ORIGINAL ARTICLE

Accessibility and Organization of Palliative Care Services in Public Health Facilities of Jimma City: An Exploratory Qualitative Study

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ABSTRACT

BACKGROUND: WHO emphasizes availability of palliative care to those in need; it should be integrated into the existing health care system to make it accessible to beneficiaries. However, many Sub-Saharan African countries, including Ethiopia, have not well integrated it with the health care system. This study assessed the accessibility and organization of palliative care services in public health facilities of Jimma City.

METHODS: Exploratory qualitative study was conducted from April to June 2023. Complementary data were gathered from key informants at the Ethiopian Federal Ministry of Health, Hospice Ethiopia, Black Lion Hospital, and Saint Paul's Millennium Medical College. Data were collected through in-depth interviews, audio recorded, transcribed verbatim and analyzed. Trustworthiness was guaranteed by ensuring credibility, transferability, dependability, and conformability. Data were analyzed thematically. Coding and ordinary analysis were done using Atlas-Ti Version 7.14.

RESULTS: Among the six public health facilities in Jimma City, only Jimma University Medical Center (JUMC) officially provided palliative care services. Eighteen months before the study, JUMC had established a dedicated palliative care unit staffed with a multidisciplinary team: physicians, nurses, psychologists, and a social worker. Access to palliative care for patients with life-threatening illnesses and their families was insufficient to meet existing needs. Major challenges included limited resources, inadequate training for health professionals, lack of integration of palliative care into primary healthcare facilities, and poor availability of essential medications.

CONCLUSIONS*: *Palliative care provision in Jimma City is at an early stage. Improving accessibility requires the integration of palliative care into the existing primary health care system, training health professionals, and strengthening palliative care advocacy.

KEYWORDS: Accessibility, Jimma, Health Facilities, Organization, Palliative care

INTRODUCTION

Palliative care is a fundamental human right that offers holistic care that addresses the physical, psychological, social, and spiritual needs of the patients and their families. The World Health Organization (WHO) emphasizes that palliative care should be accessible and affordable to all individuals in need (1). It aims to improve quality of life through the prevention and relief of suffering by addressing the holistic nature of the illness (1, 2).

Despite its importance, access to palliative care remains extremely limited in low- and middle-income countries (LMICs), particularly in Sub-Saharan Africa (3, 4). Globally, more than 56 million people require palliative care each year, with approximately 76% residing in LMICs; however, only a small proportion receive appropriate services (5). Earlier estimates suggested that about 1% of the population requires palliative care at any given time (6). In contrast, palliative care was introduced to the Ethiopian health care system very recently in response to the HIV/AIDS epidemic, increasing non-communicable diseases, and rising cancer burden (2).

According to Ethiopia's Health Sector Transformation Plan II (HSTP-II), access to rehabilitative and palliative care services remains very limited nationwide (7–9), resulting in substantial unmet need (10, 11). Although national policy supports palliative care service provision, its implementation has been very weak, with health facilities prioritizing curative and preventive services. Where available, palliative care is often fragmented and largely confined to pain management without addressing the holistic health care needs of the patient and the family (8).

Evidence indicates that many patients in Ethiopia and other African countries who require palliative care do not receive it due to limited-service availability, poor access to essential medicines—particularly opioids—and high costs of care (10,12). Geographic distance from service centers and lower educational status further limit access to palliative care services (13). In addition, palliative care services are poorly organized and insufficiently integrated into the primary health care system, despite the existence of supportive national guidelines (5). These challenges are compounded by inadequate leadership, limited awareness among policymakers and health professionals, inconsistent training, cultural barriers, and insufficient budget allocation for palliative care (5, 8, 14-15).

Although previous studies have reported poor accessibility and weak integration of palliative care services in routine health care service provision in the country, recent initiatives by the Federal Ministry of Health necessitate updated evidence. However, data on the current accessibility and organization of palliative care at public health facilities remain limited. There is a lack of recent qualitative evidence that presents how palliative care is currently organized and accessed within public health facilities at the local level, particularly in the context of recent policy and training initiatives by the Federal Ministry of Health. Therefore, this study aimed to assess the accessibility and organization of palliative care provision in public health facilities of Jimma City, Southwest Ethiopia. The findings of the study help in designing appropriate tailored interventions by all relevant stakeholders.

METHODS

Study area, design, and period: This study was conducted in public health facilities of Jimma City using an exploratory qualitative study design to explore organization and accessibility of palliative care services from April 1 to June 30, 2023. The rationale behind following a qualitative approach was to capture the rich experience of the key informants and stakeholders on palliative care organization and accessibility in the study area. Jimma City is located in the Oromia region, 346 kilometers southwest of the country's capital, Addis Ababa. The city has two public hospitals, Jimma University Medical Center (JUMC) and Shenen Gibe General Hospital, and four public health centers: Jimma, Higher-two, Mendera Kochi, and Becho Bore Health Centers. Among these health facilities, JUMC serves as the referral center for the southwest part of Ethiopia, covering a catchment population of 15 million people.

To complement the data obtained from study participants in Jimma City, additional data were collected from key informants at the national level in Addis Ababa. These included representatives from the Ethiopian Federal Ministry of Health, Hospice Ethiopia, Addis Ababa University, and Saint Paul's Millennium Medical College, who were selected due to their extensive knowledge and experience of palliative care services and its integration in to existing health care system. Moreover, the key informants were selected to explore the existing palliative care opportunities and challenges for implementing palliative care.

Study participants: Health professionals with at least six months of experience in leadership positions were included in this study. Thus, the study participants include chief clinical directors, medical directors, head nurses of oncology and palliative care units, and heads of health centers. These study participants were purposively selected from Jimma City public health facilities due to their in-depth understanding of palliative care service provision in their respective health facilities. Additionally, senior health professionals working in oncology units, hospital quality officers, and members of the palliative care unit at JUMC were included as key informants, given their direct experience with palliative care service provision. At the national level, experts in palliative care were also included to provide input that could enrich the study findings.

Study participants selection process: The study participants were selected purposively based on their experience and involvement in palliative care services. This approach enabled the researchers to obtain in-depth insights into the accessibility of palliative care services, existing opportunities and challenges, and the status of palliative care service integration into the existing health care system. As a result, a total of 21 key informants participated in the study.

To cease the data collection, data saturation was sought. Data saturation was defined as the point at which no new information or themes emerged from successive interviews. Saturation was achieved when the last three interviews yielded no additional insights (15). Redundancy was tolerated for up to three respondents. To monitor data saturation, interviews were transcribed and reviewed daily, and emerging ideas and themes were continuously assessed throughout the data collection process. The participant selection process is presented in Figure 1.

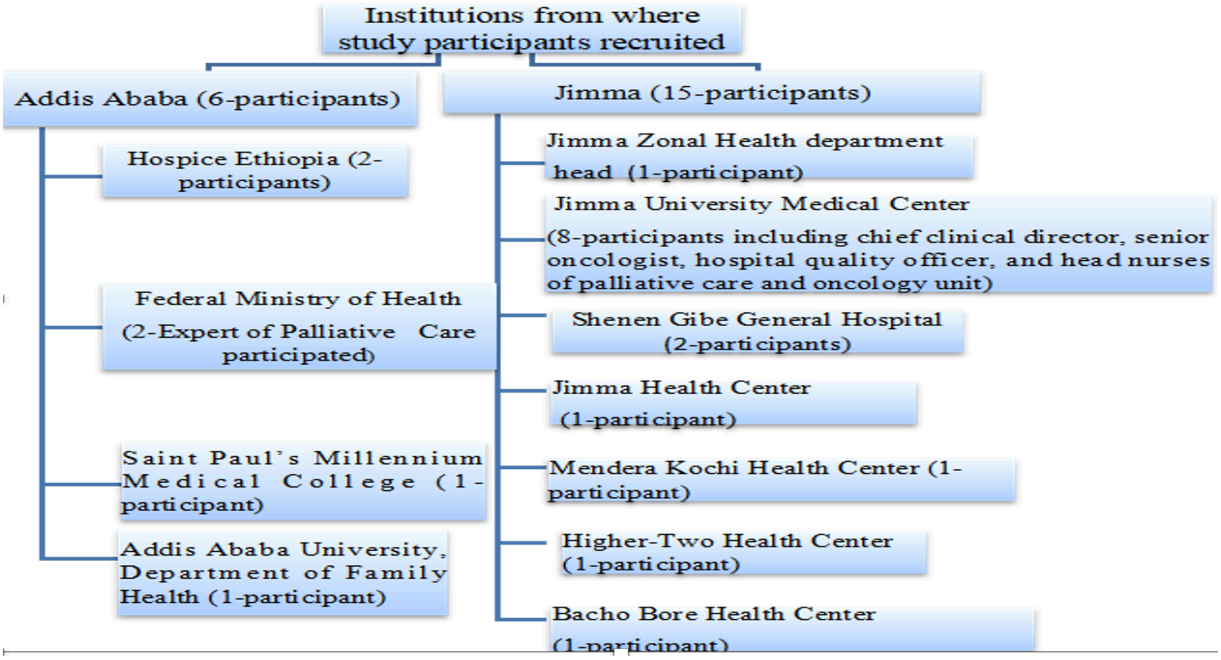

Figure 1: *Schematic diagram of the institution from where the study participants were selected for the key-informant and in-depth interview of this study.*

Data collection tool, procedure, and data analysis: Data were collected through in-depth interviews using an interview guide with detailed probing questions, prepared in English and translated into Afan Oromo and Amharic based on the study objectives (1, 2). Two trained data collectors conducted the interviews under the supervision of two experienced supervisors. Prior to the main study, the interview guide was pre-tested with two participants from the ART and emergency units at JUMC to assess clarity, question order, and interview duration. Data from the pre-test were excluded from the analysis, and the guide was revised accordingly.

Interviews were conducted in private rooms to ensure confidentiality and minimize distractions, with each lasting 45–60 minutes. Field notes were taken to capture facial expressions, gestures, and overall impressions, and interviews were audio-recorded, transcribed verbatim, and translated into English. The translations were checked for consistency by the supervisors and the principal investigator to ensure validity. Data focusing on the accessibility and organization of palliative care were analyzed using content analysis with Atlas.ti version 7.14 (3).

Data were managed by converting the narrative data into smaller more manageable segments, finally a deductive coding approach was applied, and preexisting coding framework was used. Categories and subcategories were developed in to themes for each participant and across different participants and finally the meaningful themes was interpreted

Trustworthiness: Trustworthiness was ensured through adherence to the four criteria of qualitative rigor: credibility, dependability, conformability, and transferability (4, 5).

Credibility: Prolonged engagement and triangulation of data from participants at different levels, including health center heads and national-level experts and also the interviews was undertaken after arranging suitable setting, time and place, peer debriefing was also done by providing raw data for different colleagues to look for the similarity of transcriptions by coding. Furthermore, triangulation between facilities and national level interviews and direct quotations' ensured the truthfulness of findings.

Dependability: Data collection tools were developed based on study objectives, reviewed by qualitative research experts, pre-tested, and revised to ensure reliability.

Conformability: Consistency between audio recordings, transcripts, and translations was verified by the research team and supervisors. Field notes, audio recordings, and transcripts were securely stored to maintain objectivity.

Transferability: Detailed documentation of the research process, participant characteristics, and study context allows findings to be applicable to similar settings, highlighting gaps in palliative care accessibility and organization.

Ethical statement: Ethical approval was obtained from the Ethical Review Board of Jimma University, Institute of Health, and the approval letter was shared with the managers of the participating institutions. Data collectors established rapport with participants, explained the study objectives, potential benefits, and confirmed that participation involved no risks, and obtained written informed consent. Respondents' anonymity was ensured, allowing them to share their experiences freely. Privacy was maintained during interviews by closing the room door to prevent disturbances or influence from others. Confidentiality was preserved by coding responses instead of using participants' names during data analysis.

RESULTS

Accessibility of palliative care: This section is divided into sub-sections covering: accessibility of palliative care services for those in need, availability of essential palliative care medications and supplies, advocacy for palliative care, and suggestions for improvement.

Organization of palliative care: Sub-sections in this part address respondents' experiences with palliative care, the status of service provision in their institutions, referral linkages and collaborations with other health facilities, policy

and guideline-related issues, models of care used, opportunities supporting palliative care, availability of dedicated funding, monitoring and evaluation, infrastructure, organizational challenges, and suggestions for improvement. Each sub-section is illustrated with direct quotations from respondents.

Socio-demographic characteristics of study participants: As shown in Table 1, key informants in this study were drawn from diverse organizations, positions, and educational backgrounds, ensuring the comprehensiveness of the collected data.

Table 1: Socio-demographic characteristics of the study participants.

Variables	Categories	Frequency
Position (responsibility)	Chief Clinical director or medical director	2
	Palliative care focal person	6
	Palliative Care and Rehabilitation Technical Working Group Team Leader	2
	Hospice- Ethiopia manager and staff member	2
	Oncologist	2
	Head of a hospital quality officer	1
	Zonal health department head	1
	Head nurse of pediatric oncology unit	1
	Health center director	4
Profession	General practitioner	4
	Obstetrics and gynecology specialist	1
	Family Medicine Specialist	2
	Pediatrics Hematologist and Oncologist	1
	Gastrointestinal Oncologist	1
	Public health officer	5
	Nurse	7
Work experience	1-15 years	21
Educational level	Bachelor of Science degree	7
	Masters of Science/ Masters of public health	5
	Specialist/sub-specialist doctor	5
	General practitioner	4
Sex	Male	15
	Female	6
Age	27-38	21
Marital status	Single	3
	Married	18
Ethnicity	Oromo	13
	Amhara	6
	Gurage and Silte	2

Accessibility of palliative care services in Jimma City public health facilities: Overall, palliative care (PC) is not widely available in these facilities. Among the six public health facilities, only Jimma University Medical Center (JUMC) officially provides palliative care service through an inpatient unit and home-based care for discharged patients, albeit with limited trained personnel. The multidisciplinary PC team at JUMC comprises four staff members: a general practitioner, a nurse, a psychologist, and a social worker. Inpatient care is initiated when primary physicians identify terminally ill patients and request the PC team to provide care. Home-based PC is delivered once or twice weekly, depending on patient demand. Other public health facilities in Jimma City have not officially begun providing PC services.

"…practically, our hospital tries to make palliative care accessible…through inpatient rounds and home visits for volunteer patients." (JUMC1)

"…most patients do not know what palliative care is…we provide care after identifying patient eligibility for gaining palliative care." (JUMC2)
Respondents from a general hospital indicated that lack of trained personnel, dedicated space, supplies, and medications hinder PC service accessibility:
"…since we don't have a separate room and staff trained in palliative care, its accessibility is limited. To improve, we need dedicated space, trained personnel, and essential materials and drugs." (SGGH1)
A respondent from Jimma Zonal Health Department noted that while reports suggest PC service is provided in the health facilities, its actual implementation remains uncertain:
"…the report shows palliative care service is being provided for a considerable number of patients, but I am not directly involved in provision." (JZHD)

Accessibility of essential palliative care medications and supplies: There is a significant scarcity of essential PC medications, particularly morphine, which is critical for managing severe pain. Morphine is often unavailable in health facilities and expensive in the market.
"The accessibility of morphine is very limited…this is demoralizing for staff." (JUMC1) "…patients face high costs for medications; it would be better if essential medications were provided free of charge." (JUMC2)
Palliative care advocacy: Community and healthcare professional awareness of PC is low. Only JUMC has conducted limited training for senior management, and some orientation sessions for patients and caregivers are provided. Social media campaigns have also been used to raise community awareness towards palliative care.
"Last year, we gave training for senior management on two occasions, but it is not sustainable." (JUMC1) "…patients and most hospital staff are unaware of palliative care availability; advocacy is still lacking." (JUMC2) "…we provide daily orientation for patients and caregivers and occasionally use social media campaigns to raise community awareness towards palliative care." (JUMC7)

Suggestions for improving accessibility: Participants emphasized the need for government attention, sharing international best practices, on-the-job training for health professionals, and community awareness campaigns.
"Palliative care should receive government emphasis…psychological support strengthens patients and contributes to health promotion." (JUMC1) "…more human resources need training, and public awareness should be raised." (JUMC2) "…stakeholders should support training, resources, and advocacy through local media and hospital channels." (SGGH1)

Organization of palliative care in Jimma City public health facilities:

Experience of study participants: Many hospital directors and staff reported minimal formal training in PC. Some received short-term training on pain management, while a few professionals have extensive experience, particularly in pediatric oncology.
"…I hadn't taken official PC training, but after assuming my position, I organized trained professionals to start the service." (JUMC1) "…I have eight years' experience in pain management as part of PC and train others on PC initiatives." (JUMC3) "…as a pediatric oncologist, PC has become routine practice for patients in need." (JUMC3) Nurses in oncology units reported practical experience and training in PC: "…I have good experience and have taken both basic and TOT training on palliative care." (JUMC6)

Current status of palliative care: Only JUMC officially provides PC, starting with a dedicated unit 18 months before this study. Initially focused on pediatric oncology, services now include adult oncology and medical wards, with support from Hospice-Ethiopia for home-based care.
"…it has been a year and a half since the PC service started. Documentation is good, and patients are satisfied." (JUMC1)
Despite these efforts, many staff and patients are unaware of PC, and service delivery remains limited:
"…most people do not know the term palliative care or its services." (JUMC5) "…the service is at an early stage; human resources, space, and medications are insufficient." (JUMC3)

Facilities struggle with inadequate equipment and shortage of strong opioids, affecting quality of care: "…for gastrointestinal tumor patients, feeding tubes are improvised, and NSAIDs are used for pain due to lack of morphine and fentanyl." (JUMC4)

Other public health facilities in Jimma City are unfamiliar with PC, providing only routine supportive care:

"…we haven't officially started PC…supportive care is provided only when patients come from other hospitals." (SGGH1)

Comparatively, Saint Paul's Millennium Medical College in Addis Ababa has a more advanced PC program with dedicated inpatient, outpatient, and home-based care.

Policies, strategies, and guidelines: Respondents are aware of national PC guidelines, though implementation is limited:

"…we have a multidisciplinary team and terms of reference, but official PC policy is lacking." (JUMC1) "…quarterly reporting exists, but achievement is almost zero as PC services are not officially offered." (SGGH1)

The Federal Ministry of Health has recently increased attention to PC:

"…FMOH pushed JUMC to establish a PC unit…national training manuals also exist." (JUMC3)

Model of palliative care: JUMC uses both facility-based and home-based PC models. Services are mobile, responding to unit consultations rather than systematic patient identification.

"…initially facility-based, later expanded to home-based care with Hospice-Ethiopia support." (JUMC1) "…mobile unit visits wards on consultation and provides counseling, psychosocial support, and home care. The program is nascent but encouraging." (JUMC3)

Collaboration and referral linkage: Referral linkages between Jimma City public health facilities are limited due to scarce human resources and patient reluctance to be referred.

"…limited capacity and patient reluctance hinder referral to other facilities." (SGGH1)

Some collaboration exists externally with PXL University, FMOH initiatives, and the ASLAN project in pediatric oncology.

"…external collaborations and pediatric oncology training provide opportunities to improve PC." (JUMC3)

Existing opportunities for palliative care provision: Opportunities include government policy recognizing PC as a quality indicator, advocacy by oncologists, existing PC teams, trained personnel, increasing prevalence of non-communicable diseases, and support from partners such as Hospice-Ethiopia and the American Cancer Society.

"…high demand, supportive policies, and active partners provide opportunities for expanding PC." (JUMC7)

Existing challenges: Challenges include poor awareness among health providers and the community, absence of PC in pre-service curricula, inadequately trained personnel, limited funding, lack of dedicated wards, and morphine scarcity.

"…without morphine, it is nearly impossible to provide palliative care." (JUMC5)

"…short-term training is insufficient; PC is not integrated into primary health care units." (MOH2)

Participants' recommendations for improvement: Participants recommended government recognition of PC, sufficient trained human resources, dedicated wards, equipment, and drug supply, integration into curricula, specialty programs, continuous professional development, and monitoring.

"…all stakeholders should agree on the significance of PC, incorporate it into education and service delivery." (JMC1) "…opening PC specialty training, locally or abroad, is crucial to establish foundational expertise." (JUMC3) "…local and international collaboration is mandatory for advancing PC in Ethiopia." (MOH1)

DISCUSSION

This study assessed the accessibility and organization of palliative care (PC) in Jimma City public health facilities. Among the six public health facilities, only Jimma University Medical Center (JUMC) officially provides PC. The service is

organized around a multidisciplinary team with a dedicated office, delivering care both in hospital wards and through a home-based PC model. However, the service accessibility remains limited due to the absence of a separate PC ward, insufficient trained personnel, lack of essential supplies such as morphine, and absence of referral linkages.

The limited accessibility, poor referral systems, and lack of integration of PC into primary healthcare units in Jimma City align with observations from Addis Ababa, suggesting that PC remains at an early stage nationwide. This reflects the need for concerted efforts to expand accessibility and integrate PC services into primary health care in Ethiopia. Respondents' suggestions for improvement, as presented in the results, offer valuable guidance for future interventions.

The limited access observed in this study is consistent with findings from other parts of Ethiopia and Africa, where only a small proportion of patients can access PC services in low- and middle-income countries (LMICs) (3–5). This is likely due to the overall underdevelopment of PC services in the country (16).

Challenges identified in Jimma City include a shortage of trained human resources, absence of PC in undergraduate health curricula, inconsistent morphine supply, inadequate budgets, poor ownership of PC programs, limited integration into primary healthcare, and low awareness among both health professionals and the community. These challenges not only limit accessibility but also compromise service quality, contributing to reduced community confidence in PC (12).

A major strength of this study is that the data collected from Jimma City public health facilities were complemented by input from national-level palliative care experts, which enhanced the credibility and accuracy of the findings. Consequently, the study provides a realistic depiction of the current state of palliative care in the country and offers valuable insights for stakeholders seeking to improve and expand palliative care services, particularly in Jimma City. However, a key limitation of the study is that it did not directly assess the quality of palliative care provision, making it impossible to evaluate how well the services are delivered in the facilities studied.

In conclusion, palliative care in Jimma City public health facilities is at an early stage, with substantial gaps in service delivery. Except for some professionals at JUMC, most health staff lack PC experience. Among the six public facilities, only JUMC has officially started PC provision. Major challenges include inadequately trained personnel, scarce morphine supply, insufficient budgets, limited awareness, absence of a dedicated PC ward, lack of integration into primary health care, and poor institutional ownership of PC programs.

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