



### **Hospice Jinja July report**

*Report by Jennifer Tymon Partnership Manager  
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Census: 273 with a Staff: of 3 full-time only!!

Leading causes of Death: HIV/AIDS, Breast Cancer, Prostate cancer, Cervical Cancer

While I was working with APCA, they arranged for me to visit Rays of Hope – Hospice Jinja with Abby Baguma, APCA partnership manager, Dennis Kidde, APCA Administrative Assistant and Dr. Michael Marks of Direct Relief International. We were led by Rose Kiwanuka, the National Coordinator of the Palliative Care Association of Uganda who has been working with the Jinja program since its inception. The program operates out of a small office in Jinja, Uganda. There are three paid staff members and a rotating array of visitors and volunteers.



**Figure 1 Jennifer with Hospice Jinja Staff**

While I was there a volunteer nurse from the Netherlands was working with them. In addition, a nursing resident from Hospice Africa Uganda was stationed there for a year to do his practicum.



Upon arriving, we received a warm welcome and spent time introducing ourselves to one another. After hearing about the program, we all climbed into the only Hospice Jinja vehicle (donated by Hospice Africa Uganda) to go out into the field to see patients. After driving for about 30 minutes, we parked on the side of a main road by the train tracks. We walked out along the tracks to reach the patient's home. The tracks act as a pedestrian highway, allowing people to take more direct walking routes.



The first patient that we went to see had prostate cancer.. He was experiencing discomfort from the swelling and therefore had difficulty passing urine. Rose, who is a palliative care nurse, acted as the home care nurse as a way of monitoring the clinical progress of the Jinja team.



The patient was an older, charming man. He lived in a small, mud home with a thatched roof. There was one photograph on the walls which pictured the patient and his brother when he was in World War II, serving the British forces. He lives with his wife who was not home at the time and one of their children, who acts as his caregiver. The clinical team felt that he was doing well and the patient appeared grateful for the services he received.

After a warm good-bye and many photographs, we drove another hour to a second patient. We went to visit a young woman with breast cancer. She lived in a small home constructed of mud and tree branches, brightly painted with stripes and a wooden pole to hold up the roof. The house was small, the woman's bed occupying the majority of it. She received us with a warm smile, though one could tell that she was suffering when looking into her eyes. While the clinical staff talked with her, I conversed with the family about their coffee production. About five households live off of the proceeds of a small coffee operation.



**Figure 2 Dr Mark leaving the patient house**

The nurses decided to increase her morphine and after consulting with the family, we left. On our way out, we passed a school that had just let out for the day. The children were mesmerized by the sight of several mzungu (white people) emerging from a small cluster of houses. As we piled back into the Hospice Jinja small car and drove away, we were chased by about 25 children laughing.

The final patient that we visited was another hour drive on back roads through dense bush. We were perplexed as to why we were going to visit a patient so far away, when we had a limited time frame and still had to make it back to Kampala. When we arrived, there was no question as to the rationale for taking us there. The patient was a 10 year-old female suffering from a skin disorder on her face. She was diagnosed as having melanoma, which did not seem to be the case. The condition had eaten away her nose and was slowly affecting her eyes, making them thin, cloudy slits. Although her face was not particularly easy to look at, her demeanor was so inviting and gracious that one could not resist reaching out to make some connection. She had been referred to the hospice purely as a result of most doctors' unwillingness to treat her. She had been for several biopsies at local hospitals, but had never received any results. Dr. Marks, who was accompanying us, immediately doubted her current diagnosis, but concluded that it was difficult to figure out how to treat her without biopsy results.



The grandmother cares for the girl and explained that the infection started five years ago after an ulcer on her face burst. The hospice team said that they were treating her with antibiotics and that it had improved. Unfortunately because of the severity of the infection, the girl has not been able to go to school. The girl was grateful for the visit, but we all left feeling defeated, knowing that a biopsy and proper treatment could change her life.

Overall the program was impressive, especially given the limited resources they have. One of the greatest challenges they face is that there is an endless need. There are so many individuals in the area that could benefit from the programs' services. Yet considering that all of the services are free of charge, the hospice is limited in how many patients it can absorb and still maintain a standard of care.

Recommendations:

- The program would benefit from a laptop computer, financial support and transportation.
- Help to create a volunteer caregiver program
- Visit the program

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