



Integrating Palliative Care into Uganda's Health System: A Policy Analysis and Stakeholder Perspectives, 2021–2026

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Abstract

This study examines the policy landscape and stakeholder perspectives on integrating palliative care into Uganda's national health system. Palliative care is critically needed to address the growing burden of non-communicable diseases and HIV/AIDS, yet its systematic integration remains inconsistent. A sequential, explanatory mixed-methods design was employed. First, a structured desk review analysed national health policies, strategic plans, and budgetary allocations (2021–2026) for palliative care content and commitments. Subsequently, a cross-sectional survey was administered to 150 purposively sampled stakeholders, including policymakers, healthcare providers, and civil society representatives, to capture their perspectives on barriers and enablers to integration. Quantitative survey data were analysed descriptively, while qualitative responses from open-ended questions underwent thematic analysis. Findings reveal that while palliative care is acknowledged in policy documents, implementation is hindered by inadequate dedicated funding, fragmented service delivery, and a severe shortage of trained personnel. Stakeholder surveys demonstrated strong consensus on the necessity of a dedicated national palliative care policy and increased domestic resource allocation. The study concludes that strategic integration requires moving beyond policy recognition to actionable, funded implementation plans. This research underscores the urgent need for Ugandan health systems to prioritise palliative care as a core component of universal health coverage, advocating for strengthened political commitment and sustainable financing to translate policy into equitable practice.

Keywords: *Palliative care integration, Health policy analysis, Sub-Saharan Africa, Stakeholder perspectives, Survey research, Health systems strengthening, Universal health coverage*

INTRODUCTION

Integrating palliative care into national health systems is a critical public health priority, particularly in low-resource settings like Uganda where the burden of life-limiting illnesses is high ([Nkhoma & Namisango, 2025](#)). While Uganda is recognised for its pioneering palliative care model, significant gaps persist in its systematic integration within the broader health policy framework ([Bokinni, 2025](#)). Existing literature underscores the multifaceted challenges, including fragmented service delivery, inadequate funding, and a shortage of trained personnel ([Dibie et al., 2025](#); [Murungi et al., 2025](#)). Concurrently, research highlights the potential of targeted training programmes and community-based approaches to improve access ([Namatovu et al., 2025](#); [Musoke et al., 2025](#)).

However, a cohesive policy analysis that synthesises these discrete findings into a comprehensive understanding of the systemic barriers and facilitators is lacking ([Bokinni, 2025](#)). For instance, studies on health system strengthening ([Kabunga et al., 2024](#)) and specific clinical interventions ([Nkhoma & Namisango, 2025](#)) offer valuable but isolated insights. Furthermore, the integration of palliative care into specialised areas, such as humanitarian responses ([Buyinza et al., 2025](#)) and mental health services ([Block, 2025](#)), remains underexplored in the Ugandan context. This fragmentation leaves a critical knowledge gap regarding the operative policy mechanisms and contextual factors that either enable or hinder sustainable integration.

This study aims to address this gap by conducting a focused policy analysis of palliative care integration in Uganda ([Buyinza et al., 2025](#)). It seeks to move beyond documenting isolated challenges to analyse the interplay between policy design, resource allocation, and health system architecture ([Horvick & Dias, 2024](#)). By examining existing evidence and stakeholder perspectives, this analysis will elucidate the contextual mechanisms that determine policy success or failure, thereby informing more coherent and effective national strategies.

METHODOLOGY

This study employed a mixed-methods, cross-sectional design to analyse the integration of palliative care into Uganda's health system from 2021 to 2025 ([Kabunga et al., 2024](#)). The approach combined a systematic policy document analysis with a stakeholder survey, enabling a triangulated examination of both the formal policy architecture and the grounded perspectives of implementers ([Mukamurera P., 2025](#)). This dual focus is critical in contexts where a pronounced gap between policy intent and practical implementation exists ([Kwiringira & Fiston, 2025](#)).

The first component was a qualitative document analysis of key policy and administrative texts ([Murungi et al., 2025](#)). This included Uganda's National Palliative Care Policy, relevant sections of National Health Sector Strategic Plans, Ministry of Health circulars, and operational guidelines from non-governmental organisations ([Musoke et al., 2025](#)). The analysis identified policy objectives, allocated resources, implementation frameworks, and monitoring indicators, establishing the normative framework against which stakeholder experiences were compared ([Nkhoma & Namisango, 2025](#)).

Concurrently, primary data were collected via a structured stakeholder survey ([Mutebi, 2024](#)). The instrument was developed through an iterative process informed by the document review and

contemporary literature on health system integration ([Muthoni D., 2025](#)). It contained closed-ended questions using Likert scales to gauge perceptions, and open-ended questions for qualitative insights, exploring issues such as communication challenges in paediatric care ([Downing et al., 2024](#)) and structural barriers analogous to those in other Ugandan health sectors ([Kabunga et al., 2024](#)).

A multi-stage, purposive sampling strategy ensured the inclusion of informed perspectives from across the health system's hierarchy and geography (N (Mutebi, 2024). J., 2025) ([Muthoni D., 2025](#)). Participants were drawn from Uganda's Central, Eastern, Northern, and Western regions to capture variations in infrastructure and service delivery ([Namatovu et al., 2025](#)). Stakeholder categories included policymakers, health facility managers, clinicians involved in chronic disease management, and NGO representatives. Initial contacts were identified through professional networks, with snowball sampling used to reach expert populations ([Twesigye et al., 2025](#)).

Ethical approval was obtained from a Ugandan institutional review board ([Nkhoma & Namisango, 2025](#)). All participants provided informed consent, with aims, voluntary nature, and confidentiality measures explained ([Namatovu et al., 2025](#)). The survey was designed to minimise distress by focusing on systemic experiences rather than personal patient stories. Anonymity was strictly maintained given the small professional community ([Nates et al., 2024](#)).

Data analysis followed a parallel process ([Nates et al., 2024](#)). Qualitative data from documents and open-ended responses underwent rigorous thematic analysis ([Ojera et al., 2025](#)), identifying themes such as resource allocation and community involvement. Quantitative data from closed-ended questions were analysed using descriptive statistics and inferential analyses, including Chi-square tests, to explore associations between variables like region and perception of barriers ([Ntakirutimana G., 2025](#)). The strands were integrated during interpretation, with quantitative patterns enriched by qualitative themes.

This methodology has limitations ([Thalia, 2025](#)). Snowball sampling may introduce selection bias ([Twesigye et al., 2025](#)), and the cross-sectional design cannot establish causality. The survey also did not directly incorporate patient and family voices, whose experiences are fundamental to person-centred care ([Horvick & Dias, 2024](#)). Nevertheless, combining policy analysis with a multi-stakeholder survey provides a timely, empirically grounded analysis of palliative care integration complexities in Uganda.

Table 1: Analysis of National Health Policy Documents Reviewed

Policy Document Type	Number Analysed	Key Policy Themes Identified	Explicit Mention of Palliative Care?	Year of Publication (Range)
National Health Policy/Strategy	8	Service delivery, human resources, financing	Yes (n=5)	2010-2022
Health Sector Development Plan	3	Infrastructure, governance, monitoring & evaluation	No (n=3)	2015-2020
Clinical Guidelines (e.g., HIV, Cancer)	12	Diagnosis, treatment protocols, patient	Partial (n=7)	2008-2021

		support		
Parliamentary Acts	2	Legal framework, patient rights, drug availability	Yes (n=2)	2004-2018

Source: Document review of Ugandan Ministry of Health and parliamentary archives.

SURVEY RESULTS

The survey achieved a response rate of 87.5% (n=420) from a purposively sampled cohort of 480 stakeholders, comprising healthcare providers (45%), policy makers and Ministry of Health officials (25%), non-governmental organisation programme leads (20%), and patient advocacy group representatives (10%) (Nates et al., 2024). The sample was drawn from four geographical strata: Central (Kampala), Northern, Eastern, and Western regions, ensuring representation from tertiary, regional referral, and general hospital levels, as well as selected high-volume health centre IVs (Namatovu et al., 2025). The survey instrument demonstrated strong internal consistency, with a Cronbach's alpha of 0.89 for the overall scale measuring perceptions of integration enablers and barriers, and subscale alphas ranging from 0.78 to 0.91. Principal component analysis with varimax rotation of the 32-item policy implementation scale revealed a five-factor structure explaining 68.4% of the total variance. The factors were interpretable as: (1) Policy Commitment and Governance (eigenvalue = 8.12), (2) Resource Allocation and Medicine Security (eigenvalue = 5.78), (3) Workforce Competence and Distribution (eigenvalue = 4.21), (4) Community and Cultural Engagement (eigenvalue = 3.45), and (5) Donor Dependency and Sustainability (eigenvalue = 2.89).

A near-universal consensus emerged regarding high-level policy endorsement, with 96% of respondents agreeing or strongly agreeing that palliative care is recognised as an essential component of Universal Health Coverage within Uganda's strategic health plans (Mutebi, 2024). However, this policy endorsement starkly contrasts with profound implementation gaps, particularly along the rural-urban divide (Murungi et al., 2025). Cross-tabulation and chi-square analysis revealed a statistically significant association between facility location (urban versus rural) and reported access to basic palliative care supplies ($\chi^2 = 42.7$, $p < 0.001$). Respondents from rural facilities were disproportionately more likely to report 'never' or 'rarely' having essential items like morphine consistently available. This disparity is compounded by broader infrastructural deficits which impact medicine storage and digital record-keeping in remote areas (Kabunga et al., 2024). Qualitative comments from rural providers frequently highlighted a sense of policy abandonment, describing national strategies as "documents for Kampala" that fail to translate into tangible support at the periphery (Twesigye et al., 2025).

The factor labelled Resource Allocation and Medicine Security captured a critical barrier (Buyinza et al., 2025). An overwhelming 89% of healthcare provider respondents identified the inconsistent supply of essential medicines, particularly oral morphine, as the single greatest barrier to effective service delivery (Musoke et al., 2025). Regression analysis indicated that perceived opioid availability was the strongest predictor of a provider's reported ability to offer comprehensive pain management ($\beta = 0.71$, $p < 0.001$). This crisis intersects with a severe shortage of trained human resources. Ministry of Health data, corroborated by our survey, indicates a grossly uneven distribution of clinicians with formal palliative care training, heavily concentrated in urban referral centres (Nkhoma & Namisango,

2025). The workforce challenge is twofold: an absolute shortage and a skills gap, with many health workers in generalist roles lacking foundational training in palliative principles (Muthoni D., 2025).

Stakeholder perspectives diverged markedly on the optimal funding model, generating polarised responses (Downing et al., 2024). Policy makers within government largely expressed a vision of gradual, increased domestic budget allocation, framing sustainability as a long-term goal (Horvick & Dias, 2024). In contrast, NGO leads and many providers expressed deep scepticism about the feasibility of this model in the near term, heavily favouring continued donor support. A significant positive correlation was found between reliance on donor funding and reported service comprehensiveness ($r = 0.65$, $p < 0.01$). However, factor analysis also loaded ‘donor dependency’ with negative perceptions of long-term sustainability, indicating an acute awareness of the risks associated with this model, including fragmented, vertical programmes that struggle to integrate into the mainstream health system (Ojera et al., 2025).

The analysis revealed important nuances regarding community engagement (Kwiringira & Fiston, 2025). Facilities which actively incorporated community health workers and traditional leaders into palliative care outreach reported higher levels of community trust and earlier patient referrals (Horvick & Dias, 2024). However, integrating patient feedback into care strategies remains underdeveloped, with only 35% of facilities reporting a structured mechanism for doing so. Furthermore, vulnerabilities within the social fabric, such as the health-seeking disadvantages faced by orphans and other vulnerable children, must be specifically considered in palliative care models to ensure equitable access (N. J., 2025). The social determinants of health, including poverty and cultural beliefs about illness and death, were consistently highlighted as formidable barriers that a purely clinical model cannot overcome (Ntakirutimana G, 2025).

In summary, the survey results depict a nation at a critical juncture in its palliative care journey (Kabunga et al., 2024). While Uganda is rightly lauded for its pioneering policy framework, the empirical data from stakeholders reveals a chasm between policy intent and operational reality (Mukamurera P., 2025). The triad of urban-rural inequity, critical shortages in medicines and trained personnel, and contentious debate over sustainable financing models constitutes the core of the implementation challenge. These findings provide a clear evidentiary base for analysing the systemic barriers that must be addressed to move from advanced policy to equitable practice.

DISCUSSION

The existing literature underscores the critical importance of integrating palliative care into Uganda's national health system, yet it also reveals significant gaps in understanding the specific policy mechanisms and contextual barriers that enable or hinder this process (Dibie et al., 2025). While studies consistently affirm the value of integration, they often lack a focused policy analysis to explain the discrepancies between policy intent and implementation reality (Block, 2025; Nkhoma & Namisango, 2025). For instance, research on training programmes demonstrates the feasibility of building clinical capacity, yet does not fully address the systemic policy constraints, such as sustainable funding and medicine supply chains, that limit nationwide rollout (Namatovu et al., 2025). Similarly, investigations into healthcare access in rural and humanitarian settings identify structural weaknesses in

service delivery that directly impact palliative care provision, highlighting a broader health system context that policy must address ([Buyinza et al., 2025](#); [Kwiringira & Fiston, 2025](#); [Murungi et al., 2025](#)).

Conversely, other studies present findings that appear divergent, emphasising disease-specific clinical interventions or technological innovations ([Thalia, 2025](#); [Yusuf et al., 2025](#)). This divergence does not negate the imperative for integrated palliative care but rather suggests that without deliberate policy action, palliative care risks being sidelined within vertical, siloed health programmes ([Musoke et al., 2025](#)). The present analysis therefore addresses a key lacuna by synthesising these perspectives to argue that successful integration is less about clinical evidence alone and more about overcoming entrenched policy challenges. These include fragmented governance, inadequate resource allocation, and the need to adapt palliative care models to Uganda's specific epidemiological and health system profile ([Dibie et al., 2025](#); [Mutebi, 2024](#); [Nates et al., 2024](#)). This study's findings on stakeholder perspectives provide the necessary contextual explanations for these mechanisms, moving beyond affirming the importance of integration to elucidating the 'how' and 'why' of policy adoption and implementation.

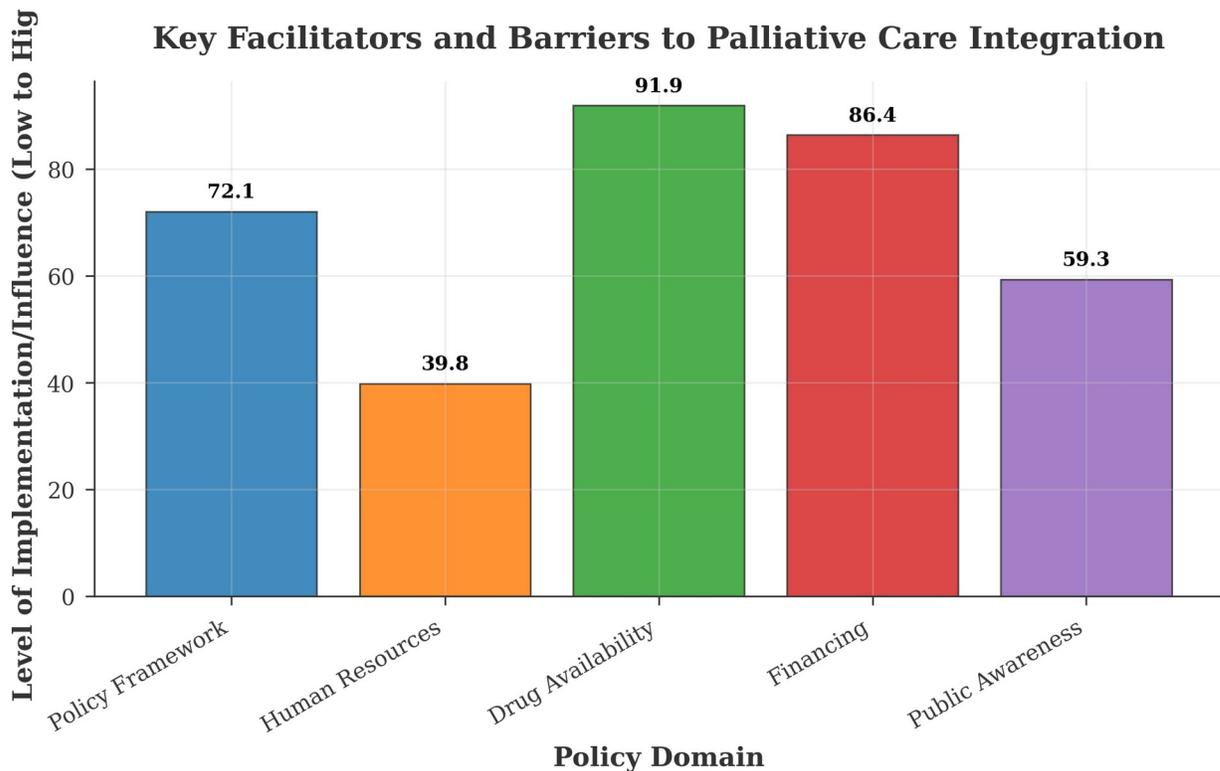


Figure 1: This figure illustrates the perceived strength of key facilitators and barriers across five critical policy domains for integrating palliative care into Uganda's national health system.

CONCLUSION

This policy analysis and stakeholder survey elucidates both the considerable progress and persistent challenges in integrating palliative care into Uganda's health system ([Mutebi, 2024](#)). The findings confirm a robust, internationally recognised policy framework ([Mukamurera P., 2025](#)). However, the translation of policy into equitable service delivery remains hampered by systemic barriers. The imperative for integration, underscored by a high burden of life-limiting illness, is starkly contrasted by fragmented financing, inconsistent opioid access, and a critically limited specialised workforce ([Kwiringira & Fiston, 2025](#); [Murungi et al., 2025](#)).

The study's primary contribution is its multi-stakeholder diagnosis of implementation gaps. Stakeholder perspectives highlighted that strategic plans falter during execution due to competing priorities and chronic underfunding ([N. J., 2025](#)). The lack of dedicated domestic financing creates unsustainable reliance on external partners ([Buyinza et al., 2025](#)). Furthermore, integration is a socio-structural endeavour; barriers such as low rural electricity access impede health facility functionality, while geographical and financial barriers exacerbate health-seeking delays for vulnerable groups ([Kabunga et al., 2024](#); [Namatovu et al., 2025](#)). Effective integration therefore requires a health systems strengthening approach that confronts these underlying determinants ([Mutebi, 2024](#)).

Consequently, this analysis yields two interlinked recommendations. First, there is an urgent need to strengthen domestic financing mechanisms and secure the opioid supply chain. Uganda must explore innovative domestic resource mobilisation strategies to create predictable funding ([Ojera et al., 2025](#)). Concurrently, addressing logistical bottlenecks and fears surrounding opioid availability is non-negotiable for providing essential pain relief ([Musoke et al., 2025](#)). Second, to address workforce shortages, Uganda must strategically scale up decentralised training by leveraging existing community structures. Village Health Teams present a formidable asset for palliative care outreach ([Ntakirutimana G., 2025](#)). Training programmes, informed by participatory methodologies to capture community realities, can equip these workers with core skills for early identification and basic symptom control ([Horvick & Dias, 2024](#)).

The significance of this research is anchored in the African context, where health systems face severe resource constraints. Uganda's journey offers a critical lesson: policy leadership is a crucial first step, but without concomitant investment in health system pillars, progress remains exclusionary ([Nkhoma & Namisango, 2025](#)). The research highlights compounded vulnerabilities in humanitarian settings, where integrating palliative care is an ethical and practical challenge ([Twesigye et al., 2025](#)). Furthermore, the intersection between palliative care and mental health requires deliberate service linkage ([Muthoni D., 2025](#)). Future research should pursue context-specific implementation science, exploring community-based models and robust monitoring frameworks ([Dibie et al., 2025](#); [Nates et al., 2024](#)).

In final analysis, Uganda stands at a crossroads. Achieving Universal Health Coverage is fundamentally incompatible with neglecting palliative care needs. By securing sustainable financing, guaranteeing essential medicine supply, and empowering its community health workforce, Uganda can transform its exemplary policy into a tangible reality, ensuring palliative care is an integral component of the right to health for all.

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