for cervical cancer, and reproductive health characteristics. Logistic regression analysis was used to determine the factors associated with cervical cancer screening.

Results: Of the 205 HIV-positive women with a mean age of 37 that participated in the study, majority (98%) were aware of cervical cancer screening. Ninety participants (44%) had ever been screened for cervical cancer and only 33 (16.1%) had been screened in the past year. Obtaining information about cancer of the cervix and cervical cancer screening from health care professionals was significantly associated with higher levels of cervical cancer screening (adjusted odds ratio = 5.61, 95% confidence interval: 2.50–12.61, $p < 0.001$).

Conclusion: This study highlights the low prevalence of cervical cancer screening among HIV-positive women and underscores the role of health professionals as an effective source of information on cervical cancer and cervical cancer screening. Patient education programs in HIV prevention and care facilities should emphasize cervical cancer screening messages to enhance the uptake of screening services.



65: Using Multiple QI Interventions to Increase Cervical Cancer Screening Among Women Living with HIV (WLHIV) at St. Francis HCIII Migyera, Nakasongola District (Ug).

Authors: Kwefuga Stephen¹, Ssekimpi Lowlence¹, Nakagwa Goreth², Ssedyabane Godfrey², Byamukama Agaba³

Affiliation: ¹St Francis HCIII Migyera, ²Uganda Episcopal Conference, ³District Health Officer Nakasongola

Background: Globally, Uganda is among the top ten countries with the highest incidence of cervical cancer about 28.8/100,000 and ranked the second in East Africa with about 4301 deaths annually. WLHIV are at high risk of developing cervical cancer due to lowered immunity, because of this, the government has prioritized cancer screening and treatment among WLHIV. At St. Francis HC III Migeera, 159 WLHIV aged 25-49 years eligible for cervical cancer screening by Nov-2021 were not screened. This was due to insufficient knowledge and skills amongst the health providers, lack of equipment and tools to use, lack of awareness on CaCx screening, and fear from the service recipients.

AIM: Multiple QI interventions were initiated with the aim of increasing CaCx screening from 0% in November 2021 to above 75% by the end of September 2022.

Method: Interventions implemented included: Re-training of staff on cervical cancer screening, developing an annual CACX work plan, line listing of all eligible WLHIV, and visible stickers placed on the files to act as a reminder. Conducting real-time screening of eligible clients, screening camps at the facility level, and community outreaches to scale up cervical cancer screening as well as continuous education talks on the benefits of cervical cancer screening and weekly monitoring of performance against the expected weekly targets.

Results: Between November 2021 to September 2022, out of 159 eligible women, 129 WLHIV were screened for cervical cancer using VIA (79.2%), of which 7 (5.5%) were positive for precancerous lesions. 1 of the 7 was referred due to suspected cancer and the 6 were treated with thermos-coagulation. The interventions significantly increased CaCx screening from 0% to 79.2% by end of September 2022 and achieve our annual target by 107.5%

Conclusion: Although cervical cancer is a silent killer, its mortality rate can be reduced through early detection of precancerous lesions.



76: Increasing Cervical Cancer Screening Among People Living with HIV/AIDS in Kyere Sub-County, Serere District

Authors: Awany Bosco¹

Affiliations: Kyere Health Centre 3

Introduction: Globally, cervical cancer (CxCa) is the fourth common cancer in women with an estimated 604000 new cases and 342,000 mortality reported in 2020. 90% occur in (LMICs). (WHO, 2020). In Uganda, CxCa estimates indicate that 6959 women are diagnosed with CxCa and of those 4607 die from the disease (Fact Sheet, 2023). Although there has been a gradual decline in cancer-related incidence and mortality, cervical cancer still imposes a significant burden on health systems as 80% of the CxCa cases diagnosed annually in Uganda present with advanced disease, cervical cancer screening programs can reduce incidence and mortality.

In Kyere H/CIII, a performance review showed that the majority of clients attending the Anti-Retroviral Therapy clinic were not screened for cervical cancer and yet they are more prone to infection.

Method: Using a client care card, the CQI committee members during the performance review meeting reviewed all the files to sort eligible clients for cervical cancer screening.

The team found that all the clients attending Kyere Health Centre III ART clinic were not screened for cervical cancer due to a knowledge gap, and untimely listing.

Results: The trends improved from 0% in December 2022 to 92% by April 2023 with 11.4% early detection.

Discussion: Cervical cancer screening has not been embraced by different healthcare workers which could be due to knowledge gap and lack of training, awareness by the community.

Conclusion: In order to prevent advanced cancer disease, mass mandatory screening for cervical cancer should be conducted periodically. Health workers should be equipped with knowledge, skills and equipment to timely and routine screening at all levels of care bringing services closer to the community.

Lesson learnt: Women have the fear related to cervical cancer screening.

There is still a knowledge gap among health care workers on cancer screening.



156: Evaluation of Palliative Care Services

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Affiliation: *¹Mbarara Region Referral Hospital*

Background of the study

This study addresses the global need for palliative care, with over 40 million individuals requiring such care annually. The World Health Organisation reports that only 20 out of 234 countries have well integrated palliative care services, while 42% have no services at all and 32% have only isolated services. When implemented early, it not only improves patients' quality of life but also reduces unnecessary hospitalizations and healthcare utilization. However, there is a significant gap in the availability of validated measures for pediatric patients in developed countries, despite approximately 8 million children requiring specialized pediatric palliative care. Cancer is identified as the second leading cause of death globally, responsible for over 25,000 deaths in 2015, with about 80% occurring in developing countries like Nigeria, Botswana, and Ethiopia. Without appropriate screening, treatment, and prevention measures, cancer-related deaths are projected to increase by 25% in the next decade. In Uganda, there is a need to train healthcare staff and involve senior hospital personnel in order to effectively integrate palliative care. The Mobile Hospice Mbarara, a branch of Hospice Africa Uganda, aims to provide palliative care services in the western part of the country.

75: Barriers to and Facilitators of Prostate Cancer Screening Among Men in Uganda Prisons: Findings from A Survey of 2565 Prisoners

Authors: *Jackson Orem¹; Lynn Atuyambe²; Alfred Jatho¹; Annabella Habinka Basaza-Ejiri³; Innocent Atuhe³, MSc; Babra Nalwadda⁴.*

Affiliation: *¹Uganda Cancer Institute, ²Makerere University, ³King Caesar University, ⁴Uganda Cancer Fund*

Background: This study aimed to quantitatively examine the perceptions, attitudes and beliefs of men in Uganda Prisons regarding barriers to and facilitators of Prostate Cancer (PCa) screening.

Method: We used findings from a qualitative study to inform a survey conducted in August 2022 among 2565 prisoners from the four major regions of Uganda selected using a simple random sampling technique.



Results: The survey that enrolled a total of 2565 participants with a mean age of 50.2 (9.8), indicated that most male inmates felt it would be better to make PCa screening mandatory for all eligible men in prison. The majority of the participants noted that what might drive them to seek PCa screening are; when they feel pain while urinating, if treatment is free for prisoners diagnosed with prostate cancer and if prostate cancer screening services are available in prisons. In addition, making services for Prostate cancer screening free of charge and provision of counselling services to the prisoners were viewed by the majority as the main motivators for PCa screening. The barriers to Prostate cancer screening were mainly myths and beliefs that may influence PCa screening practices. Besides, by the majority, the best way of helping men in Uganda prisons to get screened for PCa was training the prison medical staff on how to screen for Prostate cancer, equipping the prison health facilities with prostate cancer screening supplies, and working with the Uganda prison service (UPS) to train & equip Prison Health Centers to screen for prostate cancer.

Conclusions: Consideration should be given to developing interventions to increase awareness among the inmates, the prison health system, and the healthcare professionals regarding the importance of their role in facilitating prostate cancer screening while ensuring that the prison health facilities are equipped with the required screening logistics.

87: Infection-Related and Lifestyle-Related Cancer Burden in Kampala, Uganda: Projection of the Future Cancer Incidence up to 2030

Authors: Judith Asasira¹; Thi Xuan Mai Tran^{2,6}, Collins Mpmami¹, Henry Wabinga^{3,4}, Yikung Park, ScD, Hyunsoon Cho^{2,5,6},

Affiliation: ¹Directorate of Research and Training, Uganda Cancer Institute ²Department of Cancer Control and Population Health, Graduate School of Cancer Science and Policy, National Cancer Centre, Goyang, Republic of Korea, ³Kampala Cancer Registry, ⁴Department of Pathology, Makerere University, Division of Public Health Sciences, ⁵Department of Surgery, Washington University School of Medicine, St. Louis, MO, United States of America, Division of Cancer Registration and Surveillance, ⁶National Cancer Control Institute, National Cancer Centre, Goyang, Republic of Korea.

Objectives: In Uganda, infection-related cancers have made the greatest contribution to the cancer burden in the past; however, the burden from lifestyle-related cancers has increased recently. Using the Kampala Cancer Registry data,



we projected the incidence of the top five cancers, namely, Kaposi sarcoma (KS), cervical, breast, and prostate cancer, and non-Hodgkin's lymphoma (NHL) in Uganda.

Main outcome measure: Cancer incidence data from 2001-2015 was used and projected to 2030. Population data was obtained from the Uganda Bureau of Statistics. Age-standardized incidence rates (ASR) and their trends over the observed and projected period were calculated. Percentage change in cancer incidence was calculated to determine whether cancer incidence changes were attributable to cancer risk changes or population changes.

Results: It was projected that the incidence of KS and NHL continue to decrease by 22.6% and 37.3%, respectively. The ASR of KS was expected to decline from 29.6 per 100,000 population to 10.4, while ASR of NHL was expected to decrease from 7.6 to 3.2. In contrast, cervical, breast, and prostate cancer incidence were projected to increase by 35.3%, 57.7%, and 33.4%, respectively. The ASRs of cervical and breast were projected to increase up to 66.1 and 48.4 per 100,000 females. The ASR of prostate cancer was estimated to increase from 41.6 to 60.5 per 100,000 males. These changes were due to changes in risk factors and population growth.

Conclusion: Our results suggest a rapid shift in the profile of common cancers in Uganda, reflecting a new trend emerging in low- and middle-income countries. This change in cancer spectrum, from infection-related to lifestyle-related, yields another challenge to cancer control programs in resource-limited countries. Forthcoming cancer control programs should include a substantial focus on lifestyle-related cancers, while infectious disease control programs should be maintained.

81: Characterizing Oncology-Related Emergencies Among Cancer Patients Attending the Emergency Unit Of Uganda Cancer Institute, Kampala, Uganda in 2019.

Authors: Hanifah Nabbanja¹, Derrick Bary Abira², Henry Ddungu¹

Affiliation: ¹Uganda Cancer Institute ²Makerere University

Background: Cancer is not diagnosed until a related condition emerges, and oncologic emergencies occur at any time from presenting symptoms to end-stage disease. Oncologic emergencies are life-threatening, and associated with high mortality, and with currently available new cancer treatment strategies, survival has been prolonged, but this has increased the number of cancer-related emergencies leading to many visits to the emergency department.



Objective: The study described clinical presentations of oncology-related emergencies and associated factors among cancer patients attending the emergency unit of Uganda Cancer Institute (UCI).

Methods: It was a retrospective cross-sectional study that reviewed patients' medical records as well as files of patients who attended the emergency unit of Uganda Cancer Institute from January 01, 2019, to December 31, 2019. Two data sources were used; the register of patients at the emergency unit, and patients' files who received care at the emergency unit of UCI in 2019. Data was analyzed using SPSS and statistical analysis. The chi2-test was used to investigate significant relations between oncology emergencies and patient characteristics.

Results: 768 patients were included with a mean age of 49 years, 65.6% females, 59.6% were new patients at the UCI and 20.4% had stage 3-4 tumors. Among 768, 57.9% were admitted after resuscitation, 13.5% of whom died. The factors associated with oncology emergencies were age at first diagnosis, gender, blood counts and clinical presentation. The most presenting diagnoses were breast carcinoma, leukemia, Kaposi's sarcoma and clinical findings revealed 78.1% had generalized body weakness, 72% had anemia, 52.1% dehydration and 42.6% had lymphadenopathy.

Conclusion: Majority of the patients had lived with symptoms for weeks before seeking treatment therefore development of education programs about common oncology related emergencies targeting cancer patients and caregivers could promote early identification of common life-threatening oncology emergencies and prevent complications among cancer patients in Uganda.

113: A Study to Determine Factors Leading to Delayed Presentation for Treatment by Cervical Cancer Patients

Authors: Maria Kapuya¹, Tendai Lionel Chisamba¹, Lomtunzi Chidziwa¹

Affiliation: 'Parirenyatwa Group of Hospitals

Background: Cervical cancer is one of the most common cancers amongst women in Zimbabwe and the fourth most frequent cancer in women worldwide. Bearing in mind that early detection saves lives, screening methods are offered around the country, but still, Cervical cancer patients present in stages three and or stage four.

Aim: To determine factors that led to the late presentation of cervical cancer patients for treatment.



Method: Qualitative research was done. Inclusion criteria included all female patients who presented at the Oncology Outpatients Department with cervical cancer stages three and four in 2022. Fifty patients were interviewed by use of questionnaires and oral interviews. The questionnaire included demographic data and factors that led to the late presentation.

Results: The results showed that sixty percent of patients had no money to seek treatment after a positive VIAC result. Five percent were referred late from primary health care facilities. Twenty percent stays far from health care facilities which makes it difficult for them to go for early screening. Three percent had no knowledge on disease and its treatment modalities. Ten percent had some cultural beliefs which hindered them from seeking medical treatment for cancer as they believed that it is a disease which should not be given scientific medicines.

Conclusion: The results showed that the prevalence for late-stage presentation of cervical cancer in Zimbabwe is on the rise. Cultural beliefs, reduced level of education, financial constraints, unemployment, late referrals and place of residence far from clinics are associated with late-stage presentation of cervical cancer.

182: Estimation Of Cancer Incidence In Eastern Uganda, 2015-2019

Authors: Catherine Amuge^{1,2}, Judith Asasira², Nixon Niyonzima¹, Annet Nakaganda², Dr. Jackson Orem¹

Affiliation: ¹Uganda Cancer Institute, ²Mayuge Cancer Registry

Background: Estimating the cancer burden is essential for planning cancer control and prevention Programs. To estimate the true cancer burden in the eastern part of Uganda after Mayuge being ranked 3rd from cases registered at the Uganda Cancer Institute, Mayuge cancer registry (MCR) which is a population-based cancer registry was established in Mayuge district in 2017. The aim of this study is to estimate the cancer incidence in Eastern Uganda by calculating the age standardized rates (ASR) using population-based data.

Methods: MCR collects data from 7 districts ((Mayuge, Namayingo, Iganga, Bugiri, Bugweri, Namutumba and Luuka). Data is collected from hospitals, laboratories and hospice centers in the given districts and some from Kampala where most people seek better health services including the Uganda cancer Institute which is the national cancer Centre. Data is collected on the case registration forms, coded using the international classification of diseases for Oncology (ICD-O3). It is then entered, validated, stored and analyzed using the CanReg5 software provided by IARC. Descriptive statistics were analyzed using Stata software version 15.



Results: A total of 1646 cases were registered 2015-2019. Of these, 68% (1116/1646) were females. Among males, the most incident cancers in terms of ASR (per 100,000) were prostate (4.1), esophagus (2.5), lymphoma (1.5), mouth and pharynx (1.0) and liver (0.8) while among females; they were cervix (17.8), Breast (3.5), corpus and uteri (1.3) Esophagus (1.2), colorectal (1.1). The overall %MV was 33.1, with Leukemia having the highest (91.3) and pancreas having the least (0.0%).

Conclusion: Cervical, Breast, prostate, esophagus and lymphomas are the most incident cancers registered at MCR among adults.

TRACK 5: Psychological, social, and spiritual care

164: Establishment of Care Giver Dilemmas in West Nile

Authors: *Candia Richard¹*

Affiliation: *¹Spiritual care giver*

Background: Caregiving is a common role in hospitals, clinics and homes. Yet, as important as the role is, the challenges faced by caregivers are often overlooked. West Nile has over 3000 patients registered at the Palliative care unit in Arua Regional hospital. NELIHA volunteers in Arua visit an average of 150 patients in a year, about 10% of home care patients, besides this; the religious leaders/associates often care for patients within their zones through prayers, visits and offering material support in some occasions, however, limited time is availed to the caregivers.

Aim: Therefore, this study seeks to investigate the dilemmas caregivers encounter while offering hospital and home-based care. The study will adopt a mixed research approach, qualitative and quantitative methods, using a literature review, interviews, and questionnaires as means of data collection.

This will help to identify the relations of the caregivers, understand which category of relatives contribute most in caregiving, areas of unmatching between the patient and the caregivers as it is often a concern for the patients when the caregivers make choices on their behalf which affects their psychosocial wellbeing beside the burden of the sickness, finances among others.



163: Spiritual Care in Palliative Care in Uganda

Authors: *Bernadette Basemera¹, Mark Donal Mwesiga¹, Lisa Christine Irumba¹, Fiona Sima¹*

Affiliation: *¹Palliative Care Association of Uganda*

Goal of the work: Spiritual care is an important component of palliative care (PC), but it has been understudied and overlooked in low- and middle-income countries, particularly in Africa. In this consultative work, we sought to identify current spiritual care practices in palliative care settings in Uganda, with a focus on identifying gaps in spiritual care provision and establishing the next steps.

Approach taken: We explored spiritual care practices in Uganda through a consultative meeting and telephone discussions with palliative care practitioners. A consultation meeting with 20 key stakeholders, including spiritual leaders, hospice workers, Ministry of Health officials, and academicians, was convened. Discussions were also held with 12 healthcare professionals over the telephone.

Results: Some of the current spiritual PC practices include asking questions about spiritual issues during assessment, which questions adapted from the Hospice Africa Uganda case sheet, praying with patients when requested, and referring patients to their own spiritual leaders. The major gap in spiritual care provision is limited knowledge of the assessment and management of spiritual issues.

Next Steps and Lessons Learned: Based on the findings, the professionals require additional training in spiritual caregiving. The PC education curriculum should be enhanced with more detail on spiritual care and practical sessions from experienced professionals. PCAU should form a technical working group composed of its partners to formulate a module that can be incorporated into the PC education curriculum. Having specially trained spiritual care providers on the team will improve the holistic management of palliative care patients.

180: Empowering Child Caregivers Through Psychosocial Support to Promote their Mental Health and Well-Being

Authors: *Anita Balikobaku¹, Lisa Christine Irumba¹, Joyce Zalwango¹, Mark Donald Mwesiga¹*

Affiliation: *¹Palliative Care Association of Uganda*

Background: According to the National Child Policy 2020, over 24,063 children are heading households in Uganda on top of taking care of their parents who are



suffering from a life-limiting illness. This is done with or without assistance from their extended family and community members. The situation has compelled these children to engage in odd jobs to support their families and indulge themselves in dangerous and immoral behaviors as well as forfeiting education. The Palliative Care Association of Uganda (PCAU) in partnership with the Center for Hospice Care in Indiana USA under the Global Partners in Care established the Road to Hope program in 2012 to address, empower, and support child caregivers.

Aim: To support child caregivers from financially poor backgrounds to access education and basic needs while caring for their chronically ill parents.

Approach Taken: PCAU worked with palliative care providers to identify, assess, and enroll children on the program.

Provided child-headed families with holistic care through educational, psychosocial, medical, basic needs, spiritual support, and palliative care services for the ill. Mental health and well-being is supported with annual empowerment camps to build children's life skills. Offered mentorship, support supervision and an available dedicated telephone for them to call anytime.

Results: From 2012 to date, PCAU supported at least 64 child caregivers from 39 families in 21 districts with educational, psychosocial, medical, spiritual, basic needs and access to palliative care for the ill. 7 children have graduated in various professions like Medicine and Surgery, Community Development, Electrical, Accountancy, Hairdressing, Catering, Tailoring and are employed. Access to structural intervention where 4 houses were constructed to shelter critically vulnerable children. Improve children's self-esteem through empowerment camps.

Conclusion and Lessons Learned: The integration of psychosocial support in empowering child caregivers facing numerous challenges amidst taking care of their ill parents is key in addressing issues of mental health and the well-being of children's upbringing.



TRACK 6: Family and community involvement and empowerment

127: Impact of Cancer Diagnosis Among Care-Givers of Paediatric and Adolescents Parirenyatwa Ward A4 Special, Zimbabwe

Authors: *Lomtunzi Chidziwa¹*

Affiliation: *¹Parirenyatwa Group of Hospitals*

Background: Approximately 293 children/adolescents a year are diagnosed with cancer in Zimbabwe all are treated at Parirenyatwa Group of Hospitals, the largest tertiary and referral hospital. Twenty nurses provide care in Ward A4 Special. More Caregivers are key in the delivery of paediatric palliative care. The World Health Organisation has acknowledged the significance of family care for sick children, especially in cases of cancer and chronic diseases.

Aim: Identify the impact of cancer diagnosis among caregivers of paediatric and adolescents with cancer at PGH.

Methods: This cross-sectional study was conducted with caregivers of children with cancer. Eligibility criteria: 20-40 years speak English, Ndebele or Shona, and no other cognitive deficits. A researcher-developed questionnaire based on a topical literature search was created in collaboration with other hospital-based palliative care specialists. The questionnaire included 4 items, each scored on a Lykert-type scale (1-5) and was given to the caregivers to complete anonymously at the hospital.

Results: A total of 50 caregivers participated (10 male and 40 female). All of them (100%,n=50) expressed that they were extremely devastated when they heard their child's diagnosis (80%,n=40) majority were financially drained by treatment the treatment requirements (60%n=30) were still struggling to cope with the diagnosis (50%,n=25) indicated burnout from long term care.

Conclusion: This study provided evidence that the caregivers of children and adolescents with cancer in Zimbabwe were extremely devastated due to the child's illness and funding of the child's treatment. As health care providers and nurses specifically, we need to empower caregivers with information about cancer and management from the point of diagnosis throughout the continuum of care. The provision of more effective counseling and support should be an ongoing process to avoid burnout. Lobbying for financial assistance could benefit the patient and the caregivers.



176: A Ugandan Father's Experience of the Childhood Cancer Treatment Journey

Authors: *Joseph Kkeeya Mwanje¹*

Affiliation: *¹Ahavah Child Cancer Care Uganda*

Background and Aims: She was diagnosed with either Malaria or Typhoid but treatment was never effective. We were eventually referred to Uganda Cancer Institute where she was diagnosed with Leukemia. There we began the three-year ordeal of Chemotherapy. Hundreds of pills a week didn't offer much relief from the excruciating pain. We made endless hospital visits sometimes up to five visits a week lasting from four hours to a full day. I eventually had to quit my job to manage. Having our finances down to half I had to seek financial assistance from wherever possible. We came across a lot of challenges during her treatment including an overwhelmed medical team, lack of accommodation for patients and caregivers, lack of support drugs, and poor nutrition. Valarie lost all her hearing during treatment. She is now cancer-free and remains extremely optimistic that she will one day hear again. She is now homeschooled but misses her peers dearly.

From mine and other parent's experiences, an Organisation called Ahavah Child Cancer Care Uganda run and funded by parents and sympathizers was formed. Our mandate is to provide additional support to the amazing medical workers on the ground in order to close the gap during treatment by providing as much nonmedical support to families with children still going through the treatment journey as possible so that they can have a better and less burdensome experience.

Results: Formation of a support Organisation for children going through cancer treatment and their families (Ahavah Child Cancer Care Uganda).

Conclusions: There is a large gap in care for children suffering from cancer in Uganda and with support and assistance from SIOP and CCI, Ahavah Child Cancer Care Uganda can make a truly significant difference in lessening the treatment burden on parents and families with children going through cancer treatment.



181 Effect of Patient Navigation Program Services on Patients' Experience of Cancer Care and Adherence to Treatment at UCI.

Author: *Obote Amos¹, Fatina Tina Nakalembe¹*

Affiliation: *¹Uganda Cancer Institute*

Objective: The UCI-Patient Navigation Program (PNP) is a quality improvement intervention providing individualized Care to Patients, Caretakers, and families to enable them to overcome Barriers to Cancer Care and Improve access to Care. The program was designed and implemented with the support of the American Cancer Society. Through Physical and Clinical Navigation, targeting adult Cancer Patients accessing Care and starting treatment for the first time, and Resource Mobilization, the program has improved the quality of cancer care and transformed general Uganda Cancer Institute staff attitudes towards patient-centered care. This presentation describes different successes the program has achieved in improving patients' experience of care and also shows some challenges faced by the program.

Method: External evaluation was done after one year of program implementation by the hired team of non-Uganda Cancer I staff called Bixal who interviewed patients on service delivery after the program and they shared their results with Uganda Cancer Institute.

Results: Clinical navigators are contributing to patient understanding of their disease. Many patients described clinical navigators explaining their diagnosis, treatment and also supporting them in their psychosocial problems. This was reported as having increased patients' adherence to treatment to a great extent. Patients reported being more involved in decision-making about their treatment and were happier with the explanations. They further reported physical navigators to have helped them find the right service points timely.

Locating and accessing service points at UCI was not easy for patients before the PNP to the extent that only 19% of respondents at baseline reported to have found it very easy locating service points as compared to 71% at the second annual survey.

Conclusion: PNP was a long-awaited intervention that has streamlined service delivery at UCI. Indeed, through Resource mobilization, and clinical and physical navigation, the program has reduced barriers to patients' care, improved the experience of cancer care and increased patients' adherence to appointment schedules as well as treatment at UCI. Increasing the number of staff giving this kind of service means all cancer patients will then be reached.



175: Prevalence, Trends, and Distribution of Lifestyle Cancer Risk Factors in Uganda: A 20-year Systematic Review

Author: *Annet Nakaganda¹, Immaculate Mbarusha¹*

Affiliation: *¹Uganda Cancer Institute*

Background: Cancer is becoming an important public health problem in Uganda. Cancer control requires surveillance of lifestyle risk factors to inform targeted interventions. However, only one national Non-Communicable Disease (NCD) risk factor survey has been conducted in Uganda. This review assessed the prevalence, trends, and distribution of lifestyle risk factors in Uganda.

Methods: The review identified studies up to January 2019 by searching Medline, Embase, CINAL, and Cochrane databases. Further literature was identified from relevant websites and journals, scanning reference lists of relevant articles, and citation searching using Google Scholar. To be eligible, studies had to have been conducted in Uganda, and report prevalence estimates for at least one of the lifestyle cancer risk factors. Narrative and systematic synthesis was used to analyze the data.

Results: Overall, an unhealthy diet (88%) was the most prevalent lifestyle risk factor for both males and females, followed by alcohol use (range of 14.3% to 26%) for men, and being overweight (range of 9% to 24%) for women. Tobacco use (range of 0.8% to 10.1%) and physical inactivity (range of 3.7% to 4.9%) were shown to be relatively less prevalent in Uganda. Tobacco use and alcohol use were more common in males and more prevalent in the Northern region, while being overweight (BMI \geq 25kg/m²) and physical inactivity were more common in females and more prevalent in the Central region. Tobacco use has decreased over time while being overweight increased in all regions and for both sexes.

Conclusion: Apart from tobacco use, other lifestyle risk factors seem to be increasing in Uganda and vary among populations. Prevention of lifestyle cancer risk factors requires targeted interventions and a multi-sectoral approach. Most importantly standardization of the measurement of cancer risk factors should be a top priority for future research in Uganda.

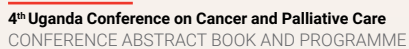


Recognition, and Acknowledgements

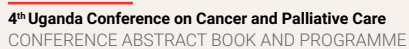
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