How to Integrate Palliative Care Into Primary Health Care

Mercy Wanjiku Wachiuri
Nakuru Level 5 Teaching and Referral Hospital, Nakuru, Kenya

Integration of Palliative Care into Primary Health Care will have a substantial amount of positive impact on Health Care in Nakuru County, Kenya. Consequently, all aspects of Palliative Care should be given to more than 2/3 population that suffer from cancers and chronic illnesses which sometimes overflow to some acute conditions. While Palliative Care focuses on Holistic Care encompassing physical, psychological, social, and spiritual aspects to adults and children, Primary Health Care operates on the principles of equity, solidarity, universal access to services, multisectoral action, social justice, centralization, and community participation. Thus, there are similarities in Palliative Care and Primary Health Care putting into consideration that the latter is based on practical, scientifically sound and socially accepted methods and technology. It is affordable, universally accessible to individuals and families in the community. Universal Health Coverage ensures that all people and communities have access to promotive, preventive, curative, rehabilitative, and palliative health services they need, of sufficient quality to be effective while also ensuring that the use of these services does not expose the users to financial hardships. The 60% of the Nakuru County population are in need of Palliative Care services, but only about 20% access these services. They suffer from cancers, non-communicable diseases, dementia, and frailty. Geographical challenges, staff shortages, and lack of Palliative Care knowledge are the main barriers to provision of care.

Keywords: integration, palliative care, primary health care, universal health coverage

Introduction

Nakuru County covers an area of 7,495.1 square kilometres and is situated 156 kilometres East of Nairobi, capital city of Kenya and Nakuru Town is the capital of Nakuru County. Nakuru County number 032 is located in the Great Rift Valley region and borders Baringo County to the North, Laikipia County to the North East, Nyandarua County to the East, Kajiado County to the South, Narok County to the South West with Bomet County and Kericho County to the West (see Figure 1).

The county government’s top leader is the governor assisted by his deputy and a senator. Nakuru County is 1,850 meters or 6,050 feet above sea level and its time zone is UTC+3(EAT). The main activities done by the people of this county are agriculture, manufacturing, and tourism which are the backbone of the economy. The GDP per capita according to Kenya Bureau of Statistics 2017 puts Nakuru in 2nd place following Nairobi with GDP of 517,462 million shillings equivalent to 10,333 million USD (Kaggikah, 2017). It consists of eight sub-counties and has eight counties in its environs all of which depend on the main county referral hospital for cancer care and other specialized treatments.

Mercy Wanjiku Wachiuri, Higher Diploma in Palliative Care, Oxford Brookes University, London, Fellow in Palliative Care, Institute of Palliative Medicine, Calicut, India; Department of Palliative Care, Nakuru Level 5 Teaching and Referral Hospital, Nakuru, Kenya.
Kenya has four-tier public health system (WHO, 2018), national referral and teaching hospitals, county referral and teaching hospitals, sub-county hospitals, and health centres. However, in our county we have four-tier public health system, county referral and teaching hospital, sub-county hospitals, health centres, and dispensaries. Currently, there are two hundred and seventy-eight government health facilities in the county with the flagship being Nakuru Level 5 Teaching and Referral Hospital. Others are four county hospitals, three sub-county hospitals, 43 level two (health centres), and 115 level one (dispensaries) distributed within the county.

The doctor to population ratio is 1:31,251. Ministry of Health is headed by the minister (CECM, County Executive Committee Member), deputized by chief officer of medical services and chief officer of public health. The chief officer of public health is the accounting officer of County Ministry of Health. There are also the director of public health, director of medical services, and director of administration and planning. The above do the administrative jobs of the health sector in Nakuru County (Health, 2017). There is a National Health Insurance fund at a cost of five dollars a month, but the majority of people are not able to subscribe, some not being consistent in paying due to instability in weather as most of them are small-scale farmers. Thus, there is need to integrate Palliative Care into Primary Health Care in order to increase financial risk protection, affordability and accessibility of care.

**Nakuru County**

**VISION:** A healthy county.

**MISSION:** To provide quality integrated services for all.

**CORE MANDATE** of the department of health is promotion, regulation, and provision of health care services to the people of Nakuru County.

**MANDATE:** To provide health services, create an enabling environment, regulate, set standards and policy for health service delivery.

**Aims**

1. To address the issues faced by 60% of the population who are suffering from cancers and chronic illnesses, and do not have access to Palliative Care especially due to long distances, poor infrastructure, and poverty in Nakuru County and its environs.

2. To mitigate or address the gaps in Palliative Care at Nakuru County up to primary level and in remote communities.

3. To develop a system of care inserted as a component integrated within the health care system in the context of Universal Health Coverage.

**Goals**

1. Improve patient outcomes by preventing and relieving the most common and severe types of suffering associated with serious or complex health problems.

2. Reduce costs for health care systems and for patients and family by reducing hospital stay at the end of life.

3. Promote Universal Health Coverage since it will cover even the community level.

Figure 1 below shows Nakuru County marked in yellow. It consists of Molo, Olenguruone, Rongai, Bahati, Mbogoini, Njoro, Nakuru Municipality, Gilgil, and Naivasha sub-counties.
Nakuru County has a population of 2,250,516 people. The 49% are male while 51% are female (see Figure 2) and they are covered by one hospice and two Palliative Care centres, which offer outpatient and inpatient Palliative Care services. There is challenge in community-based Palliative Care due to poor infrastructure.
Purpose

To provide top leadership of the county including minister of health, chief officers of health, directors of health, and other local leaders with the necessary information about the need of integration of Palliative Care services and steps of integration (implementation) into Primary Health Care.

Series 1

In the above Figure 3, it shows that 60% of Nakuru population suffer from cancers, malignancies, non-communicable diseases, cardiovascular diseases, dementia, and neurological conditions. This indicates that more than half of the population are suffering during illness and at the end of life. The remaining 40% are other illnesses which include acute illnesses for example malaria, pneumonia, and many more also including injuries. Palliative Care services are also occasionally needed in this area.
Strategy

Need is defined as the population’s ability to benefit from health care.

Assess the need for Palliative Care at county level by use of hospital data of inpatient and outpatient discharges, community health workers register, private hospitals and clinics, dispensaries, and carers of people living with chronic illnesses. Mortality data is also useful in estimating need (Gómez-Batiste & Connor, 2017).

Figure 4. Data of Nakuru County hospital incidences—2016.

Figure 5. Mortality data of non-communicable diseases—2016. Source: DHIS2.

Figure 4 above shows that in Nakuru County 2016, there were 619 patients suffering from different types of cancers, 598 had hypertension, 452 had diabetes, 282 had tuberculosis, 199 had stroke, 27 had spinal injury, 17 had renal failure, 15 had dementia, and 13 had paraplegia. All these people needed Palliative Care during the illness and at the end of life.
During 2017/2018 period, Nakuru County recorded 58% deaths that were caused by non-communicable diseases. The data above is the national average statistics which is at 55% and accounts for more than 50% of hospital admissions.

From Figure 5, hypertension leads in non-communicable diseases. This contributes to 50% of hospital admissions and over 40% of facility mortality.

Birth asphyxia and trauma is at 16.4%, endocrine disorders is 2.2%, protein calorie malnutrition is 1.8%. Diabetes accounts for 20% of the deaths and prevalence rate is between 3.1% and 4.6%. One in every 17 Kenyans has diabetes and 12,890 people died of diabetes and high blood glucose in 2017 (KNA, 2019).

Mortality data can be combined with population-based or setting based prevalence data, once systems have been described to identify patients in need of Palliative Care in all settings.

**NAKURU LEVEL 5 COUNTY & REFERRAL HOSPITAL INCIDENCE DATA 2018 - 2019**

![Figure 6. Nakuru Level 5 County Referral and Teaching Hospital incidence data (2018-2019).](image)

Figure 6 above shows data in Nakuru Level 5 Hospital during 2018-2019. The hospital recorded 1,435 cases of different cancers, 1,117 had diabetes, 403 had hypertension, 391 had rheumatoid arthritis, 366 had drug resistant TB, 162 had chronic obstructive pulmonary disease, 26 had paraplegia, 17 had dementia, and 6 had cardiovascular disorders. This is an indication of the great need of Palliative Care in the county since most of them experience suffering during the disease progression and at the end of life.

**Profile of Kenya’s Health and Illnesses, 2020 (PAHO/WHO, 2020)**

Total population 2019—52,573,967
Total cancer patients 2018—47,887
Total number of cancer death 2018—32,987
Premature deaths from NCD 2016—31,607
Cancer as % of NCD premature deaths 2016—51.3%

Population Attribute Fractions (PAHO/WHO, 2020)
Tobacco (2017)—8.8%, alcohol (2016)—5.9%, infections (2012)—31.3%, obesity (2012)—1.1%, ultraviolet (2012)—22.9%, occupational risks (2017)—0.8% (see Figure 9).

Figure 7. Most common cancer cases (2018) in Kenya.

Figure 7 above shows cancer occurrences in Kenya. Breast cancer is the most common at 12.5% followed by cervix-uteri at 11%, cancer of oesophagus at 9.1%, Kaposi sarcoma at 6%, prostate at 6%, colorectum at 4.8%, stomach at 4.4%, non-Hodgkin’s lymphoma at 4.1%, leukemia at 3.5%, and liver cancer at 2.8%. This is a reflection of occurrences in Nakuru County which shows how much Palliative Care is needed to alleviate suffering of the people.

Figure 8 below indicates Kenya’s mortality rate due to cancer which is also a reflection of Nakuru County. Cancer of the oesophagus has the highest mortality rate at 13.2%. Most of the patients avail themselves when they are not able to swallow anything, thus having depression because they are not able to do one of the most basic things in life and die when they desperately need Palliative Care. Cancer of the cervix-uteri at 10%, breast at 7.7%, stomach at 6.3%, prostate at 5%, colorectum at 4.4%, leukemia at 4%, liver at 4%, non-Hodgkin’s
lymphoma at 3.7%, and Kaposi sarcoma at 2.8%. All these patients usually have many Palliative Care needs at the time of death and need Palliative Care, including their families who are also in need of bereavement care.

**Figure 8.** Mortality data in Kenya—2018.

**Figure 9.** Population attribute fractions.
The above data is a clear indication of the need to educate and sensitize the population. With knowledge, they will be able to avoid the risk factors and to seek treatment early in case illness strikes. The incidence of advanced disease will be reduced, and this will reduce financial risks.

Figure 10 shows incidences of childhood cancers in Kenya (WHO, 2020).

**Figure 10.** Incidences of childhood cancers in Kenya.

When taking data, it is necessary to take into consideration the following symptoms (WHO, 2016):

- Physical care needs
  - All types of pain
  - Dyspnoea, cough
  - Constipation, nausea, vomiting, dry mouth, mucositis, diarrhoea
  - Delirium
  - Wounds, ulcers, skin rash, and skin lesions
  - Insomnia
  - Fatigue
  - Anorexia
  - Anaemia
  - Drowsiness
  - Sweating

Psychological/emotional/spiritual care needs:
- Psychological distress
- Anxiety
- Suffering of family caregivers
• Spiritual needs and existential distress
• Depression
• Bereavement support for family/caregivers

The above data will be used to gather political will, commitment and support by engaging county governor, minister of health, and local leaders at county level.

Once authorization has been given, a committee involving county minister of health, hospital in charge, doctor, nurse, pharmacist, and public health officer will be formed to arrange for a foundation meeting and develop a work plan.

Foundation meeting is an excellent way to formalize the start of a program. It brings together all the main stakeholders to achieve a consensus on the principles, aims, and agendas. The group should be interdisciplinary, consisting of: ministry of health officials, doctors representing physician, paediatrician, oncologists, and surgeons, nurses, psychologists or counsellors, social worker, chaplains, legal providers, physiotherapists, occupational therapists, pharmacists, nutritionists, advocacy group representatives, competent narcotic authorities, and donors to educate them and inform them and to get their buy in. The group should represent different settings: hospitals, primary care, long term care, rural/urban, home based and community.

The use of available platforms for advocacy at county level through media, churches, mosques, chiefs, schools, roadside shows and technology is key to achieve good awareness.

Media platforms are radio and television, radio being more popular because of affordability. Technology in terms of Facebook, Twitter and WhatsApp is very popular to the younger population.

There is need to review the existing work plan and guidelines and if necessary, create new ones. There is also a need to re-define Palliative Care and to establish what it needs so that everybody understands the scope of the care. This will improve the general understanding of Palliative Care to the administrative, technical, and even the general population. It improves implementation, service delivery, and even in supplies of essential medicines and commodities.

Revision of the existing guidelines and strategies is important since our country’s Palliative Care policy is not complete yet. After reviewing the necessary inputs, Palliative Care projects can be established and put in place. Measures will also be put in place to mitigate the gaps shown.

In Kenya, currently we are using guidelines adopted from strategic plan (2017-2022) (Ministry of Health, 2017) from cancer. In Pillar 3 is where there is cancer treatment, Palliative Care, and survivorship. The goals of treatment are cure, prolongation of life, and improvement of quality of life. Most of the times, we do not achieve cure because 70%-80% of our patients are diagnosed late and are mostly for palliation. Treatment methods are palliative and supportive care, rehabilitation, end of life care, and survivorship. The most important goal which cuts across is to improve quality of life of patients and their families.

Strategic objective 3.2 is about improving standards for treatment and care for those with cancer. The second objective under this one is to develop and implement national guidelines for Palliative Care which is key in Palliative Care work. Emphasis is also put in end of life care and survivorship as most of our patients seek treatment when the disease has advanced. Revision of legislation is also important to enable smooth implementation. Human resource and infrastructure are also important in running the services. Inclusion of indicators is also important to allow monitoring and evaluation of services. Development of referral policy is important in service delivery.
Strategic objective 3.3 emphasizes in improving capacity for cancer treatment and Palliative Care services by providing infrastructure, equipment, and commodities. While planning for integration, it is important to consider the basic requirements needed.

Strategic objective 3.4 puts into a lot of consideration of the need to improve human resources for cancer treatment and Palliative Care services. First, importance is put on the need to train specialties for example Palliative Care. Support of training of health care workers is emphasized preferably on pain management, breaking bad news, end of life care, bereavement, Palliative Care, depression in cancer and sexual issues after treatment. Then deployment based on skills and competences is emphasized. To ensure smooth running of the programs, it is important to sensitize county health committees and hospital management committees. There is need to train health care workers on legal issues in Palliative Care as most of our patients are at end of life and have many legal issues.

Strategic objective 3.5 emphasizes optimizing treatment and Palliative Care for children with cancers. Effort must be put to provide services for palliative, rehabilitation, and survivorship in children.

Strategic objective 3.6 puts into consideration on how Palliative Care can improve quality of life for those living with, recovering from, and dying of cancer and their families through support and rehabilitation. Provide Palliative Care and pain relief services at all levels of care including community level (home based care) for very sick patients.

Enlighten who provides Palliative Care in the county currently by use of county’s database.

A list of who needs to be involved in Palliative Care has to be made so that it enables filling of the gaps of health care providers.

Establish who oversees the county’s changing profiles. This is in case of transfers, retirements, or even deaths of health care workers who work in Palliative Care projects. Good leadership will further mitigate any issues of staff deployment. The gaps should be addressed to enable continuity of service provision.

Enlighten who funds Palliative Care currently so as to enable room for more collaboration. For example, currently the government provides for human capital, that is the health care workers, space, equipment, and essential drugs. Non-governmental organizations help in trainings, supplies, for example colostomy bags, private institutions, and individuals assisting in Palliative Care events. However, hospices, private and faith-based hospitals employ health care workers, buy essential medicines and equipment, and provide any other requirements. Sometimes, they get assistance from donors and well-wishers.

Having all the above data, it is necessary to have Palliative Care budget included in the county’s budget and also to extend to Primary Health Care and Universal Health Care budgets.

**Minimum Package**

**Minimum Package, That Should Be Accessible to Primary Care Clinics at District or Community Level**

This is inclusive of a set of safe, effective, inexpensive, off-patent, and widely used medicines for symptom control (WHO, 2016). This may also include the basic analgesics, catheters, urine bags, thermometer, blood pressure machine, colostomy bags, and dressing materials. Simple and inexpensive equipment, basic social support are also needed, in terms of sometimes a few foodstuffs.

The human resources are needed to provide the medicines, equipment, and social supports effectively and safely. This may be a doctor to head the team, nurse, community health workers, and volunteers.
Other Equipments

Wheelchairs, walkers, and canes: to improve mobility and reduce the burden on family and other caregivers.

Dying Patients

Most of our patients are diagnosed when the disease has advanced and are at the end of life. Therefore, the sole goal of care at this time is comfort and to maximize quality of life. Preventing and relieving suffering of patients dying at home is an essential task for primary care providers. Aggressive efforts to alleviate pain and other symptoms are necessary to improve the quality of life. Bereavement support should be made accessible. Community health workers or volunteers with basic training may be able to offer this support.

Important Considerations

The mission of Palliative Care programs is to achieve Palliative Care networks inserted into the national health care system with principles of universal coverage, access, equity, and quality.

The vision consists of developing comprehensive health care systems to look after patients with advanced life threatening illnesses and life limiting conditions in order to promote their care and quality of life throughout the life course, in a context of universal coverage and promoting integrated people centered health care services.

It is important to include Kenya Hospices and Palliative Care Association (KEHPCA) in integration process. KEHPCA was registered in 2005 and since then it has advocated for integration of Palliative Care into health services in Kenya (KEHPCA, n.d.). It is the backbone of all Palliative Care work in Kenya and offers Palliative Care trainings to health care workers, provides colostomy bags and breast prosthesis in order to improve quality of life of patients. It also provides morphine powder and syrup to institutions in order to bridge the gaps. This in turn helps in mitigating one of the most depressing symptoms in patients, that is, “pain”.

As integration is implemented, all arrangements and systems should be put in place to reflect the above.

Palliative Care Roles in Primary Health Care

For successful integration of Palliative Care into Primary Health Care in our setting, the following should be considered:

• Care should be given taking into consideration our local needs and values. There are different cultures which should be put into consideration.

• Due to the geographical issues of far places, it should be made accessible to where patients are and would like to be, including their homes in the villages. Even patients in remote areas should access the care.

• Relief of suffering of any kind should be provided comprehensively. This includes physical, psychological, social, and spiritual. This should include care of emotional issues.

• Including co-ordination of these roles with health promotion, disease prevention, disease modifying, or rehabilitative treatment will further increase the success of integration.

• The care should be provided by health care workers who know the patient and family and who have accompanied the patient throughout the course of illness. Sometimes, it may be difficult in our settings; therefore, proper referral systems will further enable good follow-up.
Figure 11 below shows the importance of community participation. Integration will enable the care to start at the community level where there are communities, homes, dispensaries, and health centres. With proper referral systems, difficult cases will be referred to primary level and eventually to specialized care. Community based Palliative Care is central to integration of Primary Health Care and Universal Health Coverage.

**Community Participation**

Community health workers live in the same areas, towns, villages as patients and are able to visit them regularly if necessary. They need a few hours of training to be able to provide emotional support, to observe uncontrolled symptoms, unmet social needs, and improper use of medicines. They will need to report observations to the supervising nurse or clinician. If the patient needs more care, he or she can be taken to dispensary or health centre and proper referrals to be done if need be.

If community health workers are few or hardly available, then the use of volunteers can be done. They will be needed to assist the patients and families to complete the Edmonton symptom assessment form (Caritas Health Group, 2005) or use Palliative Care outcome assessment scale (Lind, Wallin, Fürst, & Beck, 2019) to enable monitoring of symptoms. Community health workers or volunteers should be provided with the forms and they should have been trained on how to score.

To be monitored are the following symptoms: pain, tiredness, nausea, depression, anxiety, drowsiness, appetite, wellbeing, shortness of breath, or any other problem. For Palliative Care outcome scale, pain, shortness of breath, weakness or lack of energy, nausea, vomiting, poor appetite, constipation, sore or dry mouth, drowsiness, and poor mobility are measured. The completed forms should be given to the nurse or clinician to enable symptom control. The results help to control symptoms when the patients are in their homes. Training of volunteers is very important, to enable symptom control even in the villages and communities.

**Essential Controlled Drugs**

It is important to ensure that essential drugs are accessible, available, and affordable. However, in Kenya, we have challenges as follows (KEHPCA, 2013):
Accessibility—Opioids do not reach patients as the majority of health care workers within easy access of patients are prohibited by law to prescribe opioids. As it is evident, majority of hospitals in Nakuru County are health centres and dispensaries and are run by clinical officers or nurses who are not allowed to prescribe morphine. Morphine is only stocked at Nakuru hospice, Nakuru county referral and teaching, and Nakuru county referral hospitals.

Availability—There are very few Palliative Care service provision sites in the county, one hospice and two Palliative Care centres which are 100 kilometres apart. They do not offer all components of Palliative Care and the only health workers allowed to prescribe morphine are doctors and they are very few.

Affordability—Most of the patients in Nakuru County are farmers and do not have regular income. Therefore, very few patients afford opioids. Tight legal controls on narcotics hinder the supply of opioids which results in high prices.

Innovation

Ensuring the inclusion of Primary Health Care budget into the county’s budget will further improve sustainability. Lobbying with organizations for funding either monetary or in terms of supplies, trainings, and human capital will further improve sustainability.

Programme

To establish the population of Nakuru County and staff establishment trained in Palliative Care and explore the training needs, the following should be considered for training:

- Doctors, clinical officers
- Nurses
- Social workers, psychologists, counsellors
- Allied health care workers
- Pharmacists
- Community health workers and volunteers
- Family caregivers

Since most of the patients are diagnosed when the disease has advanced, the following should also be considered for training:

- Nutritionists
- Physiotherapists
- Pastors
- Occupational therapists

Pain and symptom control, Counselling, communication, bereavement, end of life care, are some of the topics to be considered for training. Research on training needs of health care professionals should be done, for example: Who should get the basic Palliative Care course, intermediate or advanced course?

Research on existing guidelines, strategies, and policies is very important to embark on improving the current ones.

Implementation

For successful implementation of the programme, the following should be considered:
First is to gain political goodwill and support from top level leadership in the county including various ministries which are key to success of Palliative Care service provision.

Identify leaders and settings in which to start services. Good leadership is key to success of any project:

- To organize a foundation meeting which includes all stakeholders.
- To assess need, using population, incidence, prevalence, and mortality data.
- To ensure that there is a reliable action plan in line with the county’s vision.
- To ensure that national policies or strategic plans are in place and up to date and ready for implementation.

There should be training of necessary staff before and during service delivery, continuous medical education. In order to ensure that there are proper and reliable referral systems. From community to dispensaries or health centres, then to county referral hospitals and eventually to county referral and teaching hospitals for specialized treatments.

Availability of proper infrastructure to improve decision making is very key to successful service delivery.

It is important to ensure availability of trained and skilled pharmacists with shared documentation. Shared documentation is for monitoring essential drugs distribution from one county to the other to avoid dispensing drugs to the same person in different sub-counties i.e. duplication of drugs, especially morphine.

To ensure availability of all essential medicines needed according to the WHO essential drug list, proper procurement systems should be put in place to ensure availability of essential Palliative Care medicines and other supplies. Adaptation to change is possible due to good performance systems.

Good spiritual (pastoral) care and support of Palliative Care services should be available as most of our patients seek treatment when disease has advanced and they are in need of spiritual care.

Inclusion of volunteers in service delivery of Palliative Care is very key in order to achieve good coverage at the community level and promote accessibility of care. There should be good awareness of Palliative Care at every level of the population. Fostering public-private collaboration will improve sustainability of programs and complement the input that the government provides. There should be a government-sanctioned national stakeholders and experts board.

### Advantages of Integration

Integration improves accessibility of care, that means patients and their families do not need to travel long distances to get the services.

There is reduction of cost of treatment for the patient and family in terms of medical and non-medical costs. The government also reduces costs in terms of reduced hospital stay.

Integration reduces hospitals overcrowding and reduces financial risks for patients and their families.

Integration of Palliative Care into Primary Health Care will strengthen the systems’ capacity for health promotion, disease prevention, and early recognition of disease.

Integration of Palliative Care into Primary Health Care when perfectly done will improve their performances, reduce costs, and promote Universal Health Coverage.

Palliative Care home visits improve adherence to outpatients’ treatments for example breast cancers, HIV/AIDS, diabetes, tuberculosis and will improve follow-up.

The care also addresses physical, psychological, social, and spiritual aspects of patients and their families starting from community level. It reduces overuse of hospitals and unnecessary interventions.
Outcomes

Integration of Palliative Care into Primary Health Care achieves the sustainable developmental goal 3.8 (WHA) which addresses the Universal Health Coverage which embarks on equity in access to health services. All people who need the services should be able to get including the ones who are not able to meet the costs.

The quality of health services should be good enough to improve the health of those who receive the services.

Integration of Palliative Care into Primary Health Care protects patients and their families against financial risks. Precaution must be taken and ensure that the cost of using the services does not put people at risk or financial harm.

Importance of Universal Health Coverage

It is important to integrate Palliative Care into Primary Health Care as well as to include Universal Health Coverage since it enables everyone to access the services that address the causes of diseases and death, and ensures that the quality of these services is good enough to improve the health of the people who receive them (WHO, 2014). It is a sustainable health care system which reaches even the lower income groups of people.

Discussions

Although data from Nakuru County is not wide, the Nakuru Level 5 Hospital’s incidences of non-communicable diseases and mortality data clearly indicate the need of integration of Palliative Care services. The Nakuru County data reveals the high incidence of cancer and non-communicable diseases and the high rate of mortality. Note that more than 50% of patients in Nakuru County are hospital admissions with non-communicable diseases and account for 40% of deaths. This mortality surpasses the national average.

The inclusion of Kenya’s data reveals the extent to which the patients suffer during the disease progression and in their end of life. The 70%-80% of these patients are diagnosed when disease has advanced; therefore, they are at the end of life. Most of these patients will get palliative chemotherapy to improve quality of life, but they also present with numerous unmet and complex needs. Integration of Palliative Care into Primary Health Care is of utmost importance and highly needed in Nakuru County to allow care to be offered from the community level where geographical distances and remote areas will be covered.

This triggers the revision of strategies and guidelines to offer changes that may favour the needs and cultures of the people of Nakuru County. The question as to why patients avail themselves late for treatment is the fact that apart from lack of knowledge and long distances, many of them have traditions and beliefs that they have their own traditional herbal medicines.

Availability of essential medicines should be taken with a lot of consideration to combat the suffering of patients at the end of life because many of our patients’ quality of life is interfered with and has low esteem.

Conclusions

As it is evident from the findings through data of Nakuru County and Kenya at large, it is utmost important to integrate Palliative Care services into Primary Health Care and include Universal Health Coverage
both in service delivery and funding. This will ensure the success of the project and the patients’ quality of life will be improved. They will also start seeking treatment early and will benefit from cure where possible and avoid complex unmet needs. The government will benefit from the program as there will be reduction of unnecessary interventions and use of hospitals. This will have a positive impact as there will be more people contributing to the economy of the county and the country at large.

**Key Recommendations**

1. Palliative Care should be integrated into Primary Health Care and its budget included in the county’s budget.
2. Health care professionals should be trained on Palliative Care. Palliative Care education should be integrated and taught in all medical schools and institutions as part of the curriculum.
3. Volunteers should be incorporated in the provision of care and given the necessary trainings.
4. There should be a reliable action plan in line with the county’s vision, mission, and mandate.
5. National guidelines and policies should be put in place and be up to date.
6. Availability, accessibility, and affordability of essential medicines should not be compromised. The medicines should include pain relief and for other distressing symptoms in line with the WHO essential drug list.
7. There should be proper referral systems.
8. Funding of Palliative Care programs should be strengthened by fostering public-private collaboration.
9. All Palliative Care projects should be implemented and placed under reliable leadership to help in sustainability.

**Monitor and Evaluate Palliative Care Programs**

The use of reports generated by hospitals, hospices, community health workers, and volunteers helps to monitor Palliative Care programs. The use of Palliative Care tools is useful to monitor and evaluate the state of symptoms in Palliative Care patients in their homes and communities. The results help in symptom control.

**Conflict of Interest**

None.

**References**


WHO. (n.d.). *Universal health coverage*. Retrieved from https://www.who.int/health-topics/universal-health-coverage#tab=tab_1