

Understanding the Need, Challenges and Opportunities for Integrating Palliative Care Services into Humanitarian Health Interventions Among Health Care Workers Serving Refugee Communities in Uganda

Nasur Buyinza^{1*}, Caroline Ryan², Dorothy Olet¹, Okello Lwanga¹ and Wilson Acuda¹

¹*Institute of Hospice and Palliative Care in Africa, Uganda.*

²*World Health Organisation.*

*Correspondence:

Nasur Buyinza, Institute of Hospice and Palliative Care in Africa, Uganda.

Received: 14 Apr 2025; **Accepted:** 15 Jun 2025; **Published:** 26 Jun 2025

Citation: Nasur Buyinza, Caroline Ryan, Dorothy Olet, et al. Understanding the Need, Challenges and Opportunities for Integrating Palliative Care Services into Humanitarian Health Interventions Among Health Care Workers Serving Refugee Communities in Uganda. *Nur Primary Care*. 2025; 9(2): 1-7.

Keywords

Integrating Palliative Care, Illegal Settlers, HIV and cancer care.

Introduction

Within Sub-Saharan Africa, cancer and HIV/AIDS are usually diagnosed late, which can result in challenges of a very low survival rate for sufferers. With the increase in cancer deaths, there is a need to make sure that palliative care is provided for those in need of it at their end of their lives [1]. According to the World Health Organization [2], palliative care is “an approach that improves the quality of life of patients facing the problems associated with life threatening illnesses, through the prevention and relief of suffering by means of early identification and impeccable assessment” which of course aims to improve the holistic wellbeing of patients and their families. Whether they make a significant contribution to the national economy or not refugees and dwellers in crowded slums are largely excluded from medical and other social services mainly because they are often considered as being either criminals or illegal settlers [3].

The overarching need for palliative care across Africa remains a mammoth task and is further challenged by health policies that prioritize preventative and curative services in health, particularly in supporting health in development contexts. This often overshadows those with chronic disease states and life-limiting conditions who experience debilitating pain and suffering. Despite freedom from pain being an international human right (UDHR, Article 25), the mainstream integration of palliative care as an essential component of all health interventions is not fully realized. A growing refugee population in the East African region is one group that has been identified by Hospice Africa Uganda

as particularly vulnerable to falling beyond the reach of palliative care and in dire need of intervention.

Shortage of health care workers for the provision of cancer care to the terminally ill is a living challenge which is expected to rise even further in the coming years, yet available interventions to train additional care providers lacks the capacity to quickly arrest the situation. Available care and support among teams and individual clinicians seems uncoordinated, pitting sufferers to look around for the often fragmented, unprofessional care givers [4].

In the whole of Africa, Uganda is ranked the third largest destination and host for refugees because of her accommodating laws regarding refugees [5]. Currently, Uganda hosts nearly two million refugees. Ongoing conflicts bordering Uganda in eastern DRC, Burundi and more recently the catastrophic crises in South Sudan assumes this number will increase before it declines. By the end of 2017 for example, it was predicted that over 350,000 additional refugees will have fled from South Sudan to seek refuge in Uganda. There is insufficient published data that measures the extent of palliative care needs among refugee populations during humanitarian crises, which delays decision making.

Currently, international aid agencies serving refugee populations prioritize preventive and curative services or target defined groups leaving those with palliative care needs unattended to. Refugees flee from areas of insecurity with few resources and loss of access to health services is one of the biggest challenges. Debilitating pain among this group may result from conflict related traumas, untreated fractures, disabilities and debilitating disease states resulting from the overburdened teams offering

curative services as well as diabetes, HIV and cancer care. The resultant suffering affects males and females, children, adults, the elderly and those with disabilities. In other words, palliative care needs among the refugee population cannot be placed within simple categories according to age or as a specialized intervention outside of primary health care. A gap in evidence based research, myths of palliative care, negative perceptions towards the use of opioids and misperceptions that palliative care is solely an end of life intervention need to be understood better before advocating and planning for the integration of palliative care into health interventions targeting refugee populations. The role of palliative care in humanitarian crises is an important health policy area to be addressed at the local, national and global levels.

This study therefore aimed to explore the needs, challenges and opportunities for integrating palliative care services into refugee contexts in Uganda. The study can contribute to informing policy and best practice for planning effective integration of palliative care services in refugee hosting communities in Uganda in the near future.

Methods

This study adopted a cross sectional qualitative design applying Focus Group Discussions with health care workers offering health care services to the refugee population in Uganda. District health officials, palliative care focal persons and UNHCR officials assisted in identifying and mobilizing key participants.

A semi structured interview guide was developed to capture the experiences of health workers within the context of refugee hosting districts. Data for this study was collected between March and July 2018 from three districts hosting some of the largest refugee settlements based in deep rural areas of Uganda. These were Yumbe district hosting Bidi Bidi Refugee Settlement with a refugee population exceeding 270,000 refugees at the time of data collection, Hoima District hosting Uganda's oldest refugee settlement, Kyangwali with a refugee population above 53,000 and Isingiro District hosting Nakivale Refugee Settlement with a total refugee population way above 100,000.

We conducted one focus group discussion (FGD) for each of the three sites with nurses, clinical officers and doctors whose primary role was to offer clinical care to refugees in the study area. We recruited 12 participants for every site to participate in the discussion making a total of 36 participants for the Focus Group Discussions. Participants were stratified into each of the three categories (nurses, clinical officers and doctors) and the first four participants in each category were selected following the order of their registration. We explored participants' needs, challenges and opportunities for integrating palliative care into humanitarian health interventions in Uganda.

Information recorded by sound recorders and that noted by the research team using note books was qualitatively categorized and carefully transcribed by the research team. This process was double

checked by two independent and skilled researchers in qualitative research before we generated data for analysis.

In order to get rid of extra and irrelevant information, we employed Richie and Spencer five stage frame work analysis for this study. We started with data familiarization, followed by identification of thematic frame works then indexing, charting and eventually mapping and interpretation. To avoid subjective selection, another researcher was asked to verify the accuracy and consistency of the above process.

We sought written ethical approval from the Hospice Africa Uganda Research Ethics Committee (HAUREC) before proceeding with data collection. Written informed consent was secured from participants who met the inclusion criteria for this study. The research team also sought clearance from the office of the prime minister and the health ministry of Uganda.

Participant / Demographic Characteristics

The study population included Health care workers (nurses, clinical officers and doctors) working with UNHCR implementing partners, UNHCR and Local governments within refugee operation areas in Uganda. Participants who at the time of data collection had been involved in giving direct health care to the refugee population for at least six months were involved in data collection.

Participation in this study was purely voluntary; identities and data that were gathered from respondents have been kept confidential. All information collected for this study was only identifiable by a unique code, and its access was restricted to the research team.

Health care workers (nurses, clinical officers and doctors) working with UNHCR implementing partners, UNHCR and Local governments in refugee operational areas who had their service interrupted by study leave or leave of absence for more than three months in the last six months were excluded.

Discussions were also held during the study period with district officials, health workers and humanitarian organizations from the three Districts.

Results

All stakeholders reached by the research team expressed support for a proposed palliative care intervention and gave several examples of cases where they identified a need for palliative care services. They shared some of their challenges including a resource gap experienced within these districts that continues to limit current access to quality palliative care services. Other challenges included lack of awareness among health care workers in identifying patients with palliative care needs, inconsistencies in morphine supply, limited human resources for palliative care and complicated/costly referral services.

The Needs for Palliative Care Services

A great need for palliative care service integration into the

humanitarian health care intervention was identified across all settlements and the corresponding refugee age groups ranging from neonates to the elderly. Health workers across all three study sites identified similar age categories to be the most frequently seen in their line of duty. Participants reported diseases such as cancer, including HIV-related cancers and associated co-morbidities, chronic Hepatitis B, Diabetes, severe Injuries, Sickle Cell Anaemia and Tuberculosis as the most common life-threatening conditions they witnessed among their patients. Presenting symptoms of these patients included pain, restlessness, severe weakness, disability, psychological distress and depressive symptoms.

“PC at the moment has not been integrated; most of us have little knowledge on palliative care and the management of these patients” [FGD3, P2].

“I work in a refugee setting. According to the state of palliative care in the setting where I work, there is no palliative care service”. [FGD1, P7].

Challenges to Palliative Care Service Provision

Predominant themes common to the three study sites and refugee settlements included: Absence of trained palliative care service providers, Nonspecific patient pain assessment, Informal means of holistic patient assessment for palliative care, Lack of political will to allocate resources for palliative care services, Lack of resources to implement palliative care services, frequent stock outs common pain medications and absence of opioid analgesia for pain relief, An inefficient referral system, Lack of training opportunities, Unawareness of the existence of palliative care patients, fears of staff for their personal safety when breaking bad news, Low support for community health workers especially in the public sector.

Across all three study sites participants asserted that there was a general lack of health interventions specific to palliative care within both the refugee and public health care settings.

Statements like the one below and more others commonly emerged from all three study sites.

- I must confess that it is something that has been hidden until you people have come on ground, I’m even surprised to myself, but I didn’t know that hepatitis B was one of the cases we would look at for palliative care [FGD1, Y3].
- Even if a patient came to the facility and needs palliative care treatment, you find that patient goes unnoticed, staff are not so much aware [FGDII, K8].

Not that we do not have patients in need of palliative care, but it’s because of the knowledge...that this type of patient needs palliative care [FGD1, Y7].

Diagnostic procedures done at local facilities are not always effective. It took like a month or two. the problem is that I lost my clients even before seeing their results (.) so the diagnosis delays

[FGDII, K7].

- One of the challenges we are also having with the patients that we send to Mulago, these patients with chronic disease is that when they come back, they don’t send them back to us. You find they come back from the special clinics straight to the community. We don’t know what has been done; we don’t know the illnesses they have. Sometimes we don’t even know when they are supposed to go back [...] So that linkage has not been there [FGD, Y5].

These and many more others were reported to result in patients being referred to higher level health units for specialized diagnostic and curative care.

- Yes, we are having morphine but at times it is inconsistent, at times they stock out and where there is stock out, it is a big challenge [FGD1, Y2].
- We are more or less in a health centre III setting in the refugee camps, so it is just the oral analgesics, paracetamol, ibuprofen and the diclofenac. [FGD1, Y4].
- P5: ‘Like morphine, you will not find it there and even these ordinary painkillers, at times they are out of stock’ [FGD2, K5].
- “I have not seen morphine in Yumbe. I don’t know if it is available somewhere within the district for the patients in pain, we have those in chronic pain [...] within the camp, most of the pain killers we have when you look at the analgesic ladder, they are the ones on the first step” [FGD1, Y5].
- PO: We don’t have pethidine or even morphine at our HCII. We mainly use Panadol for pain relief.
- P9: ‘We also have aspirin and we use it for treating cardiac conditions and also for managing pain’ [FGD2, k9].

Time of Presentation for Care by Patients

- Most of our patients come when they are weak, they are bedridden and in pain, and you observe that they must have been sick for a while [FGDII, K2].
- These people, they come when they are malnourished [FGDII, K3].
- What I have observed from there is you find that they come when they are in terrible shock, others semi-conscious, others unconscious and then others have come with severe anaemia. And at times we don’t have blood here, so we are forced to refer them urgently after giving some pre-treatment [FGDII, K5].
- Some of the clients travel from very far distances and at times it makes them not follow appointments, and if they don’t even have transport they can even stay for two-three months without coming [FGD, Y2].
- When asked what they believed were the underlying challenges to palliative care services, the following themes emerged from participants:

Political Will to Budget Resources for Palliative Care Services and its Integration

- According to the way health workers are brought up, or trained

and even the health system that we have, the government is always willing to spend more money on anti-malarial than for NCDs. Our system does not prioritize treatment of chronic illnesses [FGD3, P0].

- Even the essential drug lists, government does not prioritize drugs for NCDs. Even when you fill the list of requests, they bring very few drugs for NCDs. You may find they bring a few just a few vials for hypertensive drugs for a whole health centre IV etc. [FGD3, P1]
- PO: Even for government facilities, there is no barrier but there is usually a challenge of funding because if the team have to go to visit patients, there are usually many staff that have to go to handle different diseases like TB and other illnesses and this is already expensive and if we are to add a team for PC it becomes difficult for most facilities.
- PO: To me, categorically there is none [policy for palliative care]. Because at the moment, there is a current MTI master plan in place and one of our visions is “we are not Christ but we dare to love like Jesus; breaking barriers to health and restoring boldness to the hurting world”. So if our vision is breaking barriers, then there can’t be any barriers to PC services.

Specific Pain Assessment in the Refugee Health Care Setting

The patients are there but we don’t know which data pool is capturing them. [...] So some of us who meet these patients don’t know what to do about the patients [...] the clinician just writes on the form “for review” [FGD1, Y5]

For my facility, we have not been using a clear tool or something for pain assessment, we have been doing it subjective... [FGDII, K?].

According to our facility, our setting for us we just get the information from the patient, that’s all [FGDII, K3]

PO: There is no formal way of carrying out pain assessment. There are no protocols or guidelines for carrying out assessments.

Spiritual and psychological assessment for refugees with palliative care needs

Overall it was found that health facilities did not have a formal arrangement with spiritual leaders for palliative care patients, it was mostly an informal arrangement with volunteer spiritual leaders. Responses like the one below were very common during interviews.

- They take their patient to the church, there for the Rev. Father to pray for them. It is client initiated [FGDII, K?].
- Those ones who don’t go for referrals or decline, we normally ask their tradition or where they pray and we normally link up, we tell them to coordinate with their spiritual leaders. They normally come on their own and give that service to them in the facility [FGDII, K2].
- Those people (spiritual leaders) just come on their own, preach, talk and they go away
- In Nakivale HCIII, there are usually fellowships targeting patients. At Rwekubo HC IV, every Sunday, members from a

certain church usually come to pray with the patients and do some preaching as well.

Palliative Care Training for Health Care Providers

- There has been no special type of training about palliative care since the Settlement was opened [FGD1, Y7].
- In that setting we have so many activities, but there is no activities of palliative care and this is my first time to attend a workshop [FDG1, Y8].
- It wasn’t actually training; see training is different from a workshop. So it was a workshop, but they only introduced the concept to us and because it was a workshop that’s why I still think it is weak in those facilities, otherwise there may be few people who have been trained in longer clinical courses like maybe 9 months [FGDII, K5].
- Most of these staff have not been trained in these Hospice programmes, so there is a knowledge gap, a big knowledge gap that can be hindering this palliative care service [FGDII, K5].
- For me personally, I have worked for for some years now, but I have not seen this [kind of training]. [FGD3, P0].
- We studied some bit of PC at school during our training at the medical school but not to the extent that we are learning today. It was just a little bit of it [FGD, P0].

The lack of training specific to palliative care among health workers in the public facilities serving both public and refugee communities were then reported to result in a failure to identify patients for palliative care intervention.

Discussion

Our findings show that no NGO be it local or international are delivering or have delivered palliative care services for refugees in the settlements of BidiBidi, Nakivale and Kyangwali. Currently, patients identified with life limiting conditions in Nakivale and Kyangwali refugee settlements are being referred to Mobile Hospice Mbarara and Little Hospice Hoima respectively. Those identified in BidiBidi, Yume district are being referred to Mulago Hospital in Kampala with high transport costs for UNHCR and or their implementing partners.

Some participants expressed how referring a patient was sometimes counter-productive because of financial constraints experienced by the patient because of additional transport and medical care costs.

Some patients with palliative care needs are being reached at Kyangwali through Little Hospice Hoima outreach services once a month but this is also threatened by limited funding for Hospice Africa Uganda yet the demand for palliative care seems greater than what is being offered and expected to more than double in the near future.

No health workers among the UNHCR health implementing partners in the three study sites were trained in any recognizable palliative care course. This has greatly affected palliative care

service delivery in these settlements and may be responsible for myths and misconceptions about palliative care and morphine held by some respondents.

When we tried to explore the trust participants had in their own health care system, many of them had mistrust in the capacity of local health facilities to the extent that they believed they were not doing what is required of them to help patients as health care providers.

Some participants serving refugees who access public health facilities did acknowledge that there was an attempt to integrate palliative care services into their main stream health care package but expressed several challenges affecting the public sector including absence of trained providers, frequent stock out or total absence of opioid analgesia for pain relief, myths and misconceptions of morphine use among staff and lack of financial support for palliative care services.

In the Ugandan health care system structure, morphine is only available at health Centre IV, district and regional and national referral hospitals with accredited morphine storage facilities (double locked cupboard) and legal prescribers who are usually registered medical officers and specially palliative care trained Registered Nurses. In the refugee hosting districts of Yumbe, Hoima, Kwangwali and Nakivale there is only one Health Centre IV, and the majority of health centres serving refugee communities are either Health Centre IIs or IIIs. Health workers across the three districts serving host and refugee communities reported that their health centers only stock non-steroidal anti-inflammatory drugs like aspirin, ibuprofen and diclophenac as well as paracetamol and occasionally tramadol. The strongest pain-killer available at most of the health Centre IVs where Obstetrics and Surgical operations occur was reported to be injectable pethidine. Even then, it was reported to always be out of stock in these health facilities where surgical operations were being done.

Unlike most refugee hosting countries around the world, Uganda is unique in that refugees enjoy similar freedoms to nationals in terms of freedom of movement and access to public services and engaging in business and agricultural activities. Majority of patients were reportedly lost to follow up and only re appeared after a very long period usually during head counting or to get UNHCR food rations. On getting back, their disease conditions will usually be in their late stages and this may create a palliative care challenge for providers who may need to follow them up their patients for holistic assessment.

When asked about their knowledge of palliative care, most respondents did not report having had any formal palliative care training and the few who reported having been exposed to it did so in their training schools and or a workshop. Even then, only an introductory part of palliative care was given to them save for a mere mention of it in the workshop. Many respondents believed that there were so many competing demands in their line of duty

and this would not favour provision of palliative care which requires an enormous amount of time do provide given the very big number of patients in these settlements.

Benefits of a palliative care from the perspective of respondents

Many respondents believed that palliative care would bring some improvement in patient care, especially when the holistic assessment approach is adopted. It will also help to restore patients' confidence within the humanitarian health intervention so as to receive more patients who would otherwise shy away from the care, yet with chronic diseases.

They noted that palliative care would benefit patients especially the very poor and those who would have died within a very short period for lack of proper care and pain management both physical and non-physical. This will automatically lead to refugee patients' improved quality of life. This and many more others will eventually bring about staff motivation and job satisfaction.

Some participants reported that humanitarian health workers who escort patients to government facilities during referrals are paid an allowance by their employing humanitarian organizations. This to them facilitates the I don't care attitude and demotivation on the part of public health care providers who required to remain with the referred patient for a much longer period. The above situation is also true for Village Health Teams (VHT) who are required to regularly visit very sick patients at their homes.

Our findings also indicate that humanitarian health workers experienced challenges unique to working with refugee communities. These challenges were related to language barrier, a high turnover of staff, hostile tendencies of refugees and fear for personal safety when breaking bad news, limited infrastructure and other resources and the transient behaviour of the refugee population.

Health workers reported patients' challenges

Most refugee patients are reportedly not willing to discuss with health workers what exactly is happening with them. Some are hostile to the extent that they can't freely interact with colleagues probably due to their different cultural background and political affiliations. Majority of them deny their laboratory results and occasionally exhibit aggressive tendencies to counsellors.

As a result of language problems, most patient assessments are done through translators and some of these translators come from the same community where these patients come from. Therefore, there are issues that may not come out properly because there is a third party in the consultation room and therefore no privacy. This problem has to our knowledge and findings greatly affected disclosure of the most distressing problems by patients. "We have had scenarios where these very interpreters we use are the trouble causers; they will actually go and talk in the community" [FGD, Y7]. This has brought stigma in the refugee community which was identified to be a big issue there.

During our interaction with participants, we did not get any reference to a tool being used any of the humanitarian health implementing partners either to capture palliative care data or pain assessment. “Some of us who meet these patients don’t know what to do about the patients” [FGD1,Y5]. Participants reported that some palliative care related information is collected from patients but there is nowhere to record it. Additionally, participants affirmed that neither protocols nor guidelines relating to palliative care and pain assessment exist in their facilities. If these tools were to be introduced, they would act as constant reminders to service providers to assess patients and to record palliative care data.

Interestingly, all participants were ready and willing to integrate palliative care into humanitarian health interventions as long as resources to support their care, training in palliatives care and support from top management are provided.

Limitations

This study heavily depended on responses from health workers who could have had their own biases.

Conclusion

There is an urgent need for palliative care provision and integration among refugees but before any major intervention is made, efforts should be made to know the number of refugee patients with chronic illnesses in refugee households. This will help us to understand how many refugees need palliative care and the corresponding number of palliative care providers needed.

A high competition for resources and the differing health priorities among health implementing partners working with the refugee population may affect the time and resources allocated for palliative care service delivery. In 2017, Hospice Africa Uganda (HAU) proposed a health system strengthening approach to improving access to quality palliative care services for vulnerable persons among refugee and host communities in Uganda. Findings show that no humanitarian organization providing health interventions among refugees at Bidi Bidi, Kyangwali and Nakivale Refugee Settlements provide palliative care services. This reflects the global situation where few health workers engaged in humanitarian development in either acute or protracted crisis situations are trained in palliative care (MSF, 2017).

Health care workers among humanitarian organizations and within health centers serving the districts mentioned in this report are untrained in palliative care pain management, despite being frequently faced with patients suffering from traumatic injuries, cancer, HIV, Hepatitis B, chronic respiratory, heart and liver diseases, diabetes and other life limiting conditions in their line of duty. A large number of patients from Bidi Bidi, Kyangwali and Nakivale refugee settlements presenting with life-limiting conditions are currently referred to Mulago National Referral Hospital in Kampala through an intermediary organization (Inter Aid) from where they are referred directly back to their communities without linking them back into the district health system for follow up. Current data collection tools are non-existent

or inadequate for capturing palliative care patients, and therefore the real prevalence of palliative care needs remains unknown.

Target priority areas identified for support include human resource capacity for palliative care by training or recruiting palliative care health workers, providing technical support to establish consistent and efficient opioid supply chains, development of an improved and integrated referral network between the community, district and humanitarian health implementing partners (IP’s) and planning for effective models of service delivery suited to the context such as outreach clinics and home care services.

From these initial findings HAU recommend that the integration of refugee palliative care health services within national health services is not a single step process but requires multi-partner collaboration and support from UNHCR implementing partners, MoH, District and Regional Referral facilities and the community leadership. Planning for future action needs to be informed by the experiences of those working in direct contact with patients in need of palliative care services on the ground that have a deeper understanding of the situation among refugees and host communities.

This is one of the first research studies on palliative care interventions in humanitarian contexts emerging from the African continent. Uganda currently represents one of the largest refugee hosting countries in Africa and in the world today. With continuing conflict in the region and along Uganda’s borders, the situation is unlikely to be resolved in the near future. The humanitarian crises in Uganda, following peak influxes from South Sudan and Eastern DRC in 2017 and 2018, can now be described as entering a protracted phase. Humanitarian organizations such as UNHCR are supporting the integration of refugee health interventions into the Ugandan health system.

The purpose of this study therefore was to explore an existence of the need for palliative care services and the gaps to deliver quality palliative care in refugee hosting communities from the perspective of those providing health care for refugees. The district level health facilities acknowledge the need for palliative care and are willing to support its integration into health care services as a primary care intervention. This study therefore concludes that given the basic resources required, palliative care can be integrated into humanitarian health care services in Uganda.

Recommendations

The research team identified a need to review UNHCR health implementing partner data collection tools and indicators to help in identification and capture of Palliative Care data.

- There is great need to support a follow up plan with UNHCR about the possibility of recruiting palliative care focal persons under the UNHCR structure
- APCA needs to look out for partners who can support a full scale survey to understand the need, challenges and opportunities for integrating palliative care into humanitarian

health interventions.

- Almost 100% of health workers working with UNHCR health implementing partners have never been introduced to palliative care. There is a need to mobilize resources to have them trained
- There is inconsistent oral morphine supply to the refugee host districts in Uganda and APCA needs to liaise with PCAU to solve the problem
- Much as some refugees may not have any observable life limiting illnesses, majority of them have unmet psychosocial needs that require a palliative care approach to handle
- Further research should be conducted to understand the need for palliative care among refugees.

References

1. Ibtihal Fadhil, Gemma Lyons, Sheila Payne. Barriers and opportunities for palliative care development in the Eastern Mediterranean Region. *Lancet Oncol.* 2017; 18: e176-e184. http://eprints.lancs.ac.uk/85032/1/palliative_care_paper_2Nov2016_CLEAN_VERSION.pdf
2. WHO. promoting the health of refugees and migrants. 2017. http://www.who.int/migrants/about/framework_refugees-migrants.pdf
3. Shahaduz Zaman. University of Glasgow End of life studies accessed. 2016. <http://endoflifestudies.academicblogs.co.uk/refugees-and-slum-dwellers-dying-without-palliative-care-are-among-the-worlds-hidden-people-or-huldufolks/>
4. Levit L, Balogh E, Nass S, et al. Committee on Improving the Quality of Cancer Care Addressing the Challenges of an Aging Population; Board on Health Care Services Institute of Medicine. *Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis.* Washington DC. National Academies Press. *The Workforce Caring for Patients with Cancer.* 2013. <https://www.ncbi.nlm.nih.gov/books/NBK202149/>
5. Anna Patton. In Uganda, a new approach for refugees and for Ugandans. 2016. <https://www.devex.com/news/in-uganda-a-new-approach-for-refugees-and-for-ugandans-88774>