An Ethical Argument for a Specific Model of Palliative Care in Nigeria

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AN ETHICAL ARGUMENT FOR A SPECIFIC MODEL OF PALLIATIVE CARE IN NIGERIA

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ABSTRACT

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Dissertation supervised by Professor Henk ten Have, MD, PhD

The need for palliative care in Nigeria is huge. But Nigeria has minimal palliative care activity that does not correspond to the great palliative care needs in the country. The great needs are heightened by poverty and poverty induced conditions. However, Nigeria has untapped sociocultural values that can boast palliative care in the country. Such values can be activated and constructively integrated in the practice of palliative care in Nigeria.

This project looks back to what palliative care has been in history and in developed nations to argue for a constructive and positive manner palliative care can evolve in Nigeria to address the peculiar situation of poverty and poverty induced conditions that make palliative care patients in Nigeria vulnerable. The capacities of palliative care as found in its history and its modern practice favor the integration of sociocultural values
and other favorable structures on ground that can boast palliative care in Nigeria. This will ensure that palliative care maintains its core meaning while integrating and injecting structures and values that are meaningful to palliative care patients in Nigeria. The specific model of palliative care in Nigeria as argued in this project, is designed to mobilize all affordable resources in a strategy that will ensure holistic care for the sick while at the same time attend to how they live not just how they die. The model also allows for easy access of care as it is designed to penetrate hard-to-reach communities of the country and to deliver care in any setting- rural or urban, in hospitals, palliative care units, or residential care homes.
DEDICATION

In Blessed Memory of my loving mother Agatha Nwogbo Egbe (1926-2015).

You will always be remembered and cherished. Your selfless life, unconditional love and unwavering care will be missed but not forgotten.
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Their support is always a pillar of strength to me. I have immense appreciation for the family of Dozie and Regina Obiekezie whose home is my second home in America. Their resolute friendship and hospitality will always be remembered and cherished. I will also like to thank my colleagues at the office of pastoral/spiritual care of UPMC. The positive energy they bring to the work environment was very motivational.

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>iv</td>
</tr>
<tr>
<td>Dedication</td>
<td>vi</td>
</tr>
<tr>
<td>Acknowledgement</td>
<td>vii</td>
</tr>
<tr>
<td>Chapter One: Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Chapter Two: Origin and Development of Palliative Care in Western Countries</td>
<td>15</td>
</tr>
<tr>
<td>A. Palliative Care: Origin, Evolution, and Earliest Concepts</td>
<td>16</td>
</tr>
<tr>
<td>1. Origin, and Evolution</td>
<td>23</td>
</tr>
<tr>
<td>2. Concepts</td>
<td>24</td>
</tr>
<tr>
<td>i. Earliest Concepts</td>
<td>24</td>
</tr>
<tr>
<td>ii. Modern Concepts</td>
<td>28</td>
</tr>
<tr>
<td>B. Current Practice and Models</td>
<td>32</td>
</tr>
<tr>
<td>C. Nature of Palliative Care</td>
<td>36</td>
</tr>
<tr>
<td>Chapter Three: From Developed Nations to Developing Nations: Lessons of Palliative Care in Developed Nations for Developing Countries</td>
<td>47</td>
</tr>
<tr>
<td>A. Lessons of Developed Palliative Care in Western Countries</td>
<td>49</td>
</tr>
<tr>
<td>1. Availability of Palliative Care</td>
<td>52</td>
</tr>
<tr>
<td>i. Advanced Pain and Symptom Management</td>
<td>54</td>
</tr>
<tr>
<td>ii. Attention to Psychological and Spiritual Needs/Concerns of Patients and Families</td>
<td>57</td>
</tr>
<tr>
<td>iii. Development of Multidisciplinary Teams</td>
<td>58</td>
</tr>
</tbody>
</table>
2. Adaptations to Structures on Ground........................................61

3. From Basics to More Current Pressing Issues.............................65

B. Status of Palliative Care in Developing Nations............................67

1. Lack of Palliative Care..........................................................67
   i. Characteristics of a Developing Nation.................................68

2. Palliative Care a Necessary Response........................................70
   i. Current Meaningful Efforts..............................................73
   ii. Additional Issues of Different Nature.................................76

Chapter Four: Palliative Care in Nigeria........................................88

  A. Nigeria as a Developing Nation.................................................88

   1. Nigeria: A Developing Nation with a difference .......................90
      i. Population, and Economic Growth....................................90
         a. Population..........................................................90
         b. Economic Growth....................................................91
      ii. Disease Control.......................................................92

   2. Poverty and Poverty Induced Conditions.................................95

  B. Peculiar Situation: The Double Burden of Sickness for Palliative Care

      Patients.................................................................................100

       1. The Effects of the Peculiar Situation..................................100
          i. Need for Palliative Care.............................................100
          ii. Burdens of Poverty and Diseases.................................101
             a. Burdens of Poverty.................................................102
             b. Burdens of Diseases/Sickness.....................................103
 iii. Burdens from Weakness in Health Care Delivery .................. 107

C. Current Palliative Care Activities .................................................. 113

Chapter Five: Sociocultural and Religious Factors in Nigeria ................. 129

A. Nigerian Traditional/Cultural Worldview and Attitude Towards Sickness, Death, and Dying ......................................................... 135

1. Concept of Sickness and, Attitude Towards Death and dying ............ 140

i. Concept of Sickness ................................................................. 143

ii. Attitude Towards Death and Dying ......................................... 146

iii. Burial/Funeral ........................................................................ 150

2. Positive and Negative Aspects of the Culture for Patients ............... 153

B. Role of family in the Care of the Sick ........................................... 161

1. Family as a Site of Care ............................................................ 161

2. Kinship, Nuclear Family and Extended Family ............................. 163

i. Kinship System as the Force of Family .................................. 163

ii. Extended Family and the Care of the Sick ............................... 164

C. Religion and Alternative Beliefs .................................................... 166

1. Religion ................................................................................. 166

2. Alternative Beliefs .................................................................. 168

D. Positive Contributions of Missions .............................................. 172

Chapter Six: Evaluation and Conclusion (The Suitable Model) ............... 184

A. Constitution and Application ....................................................... 184

1. The New Integration Strategies ................................................. 184

2. WHO Basic Principles ............................................................. 185
B. Soft Spot Approach (Shift-in-Approach Strategy)……………………………186
   1. Soft Spot Approach………………………………………………………188
C. Collaborative Approach (Extensive Collaboration Strategy)………………..192
   1. NGO’s (foreign and local)………………………………………………195
   2. Mission Structures on Ground and Faith-Based Organizations…………197
   3. Harnessing Cultural Values: Traditional Healers, and Family Care ……199
      i. Traditional Healers…………………………………………………199
      ii. Family Care………………………………………………………201
D. Millennium Goals as Ultimate Vehicle (Ultimate Goals Strategy)…………202

Conclusion………………………………………………………………………205

Bibliography ……………………………………………………………………209
Chapter 1: Introduction

General Introduction

The study of the development and practice of palliative care in developed countries has shown that palliative care is important, necessary and achievable. As an important and necessary practice, it offers many benefits to the needs of patients with life-limiting illness and their families. As an achievable practice, palliative care has capacities that allow it to develop in different times and places. Since patients and families of patients with life-limiting illness abound in all nations, lack of palliative care then, in any place, whether developed or developing nations, is not only a denial of these basic benefits to patients and their families but also ethically unacceptable. The argument here is that since palliative care is important and necessary because of its ethical values for patients with life-limiting illness and their families, then the success story of palliative care in places where it has been developed should inspire effort in places where it is lacking such as Nigeria.

Patients with serious and complex illness abound in both developed and developing nations. But the practice of palliative care for them has not been in equal measure. Many people still die in developing nations without palliative attention. Most developing nations are in a poverty trap with political instability and lack of improved technology that accelerates “the transfer of information.” These make them vulnerable and disadvantaged from the perspective of palliative care. In addition, the initial narrow concept of palliative care that focused on patients with incurable cancer did not favor developing nations. To allow this trend of inequality to continue in developing nations especially in this technological age is ethically unacceptable. The progress made in developed countries and the current efforts in some developing nations gives inspiration for palliative care for developing nations like Nigeria.
The hope for advanced pain management in Nigeria is far from being realized. Nigeria has minimal palliative care activity. In Nigeria, extensive suffering and high incidence of incurable and chronic diseases go hand in hand. Many patients die without good pain management and effective palliative care. This makes palliative care an urgent necessity in Nigeria. To address this need with only minimal palliative care activities, as is currently practiced, is not the best for the country and its suffering patients.

Also, end of life care in Nigeria is expensive, scarce and difficult to access. Only a few rich can afford it. That it is scarce implies there is not enough even for those who can afford it. It is actually accessible only in some hospitals located in the big cities. In contrast, the greater population is mostly the poor who reside in rural areas. Morphine, which is a major factor in pain management, is in very short supply in Nigerian because of poor coordination and government bottlenecks.

The current practices of palliative care in Nigeria are ethically unacceptable. This is all the more worrying because Nigeria has socio-cultural and religious structures and traditions that could be used but have not been tapped to develop palliative care. Many scholars have argued that cultural values in Nigeria favor the development of palliative care.2 Tapping on the socio-cultural and religious structures and traditions would make palliative care much more accessible.3 Unfortunately, these have not been harnessed. A specific model of palliative care is what Nigeria needs to address these shortcomings. Such a model will utilize the socio-cultural and traditional values to address the peculiar palliative care needs in Nigeria.

The objective of the project

This DHCE project makes an ethical argument for a specific model of palliative care in Nigeria. The model will utilize the socio-cultural and religious structures and traditions in Nigeria to
address the distinctive palliative care needs around life-limiting illness, regardless of diagnosis. The model will explain how care can be delivered in any setting, whether rural or urban, hospital or residential. The project will also make the case that success story of palliative care in some developing nations should inspire efforts in other countries, like Nigeria.

Because the incidences of incurable and chronic diseases are high in Nigeria, the extensive sufferings undergone by the patients make the provision of good palliative care an urgent necessity. Currently, many patients die without good pain management and palliative care. From an ethical point of view, it should be argued that lack of palliative care services is not acceptable in Nigeria just as in developed countries. Many scholars equally argue that Nigeria has many cultural values favorable to the development of palliative care. At the moment, there are only incidental and fragmented palliative care activities. The challenge is how a systematic provision of palliative care in Nigeria can be developed, improved on and be sustained. This DHCE project is committed to proposing a way.

Outline of the project
This DHCE project will develop an ethical argument for a specific model of palliative care that will serve the distinctive needs of the Nigerian people with life-threatening situations taking into account their religious and cultural context. It will also be a scheme accessible to the greater population of those who need it. The project will include six chapters. Following the Introduction (chapter one), chapter two will analyze palliative care as it has developed in Western countries. Chapter three will analyze the lessons of this development for developing countries and the status of palliative care in them. Chapter four will focus on Nigeria and its distinctive context with the aim of exploring its healthcare needs and the demands for palliative care, as well as how these are not well addressed. To prepare the ground for the conclusion, chapter five will explore
Nigerian cultures favorable to palliative care and assess the positive and negative determinants of palliative care in the various cultural, social and religious settings at work in Nigeria. Finally, chapter six before offering a conclusion will synthesize the ethical arguments in support of a specific model of palliative care in Nigeria. It will develop and present the model showing how it is constituted and how it can be applied.

Analysis of the Chapters

To pursue this thesis, the chapters are analyzed as follows.

Chapter two analyzes palliative care as it has developed in Western countries beginning with an understanding of history of care through the evolution that ushered in the modern palliative care practice. Part of this chapter will analyze palliative care as it has developed in Western countries in order to highlight some capacities inherent in palliative care that allow it to grow in different times and places. In light of this scholarship, the chapter discusses both the history of care in general and the history of palliative care in order to identify potential capacities in palliative care that can be developed elsewhere, especially in developing nations. The goal is to establish the point that palliative care is necessary and achievable irrespective of culture or geographical divide.

Chapter two will be divided into three major sections. The first section will discuss Palliative Care, its origins, evolution and earliest concepts. This section discusses and describes not only the origins and growth of hospice movement but also the history and development of palliative care. The basic principles of palliative care (including the crucial role of curing and caring) are explained. Furthermore, some of the works of Dame Saunders, the acclaimed founder of modern palliative care movement, are discussed to consider how palliative care can be practiced in other places irrespective of culture or resources.
The section is further divided into two subsections. The first subsection will focus on the origin and evolution of palliative care to highlight changes in palliative care over history. The second sub-section will discuss the concepts of palliative care, distinguishing the earliest concepts from modern concepts. The discussion will consider the sequence of concepts that gave rise to modern concepts of palliative care.

This analysis is continued in the second section to address current concepts and practice of modern palliative care. The third section will analyze the nature of palliative care exploring a variety of authors. From this discussion, the analysis will identify positive capacities and qualities in palliative care that can influence developing nations such as Nigeria. That is to say; palliative care can evolve in a positive and constructive manner in a developing nation like Nigeria.

Having explored the development of palliative care in Western nations, Chapter three analyzes lessons of palliative care for developing countries. Among the major lessons of palliative care in developed nations is that it is readily available even for the most serious and complex illnesses. The opposite is true for developing nations. This will be discussed in two main sections.

The first section discusses the lessons of Palliative care from developed nations. The section will further be discussed under subsections. The first subsection will highlight the availability of palliative care in developed nations even for the most serious and complex illnesses.

This section will discuss palliative care activities as lessons that can be applied from developed nations to developing nations. The lessons deal with these topics: Advanced Pain and Symptom Management, Attention to Psychological and Spiritual needs and concerns of patients and families, and Development of Multidisciplinary teams. The section further discusses the
importance of teamwork. Teamwork is indispensable for successful palliative care programs.\textsuperscript{15} The importance of teamwork among palliative care providers, including hospice doctors, the patient’s doctor, nurses, home health aides, grief support staff, social workers, chaplains, and volunteers is highlighted. These teams function in a variety of settings in developed countries, including hospitals, care centers, and home care settings.

The second subsection considers the importance of adaptation to structures on the ground. That is, developing nations can adopt structures that work in developed countries. These structures include a variety of topics, such as drug availability in hospitals, palliative care in hospice, education and research programs, and policies on the availability of palliative care. In particular, the analysis will explore these topics: the availability of palliative drugs, family support programs, and palliative teamwork.\textsuperscript{16}

The third subsection discusses some of the pressing issues in palliative care in developed nations.\textsuperscript{17} These issues in developed nations can be distinguished from the problems facing developing nations.\textsuperscript{18}

The second section of the chapter discusses the status of palliative care in developing nations with two subsections. First, the achievement of developed nations is lacking in developing nations. The situation of palliative care in developing nations is precarious because of the vulnerable and disadvantaged situation of poverty. Second, the analysis emphasized that palliative care is a crucial response to these circumstances of poverty.\textsuperscript{19}

Chapter four discusses the healthcare needs for palliative care in Nigeria and how these needs are not well addressed currently. The discussion is analyzed in three main sections. The first section discusses Nigerian as a developing nation with many shortcomings (the first subsection),
especially in light of poverty and poverty induced conditions (the second subsection). This discussion is continued in the second section of the chapter highlighting the double burden of sickness and poverty as a peculiar situation with serious consequences for Nigerians. The third section of the chapter discusses current palliative care activities in the country and works that address the promotion of palliative care in Nigeria. This section also considers other studies that highlight the need for a strong pain management program focusing on the availability of morphine that is currently lacking. Furthermore, this section engages broader studies such as on the relation between religion and palliative care and on the perils associated with practicing palliative care in Nigeria.

Chapter five discusses the sociocultural and religious factors in Nigeria that can foster the development of palliative care. The first section discusses the Nigerian traditional worldview and attitude towards sickness, death and dying. Concept of sickness in the Nigerian context, (first subsection), and positive and negative determinants of palliative care in various cultural, social and religious settings in Africa in general and in Nigeria, in particular, will be discussed (second subsection).

To appreciate the significance of this cultural context, attention needs to be given to the role of the family in caring for the sick (the second section) and to the impact of religion and alternative beliefs (the third section), especially with regard to death and dying.

Alternative beliefs can assist or hinder the growth of palliative care. In this regard, an important example of using culture to foster palliative care can be found in the endeavors of Anne Merriman who has been in Africa since 1964. She started in Nigeria before venturing to other parts of Africa and eventually settled in Uganda. Given her experience, she emphasized the importance of culture in palliative care approach in African countries. The fourth section
recognizes the positive contributions of the missions and faith-based organizations and argues for their importance in palliative care in Nigeria.

In light of the sociocultural and religious factors in Nigeria that can help to foster palliative care, Chapter Six concludes this project with a presentation of a specific model of palliative care in Nigeria. The model emphasizes the need to embrace the sociocultural and religious traditions. It seeks to highlight the distinctive palliative care needs of the families and patients with life-limiting conditions during their illness trajectories, regardless of diagnosis. The model is designed to deliver care in any setting (rural or urban, in hospitals, palliative care units, or residential care homes).27

The analysis is developed in four sections. The first main section discusses the Constitution and Application of the model using the works of authors who advocate for a shift in approach to palliative care, especially in rural areas.28

To explain this approach, two subsections consider integration strategies and WHO’s Basic Principles. The first subsection presents new integration strategies that will drive the suitable model of palliative care for Nigeria. The second subsection combines the general practice of palliative care with WHO’s basic principles for developing nations. An argument is made for a model that will integrate WHO’s basic principles into the existing health care system, especially developing appropriate policy, ensuring adequate drug availability, and supporting adequate health care coverage. This is designed to specifically benefit low resource areas.29

The second main section argues for a soft-spot approach as being suitable for Nigeria as resource disadvantaged nation. The analysis developed the Individual Country Report on Nigeria, as discussed by some authors.30 The Individual Country Report on Nigeria is the outcome of the research by the International Observatory Researchers to ascertain the level of palliative care
activities in the developing countries of Africa. Two individuals, in particular, contributed to The Individual Country Report on Nigeria that reviewed the activities of palliative care in Nigeria, namely, Olaitan Soyannwo and Olusola Fatunmbi.

The Report showed a soft-spot to palliative care in Nigeria in the sense that strictly speaking what is on ground in Nigeria could not be considered as palliative care but was considered for review based on the overall principle of making exceptions for palliative care in resource disadvantaged areas such as Nigeria. The analysis considers other authors who support this approach to include variety items for practical care, including the following: pain management, symptom control, counseling, psychological and emotional supports. Other items in the practical care package include spiritual care and orphan care, financial support, income generation, for food and shelter, funeral costs, school fees, and other necessary reliefs. The soft-spot approach can provide an appropriate form of palliative care in Nigeria because it specifically engages the problems of poverty and other diseases and epidemics relating to poverty.

The third main section discusses a Collaborative approach as argued by Oliver, Olupitan, and Oyebola. Their work stresses a collaborative approach to palliative care to improve healthcare education and service provision in the country. Their work acknowledges the positive results of collaborative projects between the Federal Medical Center in Abeokuta (FMCA) and two UK Hospices that helped to improve education for clinicians of the FMCA.

The argument in this section supports this collaborative approach. The approach includes not only foreign NGO’s (subsection one) but also local institutions. It recognizes the structures on the ground and the contributions of such agencies as missions (subsection two). This collaborative approach embraces cultural values, such as engagement of the role of traditional
healers\textsuperscript{34} to draw the potential benefits of their service, use of complementary and alternate medicine\textsuperscript{35}, and family care\textsuperscript{36} (in subsection three).

The fourth main section will argue for the integration of the WHO’s Millennium goals as ultimate vehicle to nurture palliative care in Nigeria. This approach has worked well in a particular state in Nigeria.\textsuperscript{37} The case of ANIDS is a practical situation that can be multiplied to the other states in Nigeria. ANIDS refers to the Anambra Integrated Development Strategy that is a novel program of action initiated by the government of Anambra state in 2006. This initiative was a multi-sectorial model predicated on the internationally acclaimed Millennium Development Goals (MDGs). These goals include the “Eradication of Extreme Poverty & Hunger, Gender Equality & Women Empowerment, Reduction of Child Mortality, Maternal Health, HIV/AIDS, Malaria and other Diseases, Environmental Sustainability, and Global Partnership in Development.”\textsuperscript{38} This model based on the Millennium Development Goals can offer a different approach to what constitutes palliative care in developing nations. The suggested model of palliative care in Nigeria with its large rural populations will directly engage these Millennium Goals as a crucial component of palliative care in Nigeria. The case of ANIDS is a practical situation that can be multiplied to the other states in Nigeria.
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Perspective
global Challenge
Have and David Clack, 1
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David Mazza, xxv
and Palliative Care in the Developing World and Marginalized Popu
"Hospice and Palliative Care: A Universal Human Imparative
Clark, 18
and the Historical Background." In
No Harm." In
Sanctity of Life and
Ethical Issues in Palliative Care
Stephen L Isaacs and Robert G Hughes, 3
Status, and Future of Palliative Care." In
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Chapter 2: Origin and Development of Palliative Care in Western Countries

The knowledge of what palliative care has been in developed nations is very important to understand what palliative care should be in Nigeria. For a task in establishing a specific model of palliative care appropriate for the future of palliative care needs in Nigeria, an understanding of the history of care from the point of view of the evolution that ushered in the modern palliative care practice is very important. The evolution found in the history of care can form the window through which one can evaluate and appreciate the current palliative care practice in developed nations. By offering not just a good understanding of the history of palliative care but also the history of care in general our discussion will assemble the capacities inherent in palliative care that allow it to grow in time and places. This effort argues that palliative care in Nigeria is important, necessary and achievable irrespective of the culture and geographical divide.

Trace will be made to the earliest concept of palliative care in the Hippocratic era. The discussion on history of care, in general, starting from the Hippocratic era and the history of palliative care in particular is aimed at identifying the potential capacities in palliative care that can be developed elsewhere, especially in a developing nation such as Nigeria.

Equally to be discussed is the movement that started the modern palliative care practice. The development of modern palliative care as practiced today in most developed nations of the world was ushered in through a movement that started in the field of care around 1960's. The movement later resulted in the establishment of St. Christopher’s Hospice in 1967. The new practice at St. Christopher’s Hospice in London, under the charismatic leadership of Cicely Saunders carried with it the knowledge from the history of early hospices and their values.1 The
practice transformed what it acquired from the old in a new pattern that addressed the palliative care need of the time as it welcomes, accepts with respect and provides the hospitality of a good home to patients.  

What we have today as the modern palliative care is the brain child of this early movement that added and applied scientific rigor, professional education and training to care, and insisted that the procedures be part of the new hospice practice. The knowledge and practice gained at this early beginning have continued to evolve to meet the needs and values of various cultures wherever modern palliative care is practiced.

This chapter argues that based on the knowledge drawn from the history of care, there are certain capacities inherent in palliative care that have allowed it to grow in places. The goal here is to seek a justification for the possibility of a veritable palliative care in Nigeria in spite of the Nigerian challenges. Palliative care can be fashioned to suit the culture and needs of the people of Nigeria.

A. Palliative Care: Origin, Evolution, and earliest Concepts

Palliative care literatures show that palliative care has not been static in practice, name and even in definitions. In other words, palliative care has been in constant evolution and transformation. In its historical transformations the knowledge of the past activities has always aided or been carried over somehow in the development of new ideas and practices. For this reason, our discussion on what palliative should be in Nigeria must look into what palliative care has been. The word ‘palliative’ is derived from the Latin word *Palliare* meaning, to clothe as to give warmth from cold. The notion of *clothe as to giving warmth* from cold informs the practice in early hospice care of the 4th century (middle ages) where a home becomes the ‘clothe’ that proves different kinds of warmth to different kinds of ‘cold’ and harshness of life; a home of
warmth and shelter for the homeless; a home of acceptance to the down trodden and the rejected; a home for security from harshness of life; a home of energy, rest, and refreshment from weariness for pilgrims etc. In this way the home becomes the ‘clothe’ that generates ‘warmth’ that can dispel the ‘cold’ of hardship and suffering as it provides hope and reassurance for people in that era who found themselves in the ‘cold’ of hopelessness of life. 6

While the name/ coinage “palliative-care” is later, the idea of clothe as to give warmth from cold has been in existence many years even in the middle ages before the current coinage to depict a kind of care in our modern time.

There has been medical use of the term as well which dates as far back as seventeenth and eighteenth centuries. Around the period as noted by some authors, the term ‘palliation’ was used in medicine to refer to a practice of resorting to symptom control instead of curative therapy in a disease whose cause cannot be reversed.7 This becomes a big deal in an era when the sole priority of a physician was to bring cure. Both the ideas of ‘Palliare’ of the middle ages and ‘palliation’ of the 17th and 18th centuries could explain how symptom control has come to form part of modern palliative care practice. Though these ideas were carried over, what emerged is that today’s palliative care has transcended these ideas and understanding to include some other ideas and practices aimed at relieving the suffering of patients.8 In other words, palliative care has been in constant evolution and transformation not just in name, practice and activity but equally in its definitions as we can now see.9

The definition of palliative care has changed significantly in years. Efforts to understand palliative care more clearly have resulted in the many definitions of palliative care. In these definitions, one can notice some changes in palliative care itself. Conversely, the transformations in palliative care have given rise to many definitions aimed at a better understanding of palliative
care such that some have limited palliative care to a particular specialty. However, the resultant effect of the new pattern of modern palliative care transcends limiting it to any particular specialty.

Palliative care literatures show that from its early practice and in its definitions, palliative care assimilates and accommodates ideas from any source that are relevant to its practice. For instance, from the beginning of modern palliative care in the late 1960s it is clear that what started as a response to one patient resulted in putting together a number of unrelated demands that were not originally there but which eventually resulted in a new pattern/synthesis. Again the response to these unrelated demands generated inputs from many sources not just from medical fields but from outside it as well. Although palliative care initially got its current name in the area/field of healthcare, and though, some probably because of this fact continue to confine palliative care to a medical specialty, the fact remains that palliative care has always had an open window that allows multi-disciplinary team work and input both from history and different other sources without hierarchy of importance among the contributors. This gives palliative care an open window for assimilation and accommodation of ideas; a feat that can be replicated in the practice of palliative care in Nigeria to meet up with the peculiar palliative care situation in the country demanding urgent attention especially when the idea of open window is supported by the definition of palliative care from the World Health Organization.

The definitions put forward by WHO invariably supports the open window inherited by palliative care from its early beginning. Thus setting in motion and supporting a process that can accommodate unrelated demands and sought input from various sources including but not limited to history, professionals from various aspects of life, researches, patients and families of patients etc. This gives palliative care an open window that suggests a potential in palliative
care to move from being just a medical specialty to an interdisciplinary specialty without hierarchy of importance. It shows palliative care cannot be confined to a particular specialty, or to a particular kind of building hence, palliative care is a kind of care that is active, total and comprehensive, an approach that utilizes active care to improve the quality of life of patients and families of patients. It is, as will be shown later, a multi-disciplinary specialty aimed at relieving and preventing suffering. Irrespective, of where palliative care belongs, the aim is consistent and the goal the same. The issue is having the right approach that will result in achieving the right aims and goals or objectives of palliative care.

A look at the 1990 and 2002 World Health Organization’s (WHO’s) definitions of palliative care shows that while the earlier definition was later tweaked and modified the goal remains the same while new approaches were added. The 1990 definition states:

“Palliative care is the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best quality of life for patients and their families. Palliative care:

- affirms life and regards dying as a normal process;
- neither hastens nor postpones death,
- provides relief from pain and other distressing symptoms,
- integrates the psychological and the spiritual aspects of care,
- offers a support system to help patients live as actively as possible until death, and
- offers a support system to help the family cope during the patient’s illness and in their own bereavement.”

This definition has not been constant. Actually, some aspects of this definition were later removed and new concepts added as WHO fine-tunes its definition of palliative care. In 2002 WHO redefines palliative care as follows:
“Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten or postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patients illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.”

This fine-tuned outcome by WHO stands out today as the current definition of palliative care. It is widely accepted and is equally endorsed by the International Association for Hospice and Palliative Care (IAHPC). The goal is still the achievement of best quality of life for patients and families with new emphasis on how this goal could be achieved. For this reason palliative care is not just an approach that focuses on relieving and preventing the sufferings and improving the quality of life of patients and families who face life-threatening illness, by providing pain and symptom relief, spiritual and psychosocial support. Rather palliative is also an approach that starts these procedures very early in the course of illness from diagnosis to the
end of life and continues to bereavement. From this new definition we begin to see some new developments.

First is the accommodative nature of palliative care. Note how “whose disease is not responsive to curative treatment” as captured in the first (1990) definition above was removed from this later definition. Note equally that “is applicable early in the course of illness, in conjunction with other therapies…” is added to the later definition. Also new is the emphasis on the “use of team approach to address the needs of patients and their families.” The implication is that we are left with a more inclusive palliative care—a kind of an open window. Palliative care is not just “limited to patients whose diseases defies curative treatment”. Palliative care includes them and extends to include all those facing the problem associated with life-threatening conditions. This explains equally the emphasis as added in the current definition that palliative care “will enhance quality of life, and may also positively influence the course of illness.” This accommodative nature of palliative care is a potential in palliative care that can be utilized in a developing and poor resource nation such as Nigeria to address her specific palliative care situation.

The evolving nature of palliative care can also be viewed not just from its definitions but from its early practice as well. For instance, the word palliation as observed earlier, has been in use for centuries in medicine as symptom control (symptomatic treatment) not necessarily as a type of ‘total care.’ In this context palliation does not seek for the total comfort of the patient. The spiritual, psychological, social etc. of the patient were left out. But the word palliative care as a type of care dedicated to (that seeks for) the overall comfort of the patient was first coined and used in 1975 by Balfour Mount to represent a unit of care he set up in a teaching hospital in Montreal, Canada where he carried out palliative activities to the needing patients in consultation with his colleagues. Before this time palliative care practice in
this context has been known and practiced under the terms like *terminal care*, and *hospice*. The term Hospice, has been in use since the 4th century, and was eventually adopted and used by the first hospice movement in London championed by Cicely Saunders the acclaimed founder of modern palliative care movement. Though the emergence of modern palliative care in the late 60’s and its current concepts is traceable to Saunders, the earliest concept could be traced to the Hippocratic era (431-404bc). Input from history including concepts from Hippocratic era became part of what began in London at St. Christopher in 1967 as a response to the demand of one patient who died in a big London teaching hospital in 1948. Saunders’ encounter with this patient- David Tasma-, a polish Jew did not only kick-start a movement founded on the Judean-Christian ethic, but also resulted in the process Cicely Saunders compared to the “assembling of a Kaleidoscope.” In other words the processes started the idea of assembling unrelated demands and bringing them together in a new pattern or synthesis.

With this we begin to see an evolution of palliative care that seeks and adopts ideas from various sources carrying with it ideas from the earliest concepts and bringing them together in newer concepts and patterns for one single purpose. That was how Saunders proposed the idea of "Total pain" and the eventual upgrade to "total suffering" requiring a comprehensive care. This has given rise to a shift from considering pain just as a symptom to a new idea of pain as an experience with physical, psychological, and other dimensions that can overwhelm an individual doctor or care-giver. According to some writers, the elevation of pain to suffering occurs when an imminent/ “impending destruction of the person is perceived and continues until the threat is removed” or controlled or the person restored in some other way. One can then say that palliative care deals with the complexity in the nature of suffering.
Seeking comprehensive solution for the hydra-headed nature of the suffering patient’s situation transcends the attention of any one single discipline hence it gathers input from many sources and has continued to do so till date. In other words, palliative care was never to be confined to any particular specialty, nation, or culture. Palliative care is equally open to new ideas and changes as some shifts, changes and the power of palliative care to evolve is noted in its time and history.

1. Origin, and Evolution

There is a general agreement among authors that Palliative care- the new field of care- is traced to Cicely Saunders who founded the modern practice in palliative care. The new practice aims at giving comfort and relief from suffering for patients, and families of patients with serious and complex illness as a way of ensuring the best quality of life for them. Though new, its concept can be traced to the Hippocratic era as well as from moral traditions. In other words, there has been shifts and changes associated to the ways palliative care was understood and operated. Transforming and sustaining its core values through such changes indicates the power of palliative care to evolve in time and history to suit/fit-in in every culture and place.

First the earliest notion of palliative care though in concepts only, can be traced to the Hippocratic era. From there it evolves as it existed only in concepts in that era. It was Heraclitus (540-480 BC) a Greek Philosopher who said that the only thing constant in the world is change. In other words, change always occurs and palliative care is no exception from the effects of change. Palliative care evolves. Authors have shown that there have always been shifts and changes in the understanding and applications of palliative care in time and history. Some equally maintain that palliative care is not only noted for its small beginning, but is also noted for
its evolving nature. In the Hippocratic era, there is an obligation to care for the sick. However, the obligation to care for the sick was not extended to the terminal ill as it is today. Later in history the notion of palliative care was expressed in the Christian commitment towards the needy-the sick and the destitute as the Christian Church attempted to carry the burden of the sick, the poor and countless pilgrims and crusaders throughout the Middle Ages. At one time, palliative care was only for patients with terminal illness, at another point it was focused on all cancer patients. Later it extended to include AIDS/HIV and lastly it is now for all patients whose illness brought a lot of suffering and pain and can be applied at any stage of the illness in combination with the regular treatment therapy. Even when it has acquired modern status, it only existed in developed nations for years before making in-route into developing nations. Today traces of palliative care can be noticed in some developing nations and it is hoped to continue the expansion until it gets to all places where it is needed. In other words, despite the power of palliative care to evolve and expand it is not yet found in all palaces where it is needed especially in developing nations such as Nigeria but the hope is that with little efforts and commitment from the stakeholders, the activities of the palliative care in some developing nations will eventually be extended to all the places it is needed.

2. Concepts

i. Earliest Concepts

The earliest trace of the concept of palliative care is in the Hippocratic era: The word palliation/palliative care which is relatively new was not used in the Hippocratic era but its concept can be drawn from the obligation to benefit the patient and not to harm as was practiced in that era. Of note is that the practice in that era even contributed to the development of ethical principles for health care in our time as the obligation to do no harm is carried over and
formulated in a manner that nurtures the palliative care movement. While the practice in the Hippocratic era helped in the formulation of our modern ethical principles, modern ethical principles help to draw ethical meanings from the practices in the Hippocratic era. In this regard, the obligation to ‘do no harm’ is a case in mind. Looking back, palliative care concept can be extracted from the Hippocratic tradition or obligation to ‘do no harm.’ In the way it is packaged today in our modern ethical principles this obligation can be drawn either from the point of view of providing benefits to others (usually called beneficience) or from the point of view of not doing harm to them (usually called Nonmaleficence). Accordingly, as noted by some ethicists, Beneficence is a moral principle that asserts obligation to provide benefit to others. It is derived from the ideas of act of mercy, kindness and charity. As a principle it establishes an obligation to help others further their important and legitimate interest. 

We now see how the ideas derived from the ancient practice of mercy, kindness and charity as practiced in the notion of *palliare*—the idea of providing warmth as from cold; in the Christian commitment and hospice practice of the 4th century, in the Hippocratic tradition etc. have contributed in the formulation of part of ethical principles that continues to sustain palliative care till date. In the clinical setting, health care professionals are obligated by the principles of beneficence and nonmaleficence to further the interest of the patients and not to harm them. However, even in the face of these obligations, terminal ill patients and patients with incurable diseases have always been victims of neglect and abandonment by Hippocratic doctors. The reason being that Hippocratic tradition viewed medical treatment in such circumstances as against the will of the gods.

Modern researchers have shown that what was practiced in Hippocratic era even with the obligation to ‘do no harm’ was only a part of care called somatic care. Care aimed at bringing
bodily healing only.\(^{36}\) Curing the sick is the only kind of care known to that tradition and in the absence of such remedy they were ignorant of any other kind of care that could have benefited patients with incurable illness. Even though curing the incurable is against the will of the gods according to Hippocratic tradition, they neglected caring for them as if cure and care are the same. For this reason, today’s palliative care includes providing benefits to the terminally ill patients whose conditions have defied every medical procedure aimed at bringing cure.

Another concept of palliative care is traced to the type expressed in the work in the Eastern Mediterranean countries that had great influence on Christian commitment towards the needy-the sick, and the destitute. Again the ingredients found in this commitment and practice were acts of mercy, kindness and charity. According to the research put forward by Cicely Saunders,\(^{37}\) palliative care is a gradual assembly of history. For this reason, act and the inspiration from the early Christian commitment to the sick and the needy, and the values found in the early hospice practice were carried over to form part of the modern practice in palliative care. For instance, some authors observed that the personal emphasis in the commitment of the early Christians as they carried the burden of the sick, the poor and countless pilgrims and crusaders throughout the Middle Ages is the key to being a palliative care personnel.\(^{38}\)

A similar connection is noticed in the early hospice practice. As an early concept of care, the origin of the word Hospice is traced to a 4th century Roman Matron Era Fabiola. She was inspired by her Christian commitment to open her home to care for the pilgrims, the sick and the destitute. The word Hospice in that context refers to the relationship emanating from the hospitality shown to the guests or strangers. Both the word Hospice and the personal emphasis and commitment in the care found in that era, authors agree, are still key factors in modern practice of palliative care. Basically Hospice, as a concept of caring, derived from the mediaeval
era symbolizing a place of caring. In this context, it represents a place where travelers, pilgrims and the sick, wounded or dying could find rest and comfort. Hospice in its contemporary practice offers a comprehensive program of care to patients and families facing a life threatening situation. In this context hospice is primarily a concept of care, and not necessarily a specific place of care.

Also, based on modern classification of care, the care witnessed in the early Christian commitment to the sick and the needy, and the first hospice practice of the 4th century which-anchored on personal emphasis and commitment is the equivalent of modern-day nursing care role. This has formed part of early concepts carried over and incorporated in our modern palliative care practice. A similar kind of commitment is noted by some authors in the extended family solidarity found in some developing nations especially in Africa.

Family care can also be considered as one of the early concepts of care carried over to modern palliative care practice. Care has been noted by writers as one of the ancient practices of humankind and family has always been the site of caring. Family care therefore can be seen equally among the earliest concepts of care that is carried over to modern palliative care practice.

Though, holistic approach to care which modern palliative care represents is getting more and more professionally oriented in developed nations, family care still has the potential for greater roles especially in Africa where extended family system is still practiced with great commitment.

In sum, the care practice in the Hippocratic tradition contains the earliest concepts of palliative care that transited with new understanding and practice through different era to form the key factors in our modern palliative care practice. Part of the strength of modern palliative care can be traced to its ability to draw ideas from the old to form and sustain the present and the
challenges of the future. The consistency in the practice is a good indication of what palliative care in developing nations stands to gain especially in Nigeria as it seeks for suitable/specific model of palliative care practice that will suit her palliative care situation.

ii. Modern Concepts

Modern concepts and practice of modern palliative care could be traced to Cicely Saunders whose encounter with a Jewish patient in 1948 triggered the process for the first formation of modern hospice movement in the 1960s. As a concept of care though different from that of the standard medical practice, modern palliative care has a small beginning. It has a humble beginning because it started with just ordinary response to one single patient’s situation aimed at providing the best quality of life for people who found themselves in hopeless situations of life. Modern palliative care is the brain child of this early encounter.

The development in the response to this early encounter adopted ideas and earlier concepts of care as it carries over the knowledge of early hospices and their values. In effect, modern hospice practice expanded the earlier concepts and made hospice not just a home or a place but a concept of care as well. It became a concept of care that applies both the ideas of ‘palliare’ of the 4th century and middle ages where warmth is provided, hope restored; and the ideas of the palliation of the 17th and 18th centuries as symptom control becomes part of the care. A concept that insists that care for the terminally ill must be taken away from the hospital setting hence the establishment of St. Christopher’s hospice. From here we begin to see a consistent shift from the old idea of care or earlier concepts of care to something pretty new.

The movement that ushered in the modern concept of palliative care made the first modern demarcation between the type of care provided in the hospital and the care provided in the hospice. At that time hospital was not a good place to manage terminal ill patients as greater
attention was focused on curative therapies. The transition took the care of the terminal ill away from the hospital because the patient need to be studied and understood in their situation in order to care for them adequately. This gave birth to the practice and application of scientific rigor, professional education and training that has formed part of the modern palliative care practice. The chain continues because the scientific rigor and educational trainings that follow gave rise to the understanding of the personal side of sickness which in turn gave rise to the addition of other concepts in the activities of modern palliative. Of note is that initially care was limited to the terminal ill patients hence the term terminal care was once used for palliative care.

According to some ethicists and authors, palliative care is a type of care with a small beginning, a beginning that started with the understanding of the personal side of sickness. Understanding of the personal side of sickness gave rise to the idea of total pain and total suffering and the need to help patients with incurable disease deal with the symptoms associated with their condition. The practice eventually extended to include not just patients with terminal diseases such as cancer and HIV/AIDS but patients with life threatening illness in general and their family as well. Palliative care is no longer seen or employed at the end of life when every other treatment therapy on the underlying disease is exhausted and further continuation considered inappropriate. Rather both the treatment of the underlying disease and the active treatment of the medical problems go hand in hand from the moment of diagnosis. This makes palliative care an active practice that is applied early in the course of illness aimed at offering best quality of life for both the patient and the family of patients.

Understanding of the personal side of sickness has equally led to classifying of cares. According to some authors four kinds of cares can be identified with different roles attached to them. Medical care which deals with somatic cure has the physician role- this of course is the only kind
of care known in the Hippocratic tradition. In that era, they have no role for the incurable patients; the nursing care which deals with technical bodily care has the nursing professional role- the kind of care found in the early Christian commitment to the sick and pilgrims; family care has the specific care of family members as found in most developing nations especially in Africa including Nigeria; and spiritual care with priestly role. These rhyme with the findings of some researchers that suffering or critically ill patient has a compound of issues bordering on physical, social, psychological, spiritual, and existential. Each of these issues demand a type of care but the individual as a whole needs a care that will be holistic and comprehensive in nature. For this reason, modern palliative care concept involves the convergence of all types of cares needed to address the complex care needs of the patient.

Apart from these four kinds of care currently employed in modern palliative care practice, some other writers point to the presence of another kind of care–the traditional healing care. This traditional healing care as discovered in Africa could be employed as modern palliative care finds its way into developing nations. According to the study carried out by these writers, the service is provided by traditional healers through the provision of traditional medicine. Again the care provided by the traditional healers is noted to have great potentials in relieving pain symptoms especially in the rural areas where healthcare services are lacking. The implication is that there could be possibilities of other kinds of care that might be of benefit to modern palliative care practice in other cultures. Such care practices could join in the palliative care team aimed at achieving a holistic and comprehensive care that the patient requires. As in the nature of palliative care when it encounters other cultures, its open window approach can always welcome any other kind of care out there that can contribute to attending to the hydra-headed nature problems of the palliative care patients.
Today as informed by concept of modern palliative care, the practice involves a holistic approach requiring team work. The team work involves not just the aggregates of cares already mentioned but one that is open to adopt any other type of care adjudged to be beneficial to the overall needs of the patient. It is therefore, the understanding of researchers that there is a holistic dimension to pain/suffering that requires holistic approach. The holistic approach is informed by the concept of modern palliative care that there is a complex issues involved in the care for the palliative care patients.

In sum, modern concepts of palliative care in its humble beginning adopted and carried over some of the ideas found in the earlier concepts of care. The values carried over were adapted, transformed and modified to attend to the complex personal side of the needs of palliative care patients. In effect the modern palliative care concepts apply holistic and comprehensive approach to address the numerous palliative care needs of the patient. As discussed, the concepts of modern palliative care can be extracted from its 9 main goals as provided by WHO. The modern concepts imply the convergence of all the aggregates of cares as mentioned—working as a team to improve the quality of life for suffering patients. The multidisciplinary team approach is required to ensure that; - relief from pain and other distressing symptoms is provided through a comprehensive pain management approach, research and counseling; that care is provided to cover other overall needs of the patients and family of patients, which includes physical symptoms spiritual, emotional, social, cultural, and psychological needs. Partnership strategies are also employed to bring stakeholders together. Stakeholders like public health planners, clinicians, government and non-governmental organizations (NGOs), business and academia are brought together. Their efforts are even made solid through evidence based in rigorous research work. The modern concept equally affirms life and regards dying as a normal process for which
reason death is not hastened or postponed rather the patient is supported to live actively as possible towards enhancing their quality of life to a positive recovery or till death. The same support is offered to the family to help them cope during the patient’s illness and bereavement - should that be the case. In addition, the modern palliative care concept implies that the principles of palliative care be applied early in the course of illness together with other curative therapies. Finally modern palliative care is open to adopt -and adapt to- new cultures.

**B. Current Practice and Models**

Current palliative care practice applies a holistic approach to achieve the total care needed by the palliative care patients. For this reason, today palliative care includes in its practice, the use of opioids in pain management and symptom control that involves a comprehensive pain assessment and multimodal treatment approaches, multidisciplinary team approach to the management of medical problems, and inclusion of patient and family as the unit of care etc. The practice involves the application of the 9 palliative care principles or goals as contained in WHO’s 2002 definition of palliative care. As practiced in many developed nations the practice is anchored around the following Palliative care activities namely- Advanced Pain and symptom manage; Attention to psychological, social and spiritual needs/concerns; and Development of multidisciplinary teams. Today, these services can be provided in the hospital setting, ambulatory setting, nursing home, and in a home setting. In most places it is recommended that palliative care be integrated in the overall healthcare system. This feat was not achieved in one day.

Like its concepts, the current palliative care practice has had a long history. First it started as a protest against the limited attention given to the terminal ill in the modern hospitals. Such attitude of not offering any care to the terminally ill as already observed was itself inherited from
the Hippocratic era where the objective was to cure. For this reason, when the modern movement for palliative care started in the 60’s, the hospice institutions took the care of terminal ill patients away from the hospitals. However, when it became clear that medicine has a part to play as it got involved in the progress made in research and teaching, hospice as developed in London at St Christopher’s in late 1960’s care once more went back to the hospitals as physicians begin to accept caring as a related practice. However, the care offered at the hospital at this point was taken to another extreme level by subjecting the terminal patients to the powers of medicine as palliative care becomes intensive care. The implication was the continuation in the protest by modern palliative care.

Medical powers now replace limited attention and none is good for palliative care and has to be protested. In order words, apart from the limited attention offered to terminal ill in the modern hospitals for which early palliative care protested, modern palliative care was again seen as a reaction against medical power. What happens is that the palliative care through the powers of medicine is done in the intensive care units of hospitals. The consequence is that medical power turns palliative treatment into intensive treatment which at times is harmful to the patient. Authors describe this tension as a silent rebellion against a technology-dominated dehumanized health care system. In this regard, like euthanasia, and forgoing medical treatment, palliative care is seen as a reaction against medical power that subjects a terminally ill patient to prolonging life only by mechanical interventions. For this reason, some writers were quick to observe that what terminally ill patient needs is palliative care instead of intensive care. Drawing from the comments of these authors and writers, another short coming and set back to palliative care at that era -of life support and intensive care strategies- is that care was focused on the terminal ill patients. However, despite the short-comings and the protests, taking palliative
care away from the hospital was not an option. Retaining palliative care in the hospital is still very important as it aids in the development in research and advance pain management.

The hospital practice also influenced palliative care practice for some time. For instance, the practice of limiting palliative care to the terminally ill patients was retained in palliative care for some time. The practice was even reflected in the first definition of palliative care offered by World Health Organization (WHO). According to this earlier definition, palliative care stands “as the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best possible quality of life for patients and their families.” This definition later changed because it did not capture the holistic nature of palliative care as palliative care concepts continues to evolve and new stipulations added as can be witnessed in the current practice that now allows palliative care in hospitals as well.

Effort to retain palliative care in the hospital setting and at home setting was made by Professor Balfour Mount as already noted. Till date modern palliative care is practiced in most hospitals in developed nations. The movement of palliative care back and forth of hospital contributed immensely to the formulation or formation of different models of palliative care.

Authors agree that the evolution of palliative care resulted in the three pioneer patterns or models of palliative care emanating from different regions of the developed nations. Hospice Care as practiced at St Christopher, London (which has been discussed in detail) was in-patient home care (nursing home). It operated as in-patient care provided outside a hospital environment at a different house though not a patient’s actual home but strives to make the patient feel at home. The care in this setting involves providing the patients the hospitality of a good home, constant
interaction with the patients aimed at understanding them and their problems more. This interaction is even done with scientific rigor, coupled with professional education and training to aid the care providers. The practice at St Christopher was carried over and adapted to suit the hospital setting at Royal Victoria Hospital Montreal. Palliative care as practiced at Royal Victoria Hospital Montreal, Quebec, Canada- was both in-patient within a hospital unit and out-patient home care. The third one from USA is a hospice caring for patients whose life expectancy must not be more than six months. Care is brought to them at their own homes; more of a peripatetic team without a backup bed of their own.68

From this model we see another attempt in taking palliative care to the home of the patients. However, because the care is meant for terminal patients, palliative care was actually relegated to the last stages of life. While modern palliative care practice retains this type of hospice care or terminal care as an important aspect of palliative care, it provides it as one component of the continuum of care that should be provided.69 Today the three pioneer models or patterns of care have no boundaries. They can be practiced in any place, region, or culture. They can be integrated and can be provided in the hospital setting, ambulatory setting, nursing home, and in a patient’s home setting with the application of the basic principles of palliative care.70

Currently the stipulation of WHO, is that the principles of palliative care be “applied as early as possible in the course of any chronic, and life threatening illness.”71 In other words modern palliative care practice is not just about suffering patients at the end of life but for suffering patients, and families of patients with serious and complex illness as a way of ensuring the best quality of life for them.72 Going by WHO's earlier definition which laid emphasis on patients not responsive to curative therapy, palliative care can be relegated to the last stages of life. However, WHO has realized that palliative care should not wait until the last stages of life. Hence it
broadened its approach to palliative care. In its new approach, palliative care is also for patients with life threatening conditions as it is for patients with chronic and incurable illness like cancer and HIV/AIDS. Again the principles of palliative care should be applied as early as possible in the course of any chronic, and life threatening illness. Nigeria as a developing nation with rich cultural values stands to gain from these models of care. The ability to adopt and adapt as found in the modern palliative care practice can be utilized as the rich cultural values can be assimilated in the new practice. In order words in seeking a palliative care model suitable for Nigerian palliative care situation and needs, the current models as practiced in the developed nations can be engage in such a way that will suit Nigerian current palliative care needs by incorporating and appropriating her local values as well.

In sum current practice and models of palliative care is provided across a range of care settings-in specialist as well as general settings including patient’s home. The practice integrates palliative care into existing health structures where it is possible. Equally palliative care concepts are adopted and adapted to reflect local traditions, beliefs, and cultures of different places where it is practiced or provided. In this way seeking a model of palliative care approach appropriate for Nigeria situation will engage and adapt the models to suit her local situation which vary from current situations in developed nations where modern palliative care is practiced.

C. Nature of palliative care

There are lots of positive things in the nature of palliative care that allow it to grow in time and places; in different cultures, and in different religions. We just observed from the preceding section that palliative care has a capacity to transform and extend across cultures, nations and situations in time and history. It transformed in history from the ordinary notion of caring for the
sick in the context of bringing cure to the sick person by the Hippocratic doctors, through the care for the needy and pilgrims in the early Christian era. It evolved from the first hospice care in the 4th century to a more encompassing concepts of modern palliative care that include respect for the individual, compassionate care, holistic approach and the incorporation of the relatives and family members as part of the care team. With this type of capacity, palliative care can find its way into developing nations and can make a great impact as well. Traces of Promoted Palliative care in developing nations is an attestation to this and an indication that palliative care can now find its way into developing nations just as it did in the other cultures including developed nations.

Again, there is consistency in the nature of palliative care. Palliative care has been consistent with growth and progress. As observed by various writers, before palliative care emerged in the form it is known today as a discipline of its own with clear definitions, it always existed in concepts as its notions could be found in Hippocratic era and moral traditions. Since then, Palliative care has made a huge journey in history encountering obstacles and making retreats and coming out of them stronger. The explosive growth it witnessed in areas and places it found its way is a great attestation to this. For instance, the encounter with one patient, a Polish Jew in 1948 metamorphosed into today’s modern palliative care practice. A single hospice in London in 1967 resulted in so many across the region and across the continent. Again, a cancer institute that was founded in 1974 in New Haven Connecticut, USA, from 1974 to 1977 evolved into ‘The Connecticut Hospice” itself resulted in the escalation of hospice program in the United states from just one to over 3,000 in less than a quarter of a century. A similar situation as reported by some authors is, recorded in London where it first started and in many developed nations. Writings from authors as will be discussed later show a similar sequence in the activities of
promoted palliative care in developing nations. In a region in India for example, it is reported that a network called the Neighborhood Network in Palliative care is making a tremendous progress. The humble beginning from one volunteer to a community of volunteers; from a single clinic in the premises of a hospital to 57 palliative care units spread across the six northern districts of Kerala, India is a strong confirmation of such progress. A similar scenario is reported in Sub-Saharan African region where Hospice Africa, Uganda, and the African Palliative Care Association are carrying on the activities of promoted palliative care. Equally in Botswana a case is being made for adequate pain management. A similar progress is reported in Latin American, Chile where currently effort is in progress to incorporate palliative care as important health care priority in development of opioids and policies. Also some of these authors observed that the explosive growth associated with palliative care is powerful evidence that society perceives hospice care as meeting an urgent need. For this reason therefore the presence of promoted palliative care in developing nations is to attend to the urgent need of the suffering patients in those regions as we shall later see. One remarkable thing about palliative care in those places is that while they retain one or two or even all the known models as found in developed world, they appropriate the cultural values that work well with palliative care. Hospice Uganda is a good example. Nigeria has rich cultures especially in the area of family support and grieving that can be utilized in seeking the best approach for palliative care activity in the country.

Apart from the presence of the urgent need which Nigeria share in common with other developing countries, another common factor among the developing countries where palliative care makes progress is that the governments and stakeholders were ready to partner with palliative care promoters. This type of commitment is seriously lacking among the stakeholders.
in Nigeria. For any effective model palliative care to be efficient in Nigeria, government commitment must be paramount. The lack of serious commitment is itself an invitation to palliative care for Nigeria.

Palliative Care has been consistent with fighting for the needy and the neglected whose lives were threatened by serious illness. Palliative care cannot be intimidated in any culture, circumstances, or by any kind of illness. It is in the nature of palliative care to fight for the wellbeing of the neglected even in the most difficult circumstances. It defended patients held by the most serious diseases of the world such as Cancer and HIV/AIDS. It battled the powers of medicine that slow down its task of bringing relief to the suffering patients and families.

According to some ethicists, palliative care fought against medical power that subjects the individual to the powers of medicine. Palliative care scaled through rough history to make a name. It battled the powers of medicine in developed nations and made a positive impact fighting for the welfare of the suffering patients subjected to the ugly hands of machines. The same consistency is maintained in the activities of promoted palliative care in developing nations as it battles poverty and the powers of government that fail to acknowledge palliative care as public health care priority. With such inbuilt potentials, palliative care succeeded in developed nations with great amenities and can be shown to be making serious in-root into developing nations; nations known for their minimal or no resources at all. This is an indication that even in the face of poverty palliative care can be extended to the individual poor with life threatening sickness. No government including Nigerian government will use poverty as an excuse to deny palliative attention to its suffering populace. What palliative care demands from the government is effective policies and active commitment. It is on record that some donor agencies have refused to assist palliative care in Nigeria because of lack of national palliative care policy.
Another inherent capacity of Palliative care is the capacity of attracting supporters and sympathizers that help fight its cause. As discussed above, before its modernization, palliative care enjoyed the support of the early Christian commitment to the poor and needy as well as great individual support to pilgrims in the 4th century. Since then palliative care has not stopped receiving support from sympathizers that fight its cause. Currently, World Health Organization champions the cause of palliative care around the world and has declared Palliative care an urgent humanitarian Responsibility. Following in the WHO’s footsteps, the international palliative care community currently, is advancing palliative care as an international human right. In Nigeria there is lack of coordination between the individual palliative care promoters. This makes it difficult for them to benefit from these organizations that usually support palliative care. Though the presence of WHO is felt, especial in the area of eradication of poverty through Primary Health Care Program and in committing the government to embrace its responsibilities. Nigeria is a very large country. For any model of palliative care to function there must be a strong coordination between the individual promoters around the country and the government. Palliative care program in Nigeria must be positioned to participate and benefit from the activities of these world bodies.

The activities of the World Health Organization in developing nations are supported by other bodies sympathetic to the cause of palliative care. For instance a call for affordable access of immediate release morphine in developing nations was supported by more than 63 organizations and more than 3,000 individual signatures in less than five months of the proclamation. Currently, promoted palliative care in developing nations is actively enjoying a lot of goodwill and sympathy from such bodies as World Health Organization (WHO), the European Association for palliative Care (EAPC), the African Palliative Care Association (APCA), the
Asia Pacific Hospice and Palliative Care Network (APHN) and the Latin American Palliative Care Association (ALCP). Mention has to be made that palliative care is capable of partnering with other disciplines as well. Currently it partnered with other two disciplines human right and public health to fight for its availability to the patients with life threatening illnesses especially in developing nations. Benefits from these organizations are still lacking in Nigeria due to lack of government commitment and coordination between individual palliative care- promoters in the country. Palliative activity is always a team work. Palliative care promoters in Nigerian must come together to harness the benefits offered by these organizations. Again their coming together can even be a great force in bring the government to its knees in accepting its responsibilities to the palliative care needs. Such happened in India where a group of palliative care promoters prevailed on the government to come to the assistance of palliative care through policies and active commitment.

The accommodative and inclusive nature of palliative care is another factor of potential importance in the nature of palliative care. The accommodative capacity is expressed in the ability of palliative care to adjust its approach from care to those “whose disease is not responsive to curative treatment” to include also all those facing the problem associated with life-threatening conditions; The capacity to shift from approach limited at the end of life to include an approach that is applicable early in the course of illness, in conjunction with other therapies is a potential that can be harnessed in Nigeria. Sequel to this is the ability to allow ‘copy and modification.’ From inception, there has always been room for ‘copy and modification.’ The first modern palliative care program that was set up at St Christopher’s in 1967 was copied and modified by subsequent teams that visited the facility in such a way and pattern that suited their different circumstances and cultures.
with the commitment to openness that formed part of the foundation that modern palliative care was built on; openness not just to patient and people that would come but openness to all future challenges. Bearing this in mind, the palliative care in Nigeria stands to gain from this type of openness and accommodative capacity offered by modern palliative care as she deals with her peculiar challenges.

In sum the knowledge of the evolution and development of palliative care has shown some positive qualities inherent in palliative care. Such positive capacities/qualities palliative care can find its way into any developing nation/culture such as Nigeria and make a great impact as well. The power of palliative care to evolve is a positive nature of palliative care for future development of the practice especially in a developing nation like Nigeria. Power that allows and enhances the introduction, practice and provision of palliative care in developed nations can still do the same for a developing nation such as Nigeria.

As a conclusion to this chapter, palliative care that metamorphosed from the concepts and notions as found in Hippocratic era and in the era of personal commitment to the sick contributed immensely in the formation of modern palliative care concepts. The practice evolved and has had a long history in developed nations. The knowledge of this history has helped to show how palliative care demonstrated a capacity to adapt, transform and extend across cultures, nations and situations in time and history. This resulted in the refining of palliative care with modern concepts. Because of the consistency in its nature, the capacity is still there for modern palliative care practice to adopt and transform care practices/concepts found in other cultures that can help address their specific needs. It is for this reason that the knowledge of history of care from the point of view of the evolution that ushered in the modern palliative care practice becomes very
important for the task in establishing a specific model of palliative care appropriate for the future of palliative care in Nigeria.

In Nigeria, as mentioned briefly but will later be discussed in details, certain concepts of care and cultural values does exist. Such practices, values and capacities as found in the traditional healing care and in the extended family care system in Africa were utilized in withstanding certain crisis and bringing support and comfort to the sick. Despite their importance in the provision of care, the care values as found in Nigeria and other developing nations- like the Hippocratic and the nursing care in the early period- are not enough for the total care needed by the terminally ill in Nigeria. However, the importance of these already existing practices must not be diminished but rather can be enhanced together with other cultural values that can be adapted by modern palliative care practice to address the peculiar palliative care needs in Nigeria. They need to be studied and promoted to fit-in with the refined palliative care with holistic approach. In this way with good policies and support from the stakeholders they can boast all that modern palliative care stands to offer in Nigeria.
20. Lima and Hamzah 2004, 28; Radbruch and Downing 2010, 47.
34. Beauchamp and Childress 2001, 166.
41 Chigere 2000, 41.
43 Manima 2003, 145.
47 Gracia, 2002, p. 18; Saunders, 2000, pp. 7-8;
48 woodruff 2004, 3.
52 Campbell and Amin 2014, 6.
54 Wright, et al. 2006, 7.
55 WHO 2015.
58 Meier and McCormick, Palliative Care: Benefits, Services, and Models of Care 2013; Radbruch and Downing 2010, 48.
59 Gracia 2002, 30; Manima 2003, 145.
60 Gracia 2002, 22.
61 Manima 2003, 145.
63 Gracia 2002, 30.
64 Gracia, 2002, p. 32.
65 Radbruch and Downing 2010, 47.
67 Lipman, Rajagopal and Mazza 2003.
68 Lipman, Rajagopal and Mazza 2003, xxvii; Saunders, The Evolution of Palliative Care 2000, 10.
69 Radbruch and Downing 2010, 47.
70 Meier and McCormick, Palliative Care: Benefits, Services, and Models of Care 2013; Radbruch and Downing 2010, 48.
72 Meier 2010, 4.
74 Lima and Hamzah 2004, 35.
75 Lipman, Rajagopal and Mazza 2003.
77 Paleri and Numpeli 2005.
78 Wright, et al. 2006, 201.
82 Oliver, Olupitan and Oyebola 2011, 298.
83 Oyebola 2011, 4.
84 Gracia 2002, 30.
86 Grant, et al. 2011, 5.
87 Oyebola 2011, 4.
88 Shetty 2010.
89 Gwyther, Brennan and Harding 2009, 767.
90 Oyebola 2011, 3, 4.
91 WHO Regionary Office for Africa 2009, 8-12.
92 WHO publications 2012; Grant, et al. 2011, 1.
93 International Association For Hospice & Palliative Care, Pain and Study Group,& 60 other patners 2012; Lima and Hamzah 2004, 35.
94 Ghooi and Ghooi 2003, 4, 5.
95 Saunders, The Evolution of Palliative Care 2000, 7.
96 Saunders, The Evolution of Palliative Care 2000, 8.
Chapter 3: From Developed Nations to Developing Nations: Lessons of Palliative Care in Developed Nations for Developing Countries

Having explored the development of palliative care in western nations, it now becomes necessary to analyze the lessons such practice in the developed nations has for palliative care in developing nations. This is because the feat already achieved in developed nations is currently lacking in developing nations including Nigeria. To argue for a specific model of palliative care in Nigeria a good knowledge of such feat becomes important. For this reason, in this chapter, the lessons of palliative care in developed nations for developing countries in general and the status of palliative care in developing countries in particular is discussed. Among the major lessons of palliative care in developed nations is the presence of palliative care even for the most serious and complex illnesses. Because palliative care is readily available in developed countries, patients with complex and terminal health can receive palliative care even in hospital settings.1

As already noted, many palliative care literatures point to the protest against overbearing medical power as the major factor that started off palliative care movement.2 This initial struggle which was part of the overall story of palliative care in the developed world has its own lessons to add to the richness of what is required to build a successful palliative care in developing nations. The presence of other needs, and complex and serious illnesses especially with the problem of aging population with long life expectancy and with increased burden of chronic illness help to sustain and propel the practice. The problems on ground not only caused the beginning of palliative care in developed nations but equally dictated its direction.3 Today as attested by many authors, palliative care has gained ground with rapid and accelerated growth in developed nations even with significant innovations in most of the nations.4 Its presence can be felt from the many positive contributions it has made in most of the developed countries. The positive achievements
demonstrate that the goal of palliative care to provide a support system to help patients live as actively and creatively as possible until death comes is not an empty sentiment. For some of these writers, death policy for some of these developed nations is fairly well settled.7 For them palliative care has advanced from protecting human rights and the dignity of the terminally ill and dying patients to making palliative care a legal entitlement for all individuals.8 Also important is the loosening of laws on morphine used in the advanced pain management and the introduction of palliative care programs in many large hospitals.9 In addition, reports abound that palliative care practice in developed nations has saved many patients from expensive life-sustaining treatments, and has even led to improvements in the quality of life for patients and their families. In some cases, it has prolonged survival in patients as well.10 To the advantage of palliative care in those developed nations is the robust healthcare delivery system on ground, and the collaborative disposition of many stakeholders.11

Unfortunately, the opposites are true for developing nations, especially Nigeria. Palliative care is lacking for Nigeria’s patients with life limiting illnesses and their family in spite of the teeming number of such patients. Though poverty is said to be a major issue the situation is even precarious for seriously ill.12 This puts palliative care in developing nations like Nigeria in a vulnerable and disadvantaged situation. For this reason, one can make the case that any hope for advanced pain management in a developing country like Nigeria is far from being realized without a specific model of palliative care on ground. This understanding is informed by how such nations are characterized.

Developing nations have been characterized in certain ways. Understanding the characterizations will help develop the general characteristics of developing nations that contributed and still
contribute to lack of palliative care in such nations. This chapter will also consider the current meaningful efforts in some developing nations to overcome their shortcomings.

In sum, the knowledge of how palliative care played out in developed nations and understanding the characteristics and problems facing developing nations will be very beneficial to the developing nations including Nigeria in seeking effective palliative care for the complex and serious illnesses in the nations. Therefore, extracting more lessons from the availability of palliative care in developed nations and x-laying those lessons through the lenses of the current palliative care problems and needs in developing nations will offer a great understanding in fashioning new and corresponding palliative care approaches to such problems.

A. Lessons of Developed Palliative Care in Western Countries for Developing Countries

It is not just enough to say that there is palliative care in developed nations. It is equally important to say that it is a success story. Having overcome its struggles, palliative care is now practiced in most developed nations of the world and is readily available. The big lesson here is that palliative care in developed nations overcame a lot of obstacles on its way and became a success story. Its success story is witnessed today in various palliative care practices that attend to the needs of the whole person in order to bring comfort and improve the lives of palliative care patients. The delivery is achieved through a range of palliative care activities. These include advanced pain management, adequate attention to the various needs of the patients, development of multidisciplinary teams through education, research and policy developments. These were not possible some years ago. What made the success so interesting is how the modern palliative
care started to exist and rise. As already noted modern palliative care started as a disaffection with medicine as practiced in the mainstream hospitals. But how bad was that?

To understand and appreciate this success story in a way that it can also inspire effort in developing nations, one has to look back to the period without palliative care in developed world. According to the literatures that capture the period, it was a period of great scientific and industrial achievements. It was also a period of an effective science and powerful healthcare practice but it was not a great period of consideration of human values in the face of that great scientific achievements. Despite the robust achievements, unbearable suffering held sway especially for patients with chronic and terminal health conditions. Medicine was more interested in curative therapies that focused attention on the afflictions of the body only and not on the whole person. Some authors view this reductive practice in modern medicine as a shortcoming so long as the practice contributed more to the suffering of many patients. Such patients did not need any aggressive curative therapy that left them on hospital machines. They needed palliative care. This is why the accusation against medicine was so huge, coming from stakeholders from different works of life. Pellegrino described the situation and packaged the accusations as “sins of Medicine.” He was quick to add that those accusations could be contradictory as well.

According to him:

*The list of those sins is long, varied, and often contradictory: overspecialization; technicism; overprofessionalization; insensitivity to personal and sociocultural values; too narrow a construal of the doctor's role; too much “curing” rather than “caring”; not enough emphasis on prevention, patient participation, and patient education; too much science; not enough liberal arts; not enough behavioral science; too much economic incentive; a “trade school” mentality; insensitivity to the poor and socially disadvantaged; over-medicalization of every life; inhumane treatment of medical students; overwork by staff; deficiencies in verbal and nonverbal communications.*
The ‘sins’ were so many and so bad. The point here was that medicine has been accused of many sins against humanity and human values as it got involved with modern science and technology in its practice despite its numerous promises. The multifaceted criticism was accompanied by a great tension as the situation generated serious anxiety and debates based on how and what the critics perceived as the ‘sins’ of modern medicine. From the point of view of palliative care, part of the ‘sins’ was against terminal patients who were subjected to inhuman treatments on medical machines. This means that despite the huge promise, there were limits to what modern medicine can offer. Again, the ugly situation created by medical technology was far from a good environment required for the practice of palliative care. In other words, even if only few of those sins were true, palliative care could not have survived or thrived under such threat unless something positive was done.

Something positive was actually done. In the midst of the tension, anxiety and the numerous criticisms was a protest and a consensus in demands by humanists and ethicists. These worked to the advantage of palliative care. Palliative care of course, gained so much from those tensions and the debates. It was a double victory for palliative care. The disaffection caused the beginning of palliative care while the debates help to develop and straighten its practice.

The demands of the stakeholders in the protest against medical technology were in consonance as they all wanted a humane face in science and medicine. They demanded that medical technology be humane. In other words, they all want to see limitations to medical power that will allow patients to be free, fulfilled, and self-determining, as well as more comfortable, efficient, or productive. The demands were followed by some positive practical actions aimed at meeting the unmet needs of the terminal patients despite the high-tech of medicine. The result was the birth of modern palliative care. With all the initial struggles somehow settled, palliative care is
now not just available in most developed nations but is in a cruising altitude providing services through advanced pain management, adequate attention to the various needs of the patient, development of multidisciplinary teams through education, research and policy developments as it improves the lives of the seriously ill. Same cannot be said of developing nations.

The lesson for many developing nations from this outcome is that palliative care is not necessarily about high-tech, but more of high- humane- touch even with a low-tech. Though high-tech might be beyond their reach now, at least they can afford high- humane -touch by activating some of their cultural values in conjunction with the knowledge gained from how palliative care is now practiced in developed nations.

In sum, palliative care in developed nations was not achieved on platter of gold. It took a great deal of sustained effort. This should be a big lesson for many developing nations that currently experience a lot of obstacles that hinder palliative care development for their suffering populations. In the light of the fact that palliative care in developed nations overcame and survived greatest of obstacles that could have prevented its existence in the first place, a new hope is inspired for the future of palliative care in Nigeria and developing countries in general. Hence, the success story of palliative care in places where it has been developed should inspire effort in places where it is lacking.

1. **Availability of Palliative Care**

The studies carried out by some authors expressed the rapid growth of palliative care in developed nations following the models of hospice movement that was triggered by the response to medical powers. Some of the authors observed that in some places, the original model as practiced at St. Christopher’s was adopted, at other places modified to suite various needs of the
particular palliative care settings. The practice gave rise to different settings and variations of palliative care provisions in developed nations. The intention here is to argue that the presence of palliative care in developed nations shows that adapting different variations in the provision of palliative care was part of the overall strategy that made the development of palliative care in developed nations a success story and which stands as a lesson to a developing nation like Nigeria. Each nation fashioned palliative care according to their needs and what works out well for them without altering the core service provision and practice of palliative care. The lesson for developing nations equally, is that such strategy can be replicated in developing nations to achieve a successful palliative care story that suites their situation especially when such variations does not alter the core service provision practice of palliative care in general.

The core service provision of palliative care is informed by the understanding that palliative care patients need a total care that requires holistic approach. This understanding was not altered despite the different variations that played out in developed nations. Rather what is witnessed in the developed nations is a service provisions that is anchored around Advanced Pain and symptom manage; Attention to psychological, social and spiritual needs/concerns; and Development of multidisciplinary teams though with some modifications in the actual practice and approaches. The available palliative care in developed nations through Advanced Pain and Symptom Manage with adequate attention to the concern to the various needs of the patients and families in a multidisciplinary team work has shown to improve the care of the seriously ill by reducing symptom distress, enhancing quality of life, decreasing spiritual distress and lowering costs while improving family satisfaction and adjustment to loss.
i. Advanced Pain and Symptom Management

Palliative care literatures show that advanced pain and symptom management has always been part of the overall care practice in palliative care in developed nations. Research equally shows that pain and suffering has always been the major issue of concern in palliative care because it is one of the most frequent and serious symptoms experienced by patients in need of palliative care. Pain experience is very extensive and very wide. Different forms of pain may have different moral valences, engender different phenomenological experience that carry different social and economic and psychological effect and can constitute serious suffering. The use of opioids in advanced pain management and symptom control involves a comprehensive pain assessment and multimodal treatment approaches. It is employed in palliative care practice in developed nations in relief of pain and the associated suffering. The practice depends so much on availability and patient access to morphine and other opioids. Its focus is on assessing and treating symptoms such as pain, fatigue, and depression.

Though the issue of pain is as old as medical care, the first modern method for pain management in the context of hospice/palliative care was presented in 1963 by Saunders. Based on the results from analysis carried out on some 900 hospice patients, the initial cardinal rule for pain and symptom management was set out. The result shows that in as much as the drug used with the patients was very important, concentration was more on the method of their deployment. This includes careful assessment of symptoms that trouble the patient; assessment of the nature and servility of the pain; and the regular giving of drugs. Of note is that immediately following the discovery of these cardinal rules was a search for, and provision of a conducive atmosphere and environment for the practice. But, the hospital environment was not conducive at the time. Conducive environment was found later outside of the hospital environment with the
establishment of St. Christopher’s hospice in 1967. This means that the initial effort in relief of pain and suffering in the context of palliative care was not just in the availability of drugs alone but equally in the procedures of the drug deployment and enabling environment for the proper application of the methods.

Palliative care in developed nations is not only enjoying a conducive atmosphere within and outside of hospital environment, but has intensified effort in the area of drug availability and the methods of its management aimed at relieving pain and suffering. As early as 1986 WHO put out a publication captured in about 20 languages that emphasized “the use of morphine for the treatment of cancer pain.” In USA the joint Commission on Accreditation of Healthcare Organizations (JCAHO) put out a standard for pain management that requires expert and detailed care that is individual to each patient. In most European nations physicians support the use of analgesics and sedatives to relieve pain and suffering. All these were sequel to Saunders earlier strong affirmation to opioids use in pain management that involves careful assessment of each patient’s symptoms and each patient’s level of severity of pain. Since then, morphine and other opioids have been in use not just for cancer pains only but for other severe chronic non-cancer pains without the fear of provoking dependence. Today, the use of opiates have extended and could be applied in many other pain related issues that bring a lot of distress and suffering to the patients. Because this drug was originally preferred for treatment of cancer pains, the extension of its use in other pain related issues even makes it more important to observe the general principles guiding opioids use to avoid over-dosage or its adverse effect.

Oral morphine has been shown to have a great advantage in approaches to pain management and to palliative care practice in general in developed nations. Some writers maintain that the drug is relatively inexpensive as it is cheap, cost effective, and easy to produce. The fact that it costs
pennies per dose to manufacture informs why some other authors hold strongly that hospice care is much more cost-efficient than hospitalization. Some of these writers equally maintain that treating pain with opioids does not hasten death, instead it prolongs survival. Even, some authors indicate that measurable successes of palliative care are to be found, in the use of pain-relieving technologies and in the inventive use of antidepressants, antibiotics and anxiolytics.

Again, the huge use and consumption of opioids in pain and symptom management does not mean they did not encounter the problems of barriers and oppositions that made access to opioids impossible. Rather, the practice in developed nations overcame such barriers through sustained efforts in opposing the prohibiting laws. Such efforts led to the loosening and enacting of laws that made opioids available and patient access to morphine possible in most developed nations.

Furthermore, though, there has been issues with the real goals of palliative care, both those who accept achievement of the best quality of life for patients and their families as stipulated by WHO and as an important moral notion in palliative care, and those who thinks such goal lacks precision, still accepts and considers advanced pain and symptom management as part of the overall care practice in palliative care aimed at relieving suffering.

In sum, advanced pain and symptom management is only a part of the overall holistic approach in palliative care that is aimed at a total care for the palliative care patients and their families. Total pain requires total care delivered across the entire disease trajectory. However, pain and symptom management attend only to a subset of problems within the relief of suffering. There are other suffering related issues that pain management alone cannot resolve. Palliative care attends to these in conjunction with other approaches, such as attention to Psychological and
Spiritual needs and concerns of patients and families, and Development of Multidisciplinary teams.

ii. Attention to Psychological and Spiritual Needs/Concerns of Patients and Families

We already noted that pain is accompanied by a compound of issues requiring a holistic approach. The understanding that palliative care patients experience not just physical pain but total pain requires a total care as found in holistic care approach. Part of the holistic care approach is attention to psychological and spiritual needs and concerns of patients and families. Such needs also affect and compound the situation of patients and families and bring them much distress. The needs and concerns according to some writers include loss of independence, fear of suffering and death, existential concerns, empathic suffering, being a burden to their families, and reconciliation with family etc. These needs plus the physical pain and physical symptoms constitute total pain to the patients and families. This is why palliators insist that psychological and spiritual aspects of pain management approach be applied to help control total pain and improve the quality of life of patients. In other words, total pain and symptom management goes beyond paying attention to physical pain and physical symptoms only. It includes attention to psychological and spiritual symptoms, existential concerns, as well as empathic suffering with other distressing health issues of patients and families.

It is understandable that availability of opioid and access to morphine are emphasized in the management of most physical pains. It also remains true that the drug is unlikely to achieve much in a person who is deprived of all hope, psychological, emotional and existential concerns. These concerns are approached differently by qualified professionals under the palliative care team. Ideally, such professionals are expected to exhibit some amount of empathy and good
communication skills. Equally, emotional warmth, and genuineness are required to establish maximal beneficial therapeutic relationship with patients and families.55

Experts who followed the trend of palliative care in developed nations observed that spiritual and psychological attention to the patients concerns and needs have helped immensely in relief of discomfort, and in the improvement of quality of life and well-being. They noted that spiritual care and psychological attention as part of the total care approach have helped patients prepare for death, cope with fear of dying, minimize depression and fear, offer forgiveness and accept forgiveness, and as well find meaning in moments of suffering and death.56

A successful total care approach involves team work approach. In other words, total care approach in palliative care as practiced in developed nations involving advanced pain management and attention to spiritual and psychological needs of the patients is achieved through collaborations and team work. A typical team could comprise of nurse, social worker, chaplain, volunteer, grief support staff, patient’s doctor, home health aide, hospice doctor, and patient and family.57

iii. Development of Multidisciplinary Teams

From the preceding analysis of palliative care in developed nations, comes the understanding that addressing suffering properly involves taking care of issues beyond physical symptoms to the spiritual and psychological levels as well. The understanding that palliative care patients are besieged by a compound of issues necessitates coming together of professionals from different disciplines for a correct and comprehensive assessment, evaluation and treatment of those issues. This is why palliative care uses a multidisciplinary team approach to support patients and their caregivers. A multidisciplinary approach addresses both physical symptoms, practical needs and providing bereavement counselling.58 In other words, team work is indispensable in bringing
together the approaches of advanced pain and symptom management and giving attention to the spiritual and psychological needs of patients and families. Equally team work is needed in the collaboration between all stakeholders in the overall practice of palliative care. These played out well in propelling palliative care activities in developed nations.

Development of multidisciplinary team contributed immensely to the progress of palliative care in developed nations. A typical team includes: hospice doctors, the patient’s doctor, nurses, home health aides, grief support staff, social workers, chaplains, and volunteers. Authors have highlighted the importance of such team works among palliative care providers. The teams function in a variety of settings in developed countries, including hospitals, care centers, and homecare settings. In whatever setting, they work closely together in defining treatment goals and care plan both with and for the patient and the family. For instance, in a typical hospital palliative care setting in the USA, there is a multidisciplinary team of professionals. The team usually consists of physicians, nurses, social workers, with additional contributions from massage therapists, chaplains, psychologists, psychiatrists, rehabilitation experts and others. These work together. As a team, they define treatment options/goals with the patients and their families by providing recommendations and supports to primary and specialist physicians caring for the palliative care patients in the hospital. The composition of any particular team is usually determined by the type of setting, “the size of the program and the needs of the institution.”

The practice in developed nations expanded the scope of team work to include collaboration among palliative care providers with stakeholders like international bodies such as United Nations and World Health Organization, government agencies, local physicians, regional politicians, research institutions, policy makers, etc. Generally, collaborations in palliative care services have helped in the area of education and training in palliative care programs and
service developments, research and policy development. Such collaborations as attested to by many writers have huge results. They resulted in the establishment of enabling policies and laws, guaranteed availability and access to opioids and integration of palliative care with formal health care system. Again authors have underscored the importance of such collaborations based on the study of the development of palliative care service in seven European countries. They observed that such collaborations contributed immensely to the progress of palliative care on various levels, from enabling policies and laws to the integration of palliative care with formal health care system. In the US, for example, collaboration was pivotal in the progress of palliative care. Some fruits of such collaborations could be found in the collaboration with Joint Commission on Accreditation of Healthcare Organizations (JCAHO). It contributed in putting out a standard for pain management that requires expert and detailed care that is unique to each patient. Also collaboration with the National Consensus Project for Quality Palliative Care and, National Quality Forum established, defined, and provided a consensus process/framework for quality palliative care for the nation. Reports equally abound of collaborations with the private sector that resulted in philanthropic groups who injected strategically hundreds of millions of dollars in support of the activities of palliative care.

On its part, WHO has always been a dependable force in collaborative approach in palliative care. It sponsors lots of programs that help facilitate palliative care in developed nations. Its Collaborating Centers help in many areas including in developing methods to evaluate and improve national policies. Such policies are needed to oversee the availability and access to the medicines that are essential for relieving pain. Good enough the same gesture is being extended to the developing nations. Drawing a lesson from this collaborative approach that helped
palliative care provisions in developed nations, developing nations can key into this collaborative approach to improve palliative care education and service provision in their countries.

2. Adaptations to structures on ground

The presence of palliative care in developed nations help highlight the role existing structures or ‘structures on ground’ played in the development, progress, and provision of palliative care in developed nations. Studies carried out by some authors, showed the rapid growth of palliative care in developed nations following the models of hospice movement that was triggered by the response to medical powers. Some of the authors observed that in some places the original model as practiced at St. Christopher’s was adopted while in other places it was modified to suite needs of the particular palliative care settings. Others equally observed that development of palliative care services often started from or with existing structures.

Structures on ground vary from different cultural contexts and needs to different social and medical needs. Again, situations on ground also help determine responses. This is true not just in the service provisions of palliative care itself that allowed for adaptations, and modifications from the original practice to suit local settings. It is equally true in the overall responses that gave rise to palliative care in those nations. The intention here is to argue that the presence of palliative care in developed nations shows that different responses and adapting different variations in the provision of palliative care was part of the overall strategy that made the development of palliative care in developed nations a success story and this stands as a lesson to the developing nations.

First, developing nations can learn from the way different regions of the developed world responded differently to the same problem context. According to some writers, same problem
situation generated different kinds of responses from different regions of the developed nations. The first and earliest response was in United Kingdom. Here, the response to the medical obstacles created by scientific powers of medicine was to take the patients away from the hospital. The vehicle used was ‘the hospice movement.’ Among the many voices was Saunders. She championed the hospice movement. She championed the struggle to offer high-humane-touch to the patients so that patients can be free, fulfilled, self-determining and comfortable in the face of scientific powers. Her effort paid off as her struggle saw the birth and shaping of modern palliative care which took off at St Christopher’s. The high quality care provided for the dying at this center eventually crossed national and international borders as it became a source of reference point for new palliative care provision in many nations.

Another kind of response was recorded in United States of America. The response laid more emphasis on limiting medical interventions. This was achieved through legal firewalls that hinged on the right to autonomy, privacy, and liberty. It all started with the Karen Ann Quinlan case in 1976 at state level and culminated in the Nancy Beth Cruzan case of 1990 that established a national precedence for withholding and withdrawing medical treatment and the right to refuse treatment. Subsequent cases like that of Terri Schiavo helped solidify and rectify the right to refusing medical treatment when it comes to incompetent patients. Today palliative care practice in most developed nations utilize the consensus arrived from the policies guiding the practice of withholding and withdrawing care.

A different kind of response was recorded in Netherlands where the euthanasia debate erupted as a decisive protest against medical power. The advocates proffered (‘happy death’) as the answer to patients’ pain and suffering. Though advocates of euthanasia might have legitimate reasons for subscribing to it as a response for unbearable suffering, euthanasia remains a suspect
in the practice of palliative care. Euthanasia has compatibility issues with palliative care practices. Some authors argue that euthanasia is laden with paradoxes. They raise issues with its compatibility with palliative care practice. From the point of view of their philosophies euthanasia and palliative care are essentially and mutually exclusive of each other.81

From the foregoing, it may be said that the responses have regional effects probably due to their different cultural milieu. The issue of patient suffering vis-à-vis the tyranny of medical science was handled differently in these places. The problem was the same. But the approaches were different. In UK the response was hospice. In the USA, it was legal battles and policy changes. In Netherlands, it was euthanasia. These different countries responded differently to the one problem context that demanded attention and commitment to the cause of suffering patients and how they could achieve good and dignified death.82

These different responses help make the case that the search for a model of palliative care in a developing nation like Nigeria could be achieved differently. The search should be open to different options even if on experimentation level. Developing nations can resort to other responses that resonate with their cultural values, social context and healthcare needs. They can adopt approaches that can include a consideration and commitment on how they live. They need to see beyond concerns about dying and dignified death.83 Just as euthanasia-dignified death-case was a social experiment for the Dutch in answer to the suffering conditions of the patients, consideration of how people live in most developing nations can be embarked on at least as a social experiment to see how it improves the lives of the many suffering patients in developing nations. This much could be experimented on for many developing nations just like the Dutch euthanasia case was but a social experiment.
Equally of important consideration is the lesson that can be drawn from the organization of service provision of palliative care among developed nations. It is also significant to note that like the scenario that played out in responses to the issue of medical problem that gave birth to palliative care (as discussed above), a similar pattern correspondingly played out in the organization of service provisions of palliative care itself in developed nations. Among the developed nations that embraced palliative care, service provision was organized differently to suite their local needs and settings. Some either carried over and adopted from the pioneer/original practice, or transformed and adapted to the needs of a particular area.84 We observed earlier in the previous chapter that at the initial stage of its development, three pioneer models of palliative care emanated from three different regions of the developed world namely, U.K, USA, and Canada.85

The practice at St Christopher was carried over and adapted to suit the hospital setting at Royal Victoria Hospital Montreal, Canada. The practice in America adopted and remodeled both what was practiced in UK and Canada to suit the local needs that resulted in a bureaucratic demarcation between palliative care and hospice care in USA.86 What followed the adaption and the transformation of the three pioneer models of palliative care was expansion to other developed nations that adapted, transformed or integrated these practices to suit their needs. This is attested to in the study of palliative care carried out in some European cultures. The study shows that certain values held together were shaped, transformed and modified to suite the local settings for those European nations that embraced palliative care.87 Each nation fashioned palliative care according to its needs and what works out well for the country without altering the core service provision practice of palliative care.88 The scenario that played out here can be of great lesson to Nigeria in particular and developing nations in general.
As developing nations seek to organize palliative care system suitable to their various needs, they can tap into this ability of palliative care to carry over, adapt, transform or even to reshape the original practice/s to suit the various individual situation and settings. Such strategy can be replicated in developing nations to achieve a successful palliative care story that suites their situation, especially when such variations do not alter the core service provision practice of palliative care in general.

3. From Basics to More Current Pressing Issues

Palliative care in developed nations has gone beyond basics and transcended to discussions on what ethicists call the ‘pressing issues of the moment’—that is, issues arising from the actual practice of palliative care itself. The basics as noted previously include alleviation of suffering and pain through opioids availability, attention to the social and psychological needs of the patients and families of patients, integration of palliative care in the health system, and practice through multidisciplinary teams. Though there is substantial improvement in the actual provision of these basics, extrapolation from the observations of some authors show that the actual and routine practice of palliative care in providing these basics in developed nations resulted in many challenges and new innovations that changed the tone of ethical discussions in palliative care. Consequent upon the changes both in the palliative care and mainstream medicine is a shift in ethical discussions in palliative care from basics to more pressing issues of the moment. The pressing issues that currently occupy palliative care discussion space in developed nations include, sedation of the terminally ill, euthanasia, ethics of research in palliative care, the complexity of respecting autonomy at the end of life, and concerns about futile treatment. The lessons and arguments here should be that as the situation on ground
caused the change in the tone of palliative care discussions in developed nations, situations on ground should equally be a factor in discussions of palliative care in developing nations.

It is important to note how the palliative care situation on ground caused the change in ethical discussions in palliative care from basics to more pressing issues. First, there is a shift from palliative care’s initial protest against medical power to a rapport between mainstream medicine and palliative care. Initially, palliative care vehemently opposed mainstream medicine’s domineering and insensitive tendencies towards the dying. That opposition drastically changed as medicine become more active and attentive to the needs of palliative care patients. This new understanding in turn, coupled with enabling healthcare system resulted in accelerated progress in research that gave rise to new pain-relieving technologies. The new techniques and innovations accelerated palliative care’s attention to patients with complex and serious illnesses including those emanating from the burdens of aging population and other chronic illnesses. 

Furthermore, the complexities in the wider range of diseases requiring palliative care attention changed the initial palliative care focus on cancer pain management to include these other diseases. In other words, the achievements recorded in cancer pain and symptom control were expanded to include other chronic diseases such as cardiovascular diseases, chronic respiratory diseases, HIV/AIDS, diabetes, etc. The coverage now includes many other conditions like, “kidney failure, chronic liver disease, multiple sclerosis, Parkinson’s disease, rheumatoid arthritis, neurological disease, dementia, congenital anomalies and drug resistant tuberculosis.”

This means that many palliative care patients now pass through the walls and interventions of mainstream medicine once again. The natural consequence of this is a new level of ethical discussion on sedation of the terminal ill, euthanasia, ethics of research in palliative care, the complexity of respecting autonomy at the end of life, and concerns about futile treatment. The
discussions are geared towards guaranteeing that the new found marriage/alliance between palliative care and main stream medicine does not subject patients and their families to another kind of agony.

As palliative care in developed nations continues to guarantee good dying and dignified death to the palliative care patients by sustaining these new discussions, developing nations stand to learn so much from the entire scenario. The lesson for developing nations is that situation on ground can as well fashion the ethical discussions on palliative care in developing nations.

**B. Status of Palliative Care in Developing Nations**

This section discusses the status of palliative care in developing nations under two major themes: lack of palliative care and importance of suitable palliative care. First is to analyze the lack of palliative care in developing nations by examining why the achievement of developed nations is lacking in developing nations. Observing that the situation in developing nations is precarious because of the vulnerable and disadvantaged situation of diseases and poverty, the second theme will emphasize that suitable palliative care approach is a crucial response to the circumstances observed.

1. **Lack of Palliative Care**

The great achievements recorded in developed nations in the field of palliative care is lacking in developing nations. The general notion among scholars is that most developing nations are in a great disadvantaged and vulnerable situation. They identified what they described as the ugly situation of palliative care in developing nations and attributed the precarious situation to poverty. 94
For many years the promoted palliative care was practiced in the developed world only. And for many years there was no trace of it in developing nations until recently. These authors and researchers observed that the reason for the late arrival of promoted palliative care in developing nations is due to poverty, lack of stable government, infrastructural deficiency, difficult terrain, nonchalant attitude of some leaders, and lack of improved technology that accelerates the transfer of information. Even when palliative care found its way into developing nations, attention to palliative care needs was minimal because every effort was on public health programs directed largely to preventing and treating infectious diseases and malnutrition. These deficiencies form the characteristics of many developing nations - including Nigeria which adversely affect, and beg for the suitable palliative care provisions for those nations.

i. Characteristics of a Developing Nation

Developing nations has been characterized in certain ways. These characterizations will help develop and mirror out the general characteristics of developing nations that contributed and continues to contribute to the lack of palliative care in such (developing) nations.

Neither United Nations nor World Trade Organization has a definition of developing nations. Even World Health Organization (WHO) did not define developing nations. But they use the term constantly in articles and publications that has to do with such nations. The World Trade Organization (WTO) uses the terms developed, developing, and least developing nations in dealings with its members. Not only that it does not offer a definition of developing nations, it states categorically in its web site that it has no definition for developing countries. It allows member nations to announce for themselves whether they are “developed,” “developing,” or
“least developing countries.” In any case, it uses the criteria set by UN in dealing and assigning benefits to its members.97

The UN criteria is based on certain demographic indicators. Results measured from the following are used: “Adult literacy rate, Gross secondary school enrolment ratio, Gross national income (GNI) per capita, instability of agricultural production, instability of exports of goods and services, merchandise export concentration, percentage of population undernourished, population, remoteness, share of agriculture, forestry and fisheries in GDP, share of population in low elevated coastal zones, under five mortality rate, and victims of natural disaster.”98

Based on such indicator measures used by UN, WHO and other world bodies, some writers defined developing nations or countries as “countries that have not achieved a significant degree of industrialization relative to their populations, and which have, in most cases a medium to low standard of living.”99 In other words, they observe a strong correlation between low income and high population growth. With this outcome about 156 developing countries of the world are noted. According to the World Economic Outlook Report of April 2012, a total of 154 countries are listed by International Monetary Fund as developing countries. Nigeria makes the list. United Nations has a list of 48 least developing countries and WTO recognizes 32 of those countries as constituting its 158 member nations. 100 At times, some of these countries are often classified as least developing countries.

According to the United Nations Office of the High Representative for the Least Developed Countries, ‘the Least Developed Countries represent the poorest and weakest segment of the international community’. With a population of about 880 million people (about 12 per cent of world population), they only account for less than 2 percent of world GDP and about 1 percent of global trade in goods. Equally they are characterized by weak human and institutional deficiency
that results in their high incidence of poverty and low level socio-economic development. The fact that these nations are in poverty trap makes them vulnerable and disadvantaged. Worst still some also suffer from governance crisis, political instability and, in some cases, internal and external conflicts.\textsuperscript{101} The overall consequence of their disadvantaged situation is that, majority of the people in developing nations are faced with a lot of hardships and suffering, hunger, sickness and death. This makes palliative care in developing nations an urgent necessity.

2. Palliative Care: A Necessary Response

The need for palliative care in developing nations is long overdue and the presence of promoted palliative care in developing nations should be appreciated.

There is a great need for palliative care in developing nations because of the great pain and suffering people in those nations faced as a result of poverty stimulated diseases of all kinds and the agonizing pain, and subsequent death that follows without any relief.

The level of economic and demographic development has a lot to do with the pattern of illness and causes of death. Experts observe that people in developing nations die younger from disease conditions compared to people in developed world. For instance, in developing nations, there is high mortality from communicable diseases, maternal and prenatal conditions as well as from nutritional deficiencies.\textsuperscript{102} Poor infrastructure also adversely affects coverage of health services. There is serious lack of excellent facilities, medications, and improved technology in most developing nations. Lack of capable facilities similar to that found in developed countries affect provision of care. Where such facility does exist, the majority of the population do not have access to it.\textsuperscript{103} The consequences are premature deaths from treatable diseases and great suffering for patients with chronic and incurable diseases. This makes the situation of patients with cancer or AIDS in developing nations more horrible. Such patients lack access to adequate care that
could relieve their suffering (pain management, chemotherapy for the cancer patient and antiretroviral drugs for HIV/AIDS). Palliative care in these nations will always find a way of reaching a considerable number of these patients to bring them comfort in their suffering.

Death rates in developing nations are so high when compared with developed nations. Authors who analyzed World Health Organization’s report estimate that 56.5 million deaths occurred worldwide in 2001. About 76% of deaths occurred in developing regions where over 75% of the people in the world live.104

Statistically, HIV/AIDS and diarrheal disorders are the 42nd and 22nd causes of death respectively in the developed nations. The difference is clear when compared to the developing nations. Diarrhea for instance, is among the top five leading causes of death in developing nations of Africa, Eastern Mediterranean and South Eastern Asian regions. While HIV is the 4th cause of death worldwide, it is the leading cause of death in Africa. It is estimated that more than 70% of people with HIV infection live in Africa.105 According to the world health report on the community approach in sub-Saharan Africa, thousands of patients have incurable disease such as HIV/AIDS and advanced cancer.106 Study shows that in Uganda, a record of about 20,000 cancer patients and an estimate of 200,000 AIDS patients need palliative care. The study raised concern that more that 50% of HIV patients and 80% of cancer patients will suffer severe pain.107

Statistics on infant mortality are alarming. Medical researchers point out that about 100,000 infants born in Nigeria alone die yearly, and that about 75 per cent of 200,000 infants with sickle cell disease are born in Africa. Equally, about 100,000 infants out of 150,000 born with the disease die yearly.108 More worrisome is the situation of a greater number of patients that will suffer in the terminal phase of their illness because of lack of access to palliative care.109 Authors agree that the same scenario applies to other developing nations.110 All these make serious case
for the urgent need for effective and efficient palliative care programs in these developing nations.

Reasons like this make the World Health Organization conclude that palliative care is a public health priority that calls for urgent humanitarian responsibility and action.¹¹¹ Incurable diseases e.g. HIV-AIDS, and sickle cell anemia are of great burden for any patient and family. Advanced sickness like cancer remains a great source of concern from its early stages and even more at its terminal phase.¹¹² Serious diseases such as cancer and AIDS are diagnosed late or not diagnosed at all.¹¹³ The patients are disadvantaged from experiencing the benefits of the antiretroviral drugs that could have improved their lives. The implication is that a high proportion of cancer patients and HIV/AIDS patients are diagnosed in advanced stages when treatment is no longer effective. The result is that a good number of such patients die prematurely. These examples point to the obvious precarious predications of such patients in developing nations. They are also cogent reasons to support the promotion of palliative care in the nations. The needs are serious and urgent.

Having refined palliative care in developing nations will attend to the urgent needs that cause the patients and their family great pain and suffering. Promoting palliative care in developing nations should be a necessary response to the situations. The status quo is very inadequate. What obtain in few developing nations as palliative care make the case for the possibility of palliative care in the developing nations. Just as the current meaningful efforts in some developing nations are evidences that palliative care is possible in developing nations so does the predicament of numerous patients and families in developing nations make the need for palliative care more pressing.
i. Current Meaningful Efforts

Despite the deficiencies and challenges, meaningful efforts can be observed in many developing nations. Palliative care has managed to find its way into developing nations partly because of the serious and urgent needs in those regions, and partly due to the interest exhibited by the governments of those nations in attracting donor agencies. Some scholars observed that for the past two decades, nonprofit groups and international organizations have been active in introducing and promoting palliative care in some developing nations.114

As can be seen in the story of many nations, the success of any good palliative care is a combination of factors. The success of palliative care in some developing nations is attributed to the contributions and activities of many organizations such as World Health Organization (WHO), the European Association for Palliative Care (EAPC), the African Palliative Care Association (APCA), the Asia Pacific Hospice and Palliative Care Network (APHPCN), Diana, Princess of Wale Memorial Fund, US Government’s President’s Emergency Program, and the Latin American Palliative Care Association (LAPCA). These have recorded success in developing palliative care in some parts of Asia and Africa.115 Such organizations were even noted to have helped in revising regulations on access to pain medications and training of thousands of health professionals in palliative care in developing nations116

In Sub-Saharan African region, the Hospice Africa, Uganda, and the African Palliative Care Association are carrying on the activities of promoting palliative care.117 The government of Uganda is said to be passionately committed as it collaborates with Palliative Care Uganda in making palliative care part of the country’s overall health care program. Today Hospice Africa Uganda can produce morphine it uses as it enjoys the support of her government and that of
many international donors. In 2004, the government of Uganda passed a legislation that allows qualified nurses and clinical officers who underwent a nine-month Clinical Palliative Care Course (CPCC) to prescribe certain formulations of morphine. In a country where too few doctors oversee a huge number of patients’ population, shifting the task of prescribing this important palliative care drug to qualified nurses and clinicians is a laudable decision. It is a smart move that makes available opioids accessible to those who need them most. Thus in Uganda palliative care is now more accessible to the people. Not only that, the program is poised to see a replication of this success in other sub-Saharan countries by opening its doors to her education programs especially through the Clinical Palliative Care Course (CPCC).

Today the Hospice Africa Uganda, is looked upon as the model palliative care for Africa. They have no inpatient facility. They visit patients and their families and work with them at their homes. They also honor referrals from hospitals if the patients wanted to be seen there. The emphasis is more on working with the patients and their families in their own homes because many African patients would like to die at home.

Publications show a similar success story emanating from India, and Latin American countries, where effort is in progress to incorporate palliative care as important health care priority in the development of opioids policies. In a region in India for example, it is reported that a network called the Neighborhood Network in Palliative care is making a tremendous progress. From a humble beginning with one volunteer to a community of volunteers; from a single clinic in the premises of a hospital to 57 palliative care units spread across the six northern districts of Kerala, India is a strong confirmation of such success story. Efforts are also made to ensure the availability of opioids in India. There is a collaborative work going on between the PPSG (Pain and Policy Study Group) and its WHOCC (World Health Organization Collaborating Center).
The collaborative efforts of Indian pain and palliative experts, government officials, and non-governmental organizations have led to significant improvements in policy and opioid availability in this region.\textsuperscript{124}

In Jordan, the activities of Frank Ferris, the director of international programs at San Diego Hospice and Institute for palliative Medicine is a huge success. The program saw to the improvement in the access to pain medication by setting up a pharmaceutical company that manufactures morphine tablets in Jordan. The implication was a breakthrough increase in opiate usage up to twenty-fold from 2.5 kg to 39 kg.\textsuperscript{125}

Scholars observe that the explosive growth associated with palliative care in these nations is a powerful evidence that society perceives hospice care as meeting an urgent need.\textsuperscript{126} For this reason, it is judged that the promotion of palliative care in developing nations stands to attend to the urgent needs of their suffering patients.

The aim of some of these pioneer palliative care programs in developing nations is to act as a pilot program. Hospice Uganda is meant to be a pilot program to other sub-Saharan African countries,\textsuperscript{127} just as the ones in Kerala, India, and Chile were meant to be pilot programs to their various regions.\textsuperscript{128} Success stories recorded in places like Uganda and Kerala, India where government and voluntary non-governmental agencies were committed in the palliative care program show that promoting palliative care can be possible in other places. Many developing nations including Nigeria can still benefit from the experiences and progress made in these developing nations.
ii. Additional Issues of Different Nature

In examining and analyzing the need of palliative care in developing nations and the current efforts in some developing nations, scholars active in the provision of palliative care in developing nations discovered additional issues of concern. They agree that there are additional issues of different nature requiring different concerns when it comes to palliative care in developing nations. The issues discovered in the actual provision of palliative itself are peculiar to developing nations. They create additional burdens to palliative care patients and their families. The issues arise from poverty, hunger, infectious and chronic diseases and cultural specific issues.

Patients with serious and complex illness abound in both developed and developing nations but their specific palliative care needs differ. Also, the practice of palliative care for them has not been in equal measure for many reasons. In developed nations, patients with serious and complex illnesses are in great advantage. They enjoy the privileges and advantages presented them by industrialized economy and robust healthcare system coupled with scientific research and new approaches in palliative care. Similar patients in developing nations are heavily disadvantaged from such privileges because of their everyday living condition. Conditions that offer nothing but extra burden to their illness. A typical everyday scenario was captured by researchers who had close and actual encounter with palliative care patients in developing nation thus: “One woman caring for her nephew said, ‘I took him to over 20 traditional healers ...I spent over a million shillings (€335) on medical care that failed to heal him. To pay for that, I took my own children out of school and sold their inheritance. I sold our land, cows, goats, chickens.” This scenario demonstrates a typical everyday living situation in most developing nations. It shows
not only that poverty shaped how people die in developing nations but also how illness and futile attempts to get cure make poor patients and families poorer.

Most developing nations are not only in a poverty trap (hunger and infectious diseases) but they also contend with political instability and lack of improved technology that accelerates the transfer of information. These make them vulnerable and disadvantaged when it comes to palliative care. The overall implication is extra burden to their already complicated illness/disease.

Some diseases are peculiar to some developing nations. In Africa alone, about 200,000 infants are born with sickle cell disease yearly. Many regions suffer from high levels of epidemic outbreaks, high incidence of communicable and non-communicable diseases, high rate of malnutrition, and periodic occurrences of manmade and natural disasters. Each of these present a set of double burden to the patients in need of palliative care. Some of the diseases (e.g. sickle cell) are poorly understood. Pains and discomfort associated with sickle cell is yet to be studied. For instance, both acute and chronic pain associated with sickle cell disease (SCD) is observed to be poorly understood, unlike the cancer pain that has extensively studied. Again for other peculiar diseases mentioned such as epidemic outbreaks; high incidence of communicable and non-communicable diseases, high rate of malnutrition, and periodic occurrences of manmade and natural disasters great implications abound. Some writers equally observed that more time is given to prevention and less attention to palliative care. The overwhelming demand for attention to all these peculiar diseases, and for all the patients involved (both those needing palliative care and the general public needing protection), means more time is given to prevention and minimal attention to palliative care. When public health programs are focused
largely on preventing and treating infectious diseases and malnutrition, less attention is paid to palliative care and many patients continue to suffer palliative care needs.

Similarly, the high mortality resulting from communicable diseases (including AIDS/HIV), and non-communicable diseases, maternal and prenatal conditions as well as from nutritional deficiencies means more grieves for many families and the society who has to deal with the orphans left behind by the victims of the disease. With this, orphan care becomes an issue in the midst of poverty. The implication here is that palliative care is now faced with additional demands that need urgent and equal attention. Researchers suggest that in the face of these peculiar double burden conditions in developing nations, that other necessary components could be added. Such extra necessary components include practical care, income generation, financial support for food, shelter, funeral costs and school fees, respite, spiritual care and orphan care. These will be in addition to the provisions of the traditional routine components (pain and symptom control, counseling, emotional and psychological support) for which palliative care is known.

Some cultural and religious attitudes hinder the provision of palliative care as well. Some illnesses like cancer and AIDS are usually seen as act of God or punishment from God. In the case of HIV/AIDS, not only retroviral drugs are scarce, patients have to deal with stigmas associated with the disease. The tendency is that patients with such diseases tend not to report to hospitals. Some choose to go to a traditional or religious healers. Some report to the hospital only after hibernating with unhelpful quacks. The implication is that serious diseases such as cancer and AIDS are diagnosed late or not diagnosed at all.
There is the problem of poor infrastructure. Poor infrastructure (human and material) adversely affects coverage of health services and increased costs. Developing countries are known for poor infrastructures and facilities. Where such facilities exist, they are neither accessible nor affordable to the majority of the population.\textsuperscript{140}

Also observed, is the neglect resulting from the nonchalant attitude of some stakeholders in developing nations. The presence of palliative care is not yet felt in many developing nations because their governments have not considered palliative care a human health priority. In Africa for instance, only 26 out of the 47 countries have traces of palliative care services.\textsuperscript{141} The reluctance among some stakeholders in developing nations to take up the challenge and open up avenues for the implementation of palliative care affects the overall operations of palliative care. The implications are huge. They undermine the factors that help to streamline the operations of palliative care in achieving its fundamental goals in the region. The failure of stakeholders accounts for the lack of necessary policies, lack of implementations of WHO’s guidelines, lack of adequate palliative care personnel, lack of drug provision, difficulty in accessing the actual situations on ground, etc.

Consequently, the nonchalant attitude of some governments and stakeholders are of great hindrance to the health issues in general and to the promotion of palliative care in particular. Some authors accuse some government and stakeholders of not making enough commitment in the promotion of palliative care in their countries.\textsuperscript{142} Others accuse them of wrong misconceptions about what palliative care stands for. They contend that some governments consider palliative care a luxury and fail to pay any attention to its implementation and promotion. Some leaders in developing world believe palliative care is a luxury that cannot be afforded by countries that do not have the means to provide the needed basic curative
interventions for the population. They argue that the resources to be expended in pursuing 'luxurious' palliative care should as well be used in pursuing curative illnesses for the countries' population. Unfortunately, they fail to realize that the continuous relegation of palliative care to the background means continuous suffering for the numerous patients in need of palliative care.

More frustrating is the rigidity of some of these leaders when it comes to availability of opioids for use in palliative care. The use of opioids has always been restricted for fear of abuse. In 1952 the World Health Organization (WHO) called for a rigid control of morphine and other drugs that can cause individual and sociological damages. It issued a statement that suggests that morphine will always produce compulsive craving, dependence, and addiction in individuals. The statement prompted many governments to passed laws which were very restrictive to use of morphine. But even when WHO revised its stand on morphine, the restrictions remain effective even today, especially in most developing nations.

As things are, the World Health Organization remains the beacon of hope for palliative care in developing nations. The World Health Organization has always been a reliable force when it comes to collaboration with governments to effect meaningful changes. We already noted how WHO helped palliative care provisions in developed nations. There is prospect for such meaningful changes in developing nations especially with WHO’s strong grassroots presence already in existence in many developing nations. The hope is that through WHO’s constant engagements, enlightenment, education and other collaborative activities with the government and leaders of developing nations, the persistent nonchalance and the rigidity to opioids could be revised. This can also open up avenues for participations and collaborations with other stakeholders to make palliative care available in developing nations.
With the additional issues so far analyzed, the reality demands for a different approach. Just as realities on ground in developed nations prompted the discussions from basic to pressing issues, in the same way, the realities of everyday life in developing, nations call for discussions on additional issues that are not often discussed. Based on realities on ground in the developing nations, some experts who followed the trend of palliative care in developing nations have advocated for the concept of “total needs” in addition to the concept of “total care.” They argue that both ‘good death’ and ‘good living’ should form part of the basic ethical discussions in developing nations, especially in the light of poverty and infectious diseases.147

One can infer that in developed nations situations on ground did to warrant discussions on ‘good living’ or ‘how they live.’ The initial protests against medical power were committed to the concern about dying and dignified death. The situation in developed nations does not necessarily warrant discussions on ‘good living’ because their economic life, social life, and welfare are at its bests for most developed nations.148 With a booming and industrialized economy together with robust health care system need does not arise for any necessary debate about ‘how they live.’ The story is different for most developing nations, including Nigeria where everyday situation demands for such discussions on ‘how they live.’ In those nations, poverty, hunger and infectious diseases rank high whereas medical facilities rank low. The rot/devastation caused by these ugly situations on ground demands a shift in ethical discussions on what constitutes palliative care in developing nations- a shift that will not affect the definition of palliative care which is globally relevant but a shift to discussions on needs that are specific to the situations on ground.149
Conclusion

In sum, understanding the meaning of developing nations is a window to understanding the urgency of palliative care in developing nations. The promoted palliative care in developing nations is an urgent necessity and not a luxury. Diseases in developing nations that have double burden together with high mortality rate subject so many patients and their families to great pain, suffering, death, and grieves. Promoting palliative care in developing nations is a necessary response. It is already a success story in some developing nations. It is bringing relief to patients and families in the nations. While it is true that palliative care can be possible even in developing nations despite the difficulties involved, it is also true that poverty, neglect and lack of adequate medical infrastructure contribute to the double burden of sickness in the nation. This is why the situations on ground in developing nations call for a different kind of discussions and approaches in palliative care. Such discussions and approaches can guarantee conducive environment for the practice and provision of palliative care in developing nations, including Nigeria.
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Chapter 4: Palliative Care in Nigeria

Having considered some crucial lessons of palliative care in developed countries for developing nations, this chapter focuses on Nigeria and its distinctive context. It will explore the healthcare needs and demands for palliative care in Nigeria. It will show how these are not well addressed currently despite the fact that palliative care is important, necessary and achievable.

As a developing nation, Nigeria suffers from the short-comings affecting most developing nations, Nigeria is not immune from the effect of diseases and the double and compounded burdens of sickness in poverty. Nigeria does not have much to show in terms of palliative care. Meanwhile, there are pockets of palliative care activities in Nigeria. The current palliative care activities are not enough for the country considering the huge size and population density of the nation. Besides, they are in their humble beginnings begging for promotion. For a robust promotion and practice of palliative care in Nigeria, a good understanding of Nigeria and her healthcare needs is important especially in the light of its distinctive context as a developing nation.

A. Nigeria as a Developing Nation

Nigeria is a developing nation. It makes the list of developing countries according to International Monetary Fund listing. It equally shares in the criteria set up for developing nations by the United Nations. The country is blessed with great population, rich natural resources, and even in the recent decade with improved economic growth and progress in disease control. Ironically, these great advantages have not translated into robust economy and great human development. Though Nigeria is said to have made some progress in the areas of disease control and economic growth, these have not changed its status as a developing nation.
Like many developing nations, Nigeria still suffers from the effects of poverty, unemployment, diseases, starvation, hunger, great disparity between the highly rich and the absolute poor, urban and rural areas disparity, infrastructural deficiency, nonchalant attitude of the leaders, etc.  

These factors in the nation’s health risk and create a great burden for palliative care patients in the country. The deficiencies are of great concern in the country in general and to palliative care promotion in particular.

Because Nigeria spends so much time and energy trying to address these issues especially in disease control, it shows little time and interest to palliative care promotion in the country. The effort of the country is consumed in the fight against infectious diseases and communicable diseases and other deficiencies. In the fight against infectious and communicable diseases, Nigeria has made remarkable progress against polio and guinea worm. The country equally managed and contained the Ebola spread quite rapidly compared to many other countries that experienced the effects of the epidemics in 2014. This shows Nigeria is not lacking in expertise when it comes to fighting infectious and communicable diseases. But despite their expertise, serious diseases still remain or reoccur and continue to cause problems in the country. As encouraging as these achievements are, Nigeria still suffers the effects of infectious/communicable diseases and other deficiencies. The achievements have not removed the fact that Nigeria has deficiencies of great concern that demand a lot of attention. The focus on these other interests though important is a major distraction and hindrance to adequate promotion of palliative care in the nation. The implication is that palliative care is relegated to the background. The more time given to resolving some of these issues the less the time and attention given to palliative care. The consequence is that many patients continue to suffer and die in pain.
Effective articulation of the distinctive context of Nigeria as a developing nation has to incorporate discussions on the inconsistencies that trail every of the nation’s developmental efforts for improvement. Nigeria is not just a developing nation. It is a developing nation with a difference. There are so much controversies that trail its effort for improvement.

1. Nigeria: A Developing Nation with a Difference

The country has many advantages as a nation. Yet, in many ways it is disadvantaged. Nigeria has had many success stories both in economic growth and in disease control. At the same time, it is flawed most often with the overall end result.9 The country has a great population, huge oil reserve, progress in economic growth and disease eradication. Yet there is great poverty, starvation and diseases, unnecessary deaths and other hazards that result in low life expectancy. Life expectancy is at mid-40 years among the population. Children under-five experience greater proportion of deaths annually.10 The disparities are now discussed under the following headings.

i. Population, and Economic Growth

a. Population

Reports and literatures show that Nigeria is the seventh most populous country in the world and the most populous country in Africa. It also records rapid population growth. It grew from 118 million in 2001 to 170 million in 2006, and to 173 in 2013.11 It is estimated that about more than one fifth of all Africans live in Nigeria.12 But it has a very poor human development index. The rate of its economic growth is not in proportion with its population growth.13 Nigeria has a great population that has not translated positively to the development of the nation.
b. Economic Growth

Nigeria’s economic growth is said to have improved in the past decade. According to the World Health Organization’s *Country Cooperation Strategy report*, Nigerian is among the notable oil producing nations. Recent reports show that the economy is the largest in Africa and that agriculture accounts for about 40% of GDP, and more than 60% of total employment. Other reports on current developments in Nigeria put the Nation as fifth largest exporter of oil in the world.

It is paradoxical however, that despite the huge crude oil reserve, and the progress in economic growth, economic welfare and situation of majority of Nigerians and many social structures, including health care have not improved. The human development index for the nation is still very poor and is begging for improvement. The nation’s current youth unemployment index, for instance, is very high with 37.7% average. This marks Nigeria out as one nation in sub-Saharan African with the highest youth unemployment rate.

The economic growth is in total disparity with the alarming high poverty. There is a great disparity between the economic growth and the effect of the outcome on the general populace and the nations institutions/infrastructures. The improved economic performance as reported in the last decade is flawed by the huge economic hardships still pervasive in the country. The success recorded from better macroeconomic and fiscal management and the growth in the non-oil sector has not translated into a reduction in poverty in Nigeria. Nigeria is not capable of adequately feeding the vast majority of its population. Unemployment, poverty, diseases, poor sanitary conditions, infrastructure deficiencies including, epileptic electricity lack of portable drinking water, hunger and starvation still prevail in a nation that makes so much money especially from oil. The implication is that the country remains a ‘rich’ poor developing
nation with many economic hardships. Economic hardship in the country is really a factor. It gives rise to diseases, poverty and poverty stimulated conditions. Thus Nigeria continues to battle issues of poverty and poverty stimulated conditions and diseases.

Understandably, as more and more attention is given to these issues, palliative care suffers more neglect. Little or no serious attention is given to issues involving palliative care. Palliative care automatically becomes a secondary issue or none issue at all where infectious and communicable diseases are causing havoc. But the exuberance of infectious diseases presupposes that huge numbers will need palliative care attention. On the other hand, the neglect of palliative care implies that many palliative care patients suffer neglect. All these show that the economic growth has not translated positively to the wellbeing of the people. The point is that the palliative care suffers grievously from the economic disparity in the country. Great attention and the huge resources invested in combating infectious and disease issues allows little or nothing for palliative care to be attended to. The effort and attention directed on disease eradication and prevention in Nigeria create economic issues. It gives rise to poverty and poverty stimulated conditions.

**ii. Disease Control**

Nigeria is a nation laden with serious epidemiological profiles. The nation’s health demography shows that the country is faced with alarming presence of communicable and non-communicable diseases.\(^{20}\) It is unfortunate that such diseases abound in Nigeria despite every effort to eradicate or control them. Some common diseases in Nigeria include- malaria, wild poliovirus/polio (Though Nigeria was declared polio free in 2015 by World Health Organization,\(^{21}\) positive type 2 circulating vaccine-derived poliovirus - cVDPV2 was detected in Maiduguri, Borno State in March 2016),\(^{22}\) measles, diarrhea, cholera, Lasa fever, sickle cell, cancer, TB, HIV/AIDS, and
neglected tropical diseases. Some of the neglected tropical diseases include human African Trypanosomiasis, lymphatic filariasis, trachoma, onchocerciasis, buruli ulcer, schistosomiasis, leprosy, soil-transmitted helminths, and Guinea Worm disease.23

While Nigeria has done so much in combating these diseases even with a program that aims at eradicating the diseases by the year 2020,24 the fear is that the effects of communicable and infectious diseases will continue to be a major problem in the country. In other words, the effort in the fight against infectious and communicable diseases is also trailed with contradictions. It is paradoxical that despite all the attention being given to disease control and eradication, their effect is still alarming. The fear is that the nation’s effort in combating these diseases is usually hampered by poverty induced conditions which in turn diminish and flaws any effort in the fight against diseases in the county.25 In spite of the fact that Nigeria has made a lot of progress in the fight against infectious and communicable diseases, the diseases remain the major cause of pain, suffering and death in the nation, especially among children.26 Although the same conditions contribute to the need of palliative care in the country, the challenges of communicable diseases in Nigeria continues to hamper any effort in the promotion of palliative care in Nigeria.

The success story of Nigeria in the fight against the numerous diseases that beset the nation is met by equal amount of contradictions thanks to poverty induced conditions. For instance, the good news that Nigeria has been declared Guinea worm free is met with equal amount of bad news that Nigeria still ranks first in Tuberculosis (TB) cases in Africa.27 The success is tainted by poor coverage as it is not wide spread across the board. For a similar reason, the most resent celebration that Nigeria is polio free was punctuated with a sad news that a type 2 cVDPV2 was detected in Maiduguri.28 This development is not surprising because coverage was a serious issue in Borno State.29 Maiduguri is one of the major towns in Borno state that was ravaged by the
insurgency of Boko Haram - a by-product of poverty induced conditions that made any developmental program in the area impossible. Analysis from the UN regional report on Nigeria shows that the successful fight against malaria with the use of insecticide-treated bed nets was flawed by the high incidence of death caused by malaria in the country. While the fight was improved from 8% in 2008 to 50% in 2013 malaria still counts for the highest deaths in Nigeria among children. This causes great pain and bereavement to many families. Again, the good news on the success made by Nigeria in the reduction of the rate of HIV/AIDS in 2012 was not well celebrated because of opposing bad news that Nigeria caused the international community the opportunity of meeting its global goal in HIV/AIDS eradication. Nigeria through its multi-sectoral national responses to HIV/AIDS stabilized the epidemic in 2008 through 2012, from 7.1% annual infections in 2008 to 5.6% annual decline in 2012. Ironically, the number of pregnant women living with HIV who needed antiretroviral therapy for prevention of mother-to-child transmission of the virus was still very high, possibly because those with poverty induced conditions were not well covered. Nigeria was largely responsible for the 29% of the global gap in reaching 90% of pregnant women living with HIV. While credit is given to Nigeria for the success in immunization against communicable diseases, death from communicable diseases is still very high. The success story is that more children are being immunized at the right age and are well protected. The bad news is that about 40% of deaths under-five years of age are still due to vaccine preventable diseases. This does not lack connection to poverty induced conditions.

The issue of diseases and difficulties associated in eradicating them is tied to poverty and poverty stimulated conditions. Poverty accounts for poor hygiene, poor environmental sanitation, and poor living conditions. These lead to diseases and high death rates. It has been argued that
improved hygiene, general living conditions and environmental sanitation contributed to the decline in mortality in the developed countries. Conversely, poor hygiene, hunger/poor nutrition, poor general living conditions etc. are poverty induced and they cause and stimulate disease that lead to death in Nigeria. For Nigeria to overcome the issues of diseases and achieve improved health in the country, serious consideration has to be given to the problems of poverty and poverty induced conditions. Disease control is not enough.

2. Poverty and Poverty Induced Conditions

Reports and writings on Nigeria show that poverty in the nation is so high. Poverty have been measured in different ways that are complex too. Based on the outstanding measurements alone that involves simple living standard measures majority of Nigerians are poor. Majority of Nigerians are unemployed, have low income, lack adequate access to food, social/physical, and political infrastructure. Besides, life expectancy and infant mortality are very poor. The negative effect of poverty on the populace is pervasive and alarming. About 69% of the Nigerian population are poor while about 68% of them live on less than US$ 1.25 a day. This makes poverty a serious issue in the country.

Again, the gap between the rich and the poor is so hug and has factored so much in the nation’s woes. There is great disparity between the highly rich and the absolute poor in Nigeria. The gap is so huge that it is considered one of the greatest stimulators of continual poverty in Nigeria. It accounts for economic gap, social gap, and justice gap. It also enables ineptitude and corruption in governance and disaffection among the impoverished.

In Nigeria the rich has all the powers- economic, monetary, connections, bureaucratic, and governmental powers. They are the dominant comfortable class who live in the best and most comfortable parts of the cities (leaving slums and ghettos to the poor). With so much comfort,
they often lack political will needed to effect certain policy changes that will better the general interest of the nation. Their top priority concern is to protect their interests. The problem then is that most often their interest is equated with national interests even if it means deficit to the nation.38

The poor, on the other hand, are powerless in every aspect of the above. They are mostly peasants, unemployed or low level workers who live mostly in the rural areas and the slums of the cities. Apart from the fact that they have low income, their interests are not often considered in policy making. They lack access to most of the essential infrastructures and welfare services because so much money that could have been used in providing such amenities end up corruptly in the hands of powerful few.39 These can explain why there is a persistent “stark contrast in economic success and wealth accumulation between the rich few and the large majority.”40 poor in the country. The implication is disaffection among the impoverished and the unemployed resulting to other woes.41

Poverty conditions are responsible for many social ills. They breed disaffection among the impoverished and the unemployed especially in the youth. They provide entry point for social vices like armed robbery, kidnaping, Islamic extremism in the north (the current menace of Boko Haram is a case in mind). They entice and induce people to corruption especially in the government circles, which in turn promotes ineffective governance, and lack of faith in the government.42

None of these factors or conditions favor palliative care in Nigeria, actually they work against it. In one of her interviews, Anne Merriman who has taken Hospice Uganda to greater heights indicated that she actually started first in Nigeria but has to give up because of corruption. She abandoned Nigeria in favor of Uganda because of widespread corruption and lack of government
commitment. She relocated to Uganda where people had faith in the government and the corruption was not a very high issues. Attracting and collaborating with more foreign donors and volunteers is very important for any effective action aimed at alleviating burdens of poverty and sickness in Nigeria. For now, corruption definitely is a major hindrance to that effect.

As can be seen, there is a kind of chain reaction in the Nigerian socio-economic poverty string. Poverty and poverty induced conditions are byproducts of socio-economic deficiencies in the country. In turn, poverty-stimulated conditions not only cause the disease problems in the first place, but also account for most of the setbacks Nigeria encounters in its fight against diseases. There is a vicious-circle in effect. As a byproduct of socio-economic deficiencies, poverty creates poor sanitation that lead to sickness and diseases. It creates disparity between the affluent rich and absolutely poor. It creates slums in the urban areas and very disadvantaged rural areas. It also creates a hostile environment due to social vices etc. Diseases thrive with these conditions and these conditions make it hard to fight diseases.

The poverty induced conditions create hindrances in the fight against diseases in Nigeria. They make it impossible for the government to access the populace that need immediate attention. They also make it very difficult if not impossible for the populace who need immediate attention to access the needed services. For instance, though most services like immunization and malaria prevention are rendered free of charge, many people are not financially buoyant enough to pay for transportation to the service centers. Because of poverty, they cannot afford to transport themselves to the centers where these services are rendered. Government on its part might not be able to access the population in the suburb due to poor terrain. Casualties are huge in a case of any outbreak of epidemics in the suburbs or rural areas. For instance, in 1996, there was an epidemic of meningitis in a suburb of Kano in the northern part of the country. Out of 250000
people affected by that disease, 25, 000 people died just in one week.\textsuperscript{44} This was in the rural area. The scenario is different in urban cities. When compared to the dreaded Ebola epidemic that broke out in some cities of Nigeria in 2014, and was successfully put out within a short period,\textsuperscript{45} one implication stands out. The implication is that Nigeria operates better in cities but poorly in rural areas. Deduction can then be made that poverty induced conditions make it hard for Nigeria to provide needed services in rural and suburban areas of the country.

Nigeria operates better in cities and especially when in collaboration with foreign stakeholders like WHO.\textsuperscript{46} But every area in Nigeria is not a city. In addition, foreign donors do not always have faith in Nigeria because of corruption in the nation.\textsuperscript{47} While Nigeria may be successful in providing services in the cities, it always suffers hindrances in rural or suburban areas. In fact, there are more sick patients in the rural and suburban areas of the country as a result of poverty induced conditions. In effect, what has been observed is that every claim of successful achievement in disease eradication in cities is flawed by the presence of patients with poverty induced conditions in the suburbs and rural areas that were not well covered.\textsuperscript{48} Hence contradictions continue to trail every success in disease eradication in Nigeria. Nonetheless, it is important to note that poverty and poverty induced conditions are only symptoms in the Nigerian socio-economic sickness. Until the real cause is identified and taken care of the vicious circle will continue, and in turn, palliative care will continue to suffer the effects.

In sum, Nigeria is a developing nation with so many advantages and potentials. But the country is laden with poverty, diseases, as well as infrastructural and human development deficiencies. The advantages are weighed down by failures. The nation has not been able to turn its huge advantages into huge successes in a manner that is capable of changing the lives of its population to the better. This inability makes the nation vulnerable to all kinds of diseases, pains and
sufferings. So much effort is concentrated in the fight against diseases. But like poverty, diseases are just symptoms in the Nigerian socioeconomic sickness. Because the main problem has not been addressed the symptoms refuse to go.

The efforts of Nigeria could be analogically likened to the effort of a medical doctor who after diagnosing about 50 patients of diarrhea, was giving them antibiotics each time they showed up with the disease. Each time they got infected they go back to the doctor for antibiotics. But investigation shows that they got infected each time they drink from a spring that serves as their only source of drinking water. The doctor can decide whether to continue to give them antibiotics again and again or, take extra step to figure out what actually is wrong with their source of drinking water the spring. In the same way, Nigeria can run all kinds of program they want, buy all the insecticide-treated bed nets against mosquitos in the world, buy all the vaccines in the whole world, and make all the money in the world from oil, they are just treating symptoms. Without asking questions what actually is the fundamental problem and without addressing it, poverty and diseases will persist and many will continue to suffer and die.

Nigeria actually has to figure out why, despite all its efforts, most of its programs are not yielding effective result. Such consideration must address issues of poverty and poverty induced conditions. Actions will include political will to bridge the gap between the rich and the poor, to put in place policies that will make it hard for public money to end up in the hands of the powerful few, to embark on massive infrastructural developments (including housing, road, electricity, water supply etc.) that will improve general living conditions. The nation has to show political will not just to fight corruption but to create a governmental system that will make corruption hard to practice. Only when such fundamental issues are well addressed should other issues including palliative care begin to benefit accordingly. But for now Nigeria remains a rich-
but-poor developing nation so long as poverty and diseases continue to cause double burden to Nigerian palliative care patients.

**B. Peculiar Situation: The Double Burden of Sickness for Palliative Care Patients**

1. **The Effects of the Peculiar Situation**

The effects of the peculiar situation of Nigeria as *rich-but-poor* developing nation are huge on palliative care patients. The peculiar situation exposes so many poor patients to greater pain, suffering and agonizing deaths leaving their families in great grief. Palliative care patients and their families find it so difficult accessing help. The pain, suffering and the anguish they experience in seeking help and waiting for relief that does not come constitute additional sickness for them. Thus, the peculiar situation of Nigeria is the cause for the huge palliative care needs in the country as well as the principal culprit in inflicting double burdens in palliative care patients as they deal with their sickness. The Nigerian situation imposes additional layer of difficulty for those with palliative care needs. On the one hand are the ills of poverty, sickness and diseases. On the other is the lack of effective and efficient palliative care management and programs. The end result is that palliative care patients in Nigeria experience double and compounded burdens in their sickness.\(^{51}\)

i. **Need for Palliative Care**

One of the greatest effects of the peculiar situation in Nigeria is that it created urgent need for palliative care in the country. There is a great need for palliative care in Nigeria because there is great pain, suffering and deaths in the nation. The need for palliative care is huge bearing in mind the huge population of the nation as well as the effects of poverty and poverty stimulated diseases. Worst still the huge palliative care needs have not received desired attention. Many writers attest to the serious palliative care situations in Nigeria and add that the huge urgent
needs of palliative care lack adequate needed attention. The presence of agonizing pain and suffering resulting from unattended illnesses and subsequent deaths that follow without any relief make the need for palliative care in Nigeria huge and urgent. The toll of affliction from the deficiencies of Nigeria as a rich-but-poor developing nation means so much agony for palliative care patients in the county. In addition, the conditions that created these needs/afflictions also make it difficult to provide help. The inability of the nation to adequately attend to these needs or demands arising from the afflictions equally create double burden to palliative care patients in Nigeria.

This means that there is not just huge and urgent need for palliative care in Nigeria but that palliative care patients in Nigeria experience double burden of sickness as a result of poverty, diseases and weak health care service provisions that make it difficult/impossible for them to receive help/relief. In effect most palliative care patients in Nigeria deal with the burden of poverty, double burden of poverty and disease, and compounded burdens of poverty, disease, and poor healthcare provisions. These leave them with a lot of setbacks in obtaining help.

ii. Burdens of Poverty and Diseases

We noted that Nigeria as a developing nation has conditions that bring the nation so much setbacks. Such situations that bring pain, agony and frustrations to the population in general are so excruciating for the sick and palliative care patients in particular. Part of such conditions is the presence of poverty and a lot of diseases in the nation. We equally observed that poverty brings the nation a lot of setbacks in the fight against communicable and non-communicable diseases as most of the diseases are poverty stimulated. In the same token, poverty and disease constitute great burdens to palliative care patients in their sickness.
a. **Burden of Poverty**

The burden of poverty is huge. As already seen, poverty is a serious issue in Nigeria.\textsuperscript{53} Huge numbers of the Nigerian population are poor. Palliative care patients among this number will definitely suffer double burden in their sickness. With the majority of the poor living below 1.25 USD per day, the implication is that they will suffer from many unfulfilled needs and hardships. Poverty subjects them to the string of vicious-circle. It makes them vulnerable to many sad situations, including sickness and diseases. Their need for food will expose them to hunger and starvation. Their need for shelter would be met with dilapidated and poorly maintained homes and poor sanitary conditions. Their need for good health would be at the mercy of sickness and diseases. Their need for pain relief would leave them in pain and anguish. Their need to better their economic situation would see them impoverished all the more. And the vicious-circle continues.

Many palliative care patients lack mobility due to poverty. Poverty limits their mobility as they can only afford to live in the most disadvantaged and inaccessible places of the rural areas and city slums. Most often such places are so congested and without basic amenities. They are most often neglected, if not forgotten by the government. Palliative care patients in these places suffer more deprivations.

Poverty has shown to be a disease in Nigeria. It not only enables sickness but also constitutes double burden in sickness. It is not surprising therefore, that in Nigeria WHO combines its basic goal of fighting diseases with poverty eradication programs and improvement of the stewardship role of the Government.\textsuperscript{54} This means that including poverty eradication in the overall fight against diseases is already encouraged by WHO. The advantage will be the improvement of the overall wellbeing of the people. This will in turn reduce the rate of people getting sick, minimize
the burden of poverty and eliminate double burden when people become sick. Until this serious measure is fully implemented, palliative care patients will continue to suffer not just the burden of poverty but also the double burden of sickness in poverty.

b. Burdens of Diseases/Sickness

Authors indicate that high rate of diseases and hunger in any country means neglect in palliative care because more efforts and attention are directed to public health programs. As already seen, Nigeria is a good example of such a nation with high rate of epidemic situations.

As pointed out, the country suffers from high levels of epidemic outbreaks, high incidence of communicable and non-communicable diseases, and periodic occurrences of man-made and natural disasters, poverty, hunger, starvation, and malnutrition. In consequence, it spends so much resources in public health sector to the neglect of other sectors, including palliative care. But palliative care in Nigeria is supposed to be part of its public health program, but it is not. Rather, a lot of the nation’s effort and resources are largely directed to preventing, controlling and treating infectious diseases and malnutrition to the neglect of palliative care. This scenario accounts for part of the reasons there are serious palliative care situations in Nigeria without the needed adequate attention. Many patients with cancer, HIV/AIDS, tuberculosis (TB), Sickle cell, including those with chronic, acute, and terminal/end of life conditions, etc. suffer in Nigeria without adequate palliative care attention. Simply, there is huge unmet palliative care needs in Nigeria because of neglect due to all attention that is directed to public health.

Disease control forces the nation’s attention to one direction, namely, public health. By directing a huge chunk of the nation’s resources and efforts to one sector in neglect of other sectors (including palliative care) a greater number of the population are left without a choice but to suffer the effect of the neglect. For this and many other reasons, despite the presence of serious
palliative care needs in Nigeria, palliative care patients are not receiving adequate attention. The implication is that such patients continue to experience double burden in their sickness and pain because of so many unmet needs.

There is equally enormous burden of sickness for palliative care patients in the country. For instance, reports and literatures show that Nigeria has the largest unmet pain relief needs in Sub-Saharan Africa countries. Much of the pain relief need exist in cancer patients, sickle-cell anemia, chronic sickness, communicable and infectious diseases like HIV/AIDS, tuberculosis, and malaria, etc.

According to a 2012 research by the International Agency for Research on Cancer (IARC), there are about 102,079 new cancer cases and about 71,571 cancer deaths in Nigeria every year. From this report, five most frequent cases were identified. They include Breast, Cervix Uteri, (both rank high in women), Prostate (rank high in men), Liver, and Colorectum. These numbers were extrapolated from only three cancer registries in Nigeria namely, Abuja (2009-2012), Calabar (2009-2011) and Ibadan (2006-2012). Some literature even show a projection of 42 million cancer cases in Nigeria by the year 2020. Although these numbers are alarming, some other writers still believe the numbers were under-estimated. They believe that the real cancer burden is unknown majorly due to poor record-keeping and under-reporting. Coupled with this, many writers report that cancer registration is poor in Nigeria because the registration is hospital based. Many patients usually seek alternative treatments. Many go to traditional healers or prayer houses rather than to the mainstream hospitals. Such patients are not documented in the hospital registries. The number of such alternative help seekers are in no way small. For instance, just in one institution alone in Enugu, the Eastern part of the country, it was reported that nearly 60-70% of patients with cancer present late. More than 50% have severe pain at presentation,
and there are not enough pain medications to go around. The implications from this are multiple. First, if up to 70% of cancer patients report to the hospital late, then there are possibilities of many more who were not documented because they did not present to the hospital at all for the same reasons that the others presented late. Secondly, there is also the possibility that such patients suffered and died in their condition without relief and they were undocumented.

In all, there are so much unmet pain relief needs for palliative care patients in the country. But problem of poor cancer record keeping and under reporting of cancer cases are part of the overall health information management problems that affect palliative care in Nigeria. This will be discussed later in this chapter. Poor recording and under reporting only count for some of the reasons many patients with cancer pain still suffer in Nigeria despite progress achieved globally in the control and management of cancer pain.

The situation of AIDS patients is worse. Nigeria is said to have about 9% of all people with HIV in the world. According to a 2012 report, the country has 3.4% HIV/AIDS prevalence with about 270,000 new HIV infections cases every year. There is no doubt that this represents a decline in the number of new AIDS cases when compared to the 2007 report when AIDS prevalence among children alone was 730,000 (HIV infections of babies born yearly). This decline does not mean less work for palliative care need. For a huge number still, need palliative attention. The decline in number does not necessarily result in a decline in need. Actually, the reverse is the case in Nigeria. There is more need now. In addition, there are other contributing factors that make the case for the necessity for urgent palliative care program.

Actually, the number of those who suffer and die of HIV/AIDS in Nigeria is still high. The numbers put out by other reports show there are more people with HIV/AIDS related cases in
Nigeria than in any other sub-Saharan African countries. More than 3.4 million Nigerians currently live with HIV and more that 250,000 die annually of AIDS related illnesses/cases. The size of Nigeria’s population may be responsible for the huge numbers. Though Nigeria has lower percentage of HIV/AIDS cases when compared with other African countries, the population puts Nigeria away as the country with the highest number of AIDS victims. The care HIV/AIDS victims receive is even more problematic. Their need for relief is yet to be met. To complicate matters, in some cases, many children are orphaned due to the untimely death of their parents from diseases like AIDS. Care for these children is an issue and a serious burden for the society as a whole and for the families in particular. Truth is that we may not know the actual number of orphans in Nigeria. But we can reason out. If Uganda has 2 million orphans, that of Nigeria must be higher. The point is that Nigeria is the most populous nation in Africa and Uganda has far less population than Nigeria. Again, considering Nigeria as a country with the highest number of AIDS victims in Africa means that Uganda has less number of AIDS patients. It follows then that Nigeria must have more orphans as a result of HIV/AIDS alone. These are issues that face palliative care in Nigeria and which palliative care in Nigeria must be fashioned to tackle effectively.

Sickle cell anemia is another disease of great burden in Nigeria. The disease is a genetic disorder. Separate reports from Nigerian ministry of health and World Health Organization show that the disease is very common in Nigeria and contributes significantly to both adult and child morbidity and mortality. Statistics on the disease is disturbing. Based on the size of its population, Nigeria stands out as the most sickle cell endemic nation in Africa. The sickle cell trait affects about 23% of the population and about 100,000 children die annually from the disease. This constitutes an average of 8% of annual infant mortality in Nigeria. Unlike cancer pain that has
received extensive study, sickle cell pain is yet to be studied extensively.\textsuperscript{79} Worst still, the prospect of any extensive study on it is dim. This is not good news for patients of this sickness who continue to live and suffer in neglect, anguish and pain.

Of equal disturbing situation is the burden of Tuberculosis (TB) in the country. The result fluctuates. The fight against the disease benefited from the public health program directed against infectious diseases that saw to its decline in 2012. A decrease of TB from 15.74 prevalence per population of 100,000 people in 2000 to 5.0 prevalence in 2012 is a good news worthy of celebration. Nevertheless, recent reports show that the rate of progress in the fight against TB has declined though the number of prevalence increased.\textsuperscript{80} The new estimate shows that in 2014 about 600,000 people were infected with the disease and more than 500,000 people infected with Tuberculosis in Nigeria remain undetected. Based on the current number, the report ranks Nigeria first among African nations with most TB prevalence.\textsuperscript{81} This increase in the number of prevalence of TB has serious implication for the patients. Many patients who need palliative care continue to suffer due to the peculiar situation in Nigeria.

iii. Burdens from Weakness in Health Care Delivery

Apart from presence of poverty, sickness/diseases and their consequences, the overall poor health care delivery system compound the burden of sickness for palliative care patients in Nigeria. When WHO proposed the Universal access to health care within two decades, Nigeria was among the 134 countries at the Alma-Ata International Conference on Primary Health Care of 1978 that affirmed it. Since then, Nigeria has struggled in vain to meet up with that objective.\textsuperscript{82} The failure reflects the inadequacies in Nigerian health care delivery system. Health care has not received any adequate priority attention that it deserves in Nigeria as a developing nation.\textsuperscript{83} Though the first ever health care bill was passed in 2014,\textsuperscript{84} Nigerian health
care system is still weak and as such contributes greatly to the double burden undergone by Nigerian patients. Few samples of the major weakness in health care delivery system are here considered.

First, there are issues of dilapidated infrastructures, lack of essential drugs, lack of accessible National Health care insurance scheme and lack of adequate budgeting for health care. These contribute to the problems of limited access to health facilities and services in the country. Inadequate national health budget is fingered in the difficulties involved in the provision of health care in Nigeria. According to a report on the 2015 open budget survey carried out by *African Budget Health Network* (ABHN), Nigeria is rated poor in health sector allocations. For instance, the total budget of the country for the year 2016 was N6.06 trillion (about 32.6 billion USD). Out of this only a total of N250.06 billion (about 1.3 billion USD), or 4.14 per cent of the annual budget was allocated to health sector in the year 2016. Previous years were not better. Going back to 2006, for instance, health care budget has been lingering between 2-5% of the annual GDP. Per capita expenditure on health in 2011 was only US$ 85 despite the vast resources available in Nigeria. Thus decades of continual poor annual budgeting for healthcare account for low level of investment in health. It is also responsible for many health infrastructures in bad repair and lack of essential drugs and services that make provision of good health delivery difficult. Many magnificent hospital buildings and other health care facilities are in a very bad shape. In places where services are provided Nigerians still pay out of pocket as there is not yet accessible health insurance scheme in the country. The National Health Insurance Scheme (NHIS) that was inaugurated in 1999 only covers few privileged Nigerians. As of 2012 only about 3% of the population is covered by the scheme leaving the majority of the population uncovered. Though there has to be a special insurance for poor people who cannot
pay the normal insurance premium, these are yet to kick off. Huge effort is still needed from the government to make progress towards achieving universal health coverage for the majority of the needy populations in the country. This becomes a compounded burden for palliative care patients. They not only lack essential drugs including Morphine, that are vital for their pain control but have to pay out of pocket for any services received at the regular hospitals. This means such services are not affordable to many of them considering that many of them live below poverty level. They will continue to live with unmet needs in their suffering.

There is also the problem of inadequate decentralization of health services in Nigeria. As already noted, a lot of setbacks Nigeria encountered in its fight against diseases are as a result of inability to cover its remote places. The already existing urban/rural, rich/poor discrepancies also affect how health services are distributed. Some authors observed that there is a high level of bias in favor of the demands of elite groups in the urban areas. Urban areas are noted with concentration of better services whereas in the rural areas, the quality of treatment is inferior, and often infinitely inferior. While most health service packages could be accessed in the urban areas, the rural areas where the majority of the sick population dwells are neglected. Hence health care service in Nigerian is unevenly distributed with concentration of specialized government and higher-order commercial sources in the urban major cities.

Nigeria has the highest stock of human resources for health in Africa, but, the impact of medical professionals is not felt evenly in all the states of the nation. The situation in the rural areas is worse. Nigeria is rated as having as of 2006 about 39,210 doctors and 124,629 nurses registered in the country. This gave an average of about 30 doctors and 100 nurses per 100,000 population of the people. But, the distribution is not even within the country. There is a large concentration of medical professionals in the urban areas. These professionals, apart from not wanting to live
and work in remote or rural places with no amenities, majority of them chose to work in the urban areas. They prefer federal and state facilities in the cities where they expected to receive better social and economic amenities and high remuneration for their income. For instance, in Abuja the capital city, the average number of health providers stands at 50.5 per 100,000 population of the city. This is a total contrast to what is obtainable in most rural places in Nigeria where the average is 1.9 per 100,000 population of the inhabitants. Left to their fate and given to their situation, the rural populace source for help elsewhere.

The rural population is let to the faith and missionary based providers, spiritual and traditional healers that exist in obscurity in the country. These groups need to be recognized and be empowered as they can offer a grass root based services to the needing patients and families. Recognizing their contributions, regulating, empowering and incorporating their activities in the overall healthcare system will go a long way in alleviating the sufferings of many palliative care patients in Nigeria. Apart from delivering grass-root services to the neglected populace, Nigerian health department stands to boast its health indices from the information to be generated from these groups regarding patients they cover. Unfortunately, these services are yet to be harnessed to boast health care provisions in the country.

Another major setback in the health care delivery that compounds the burden of sickness and disease for Nigerian patients is the little attention given to health information generation. Health information generation and research are needed to build evidence for response to emerging health needs. Lack of adequate health information generation and management have always been a serious issue in Nigerian health care system in general. As already noted, these are parts of the reasons registration on cancer in the country has been very poor. Inaccurate data or information is dangerous to health management. It is not surprising that WHO Country
Cooperative reports that have vital information on Nigeria’s health indices were silent on issues of cancer. Both the 2009 and 2015 reports presented the burden of non-communicable diseases in Nigeria but were silent on cancer as no mention was made of cancer and its related burden in Nigeria. By not giving information on cancer it was not suggesting that cancer is not a serious issue in Nigeria. The action could be viewed as a way of playing safe as to avoid reporting/under-reporting of inaccurate or conflicting data. Inaccurate data or non-existent data is not a good criterion for building a kind of robust health care system that can adequately benefit palliative care practice. The implication is that without adequate information or data Nigerian health care system is devoid of what it takes to build adequate evidence based policy for any research that can benefit palliative care patients. Without such meaningful investment to aid palliative care research and other related diseases in Nigeria many patients and their families will continue to suffer from the pains of their diseases and from the pains of neglect in their condition. The end result is that the palliative care patients among them, will continue to live until death, with unmet pain relief needs and no care of their wellbeing.

The needs of palliative care patients in Nigeria go beyond the burden of physiological pain relief. The patients also experience other burdens. These include, social and psychological issues. They experience social pain as many of them deal with stigma (such as rejection and avoidance) imposed on them by the society. They also experience psychological, cultural, and religious problems like issues of guilt and fear for the source/cause of illness. Even, high death rates resulting from the afore mentioned diseases means so much bereavement and grief for many families. These will be reviewed in the next chapter. In effect, apart from the burdens of physical pain caused by their sickness, poverty and economic hardships, palliative care patients
and their families in Nigeria experience psycho-social and cultural issues that are compounded by poor health care system.

In the light of the aforementioned issues (burdens of physical pain, poverty, psycho-social issues etc.), it is important to note that compounded burdens from weakness in health care delivery are serious hindrances to palliative care practice in Nigeria. It will be very difficult to practice palliative care favorably under the above mentioned circumstances. For any model of palliative care to work in Nigeria, the entire health care delivery system has to be reviewed. But health care delivery system or health care sector in general in Nigeria is inseparable from the rest of the socio economic situation in Nigeria that need to be addressed.

In sum, palliative care patients in Nigeria have series of great burdens accompanying them in their sickness. These burdens are hardly attended to for multiple reasons. Nigeria is a developing nation with peculiar situations that have created urgent and enormous need for palliative. The vast and diverse need for palliative care in Nigeria should make palliative care a public health priority that requires urgent humanitarian responsibility and action. There is the need to make palliative care a healthcare priority by including it in the overall healthcare program. Some elements of the package for the program will include poverty and disease eradication. These has to be incorporated in a new and completely overhauled healthcare delivery system that encourages health information generation to boast evidence based for education and research. This need is evidenced by the success story of palliative care in other developing nations. A look at other developing nations where palliative care succeeded shows that palliative care does better when incorporated into the nation’s health care system. Though WHO has initiated the process in Nigeria, it is left to the Nigerian government to utilize the advantages of the activities of
World Health Organization and so step up its governmental stewardship in order to have a robust health care delivery system in place.

Nigeria should consider including palliative care in its overall public health program. Such practice is not only allowed but is also advocated by World Health Organization. Making palliative care a public health priority is an ideal action for a nation like Nigeria where the alarming consequences of lack of palliative care calls for urgent humanitarian responsibility. Unless positive actions like these are included in the overall program for palliative in Nigeria, the hope of effective palliative care in the nation will be far from being realized, especially in the current urgent need for palliative care.

The current peculiar situation in Nigeria is a great hindrance to palliative care practice. Because of this situation, the country has minimal and underdeveloped palliative care activities. The hope for advanced pain management in Nigeria is far from being realized, especially in light of its distinctive situation of having minimal palliative care activities. The point is that the extensive suffering resulting from a high incidence of incurable and chronic diseases in Nigeria lacks effective palliative care. A review of current palliative care activities in the country shows that many patients continue to die without good pain management and effective palliative care.

C. Current Palliative Care Activities

Current palliative care activities in Nigeria are very minimal, but the need for palliative care in the nation is very huge. As already established, Nigeria has huge and urgent palliative care needs. Unfortunately, despite the great urgent needs, only a minimal and (to some extent) underdeveloped palliative care activities are on ground. Moreover, the few existing activities are poorly distributed. All known palliative care programs in Nigeria operate in urban areas. The non-urban areas where the needs are greater are not covered. For a greater outreach to all those
who need palliative care more, Nigeria needs a grass-root palliative care program as well. It does not pay that Nigerian government is yet to be on board on issues involving palliative care in Nigeria. Opioid consumption is negligible due to government erratic responses. The average opioid coverage rate is low. It is estimated that about 180,000 deaths occur annually in untreated pain.\textsuperscript{107} The specific type of palliative care needed in Nigeria is yet to be achieved as a result of these and other challenges.

Despite the challenges, acknowledgement has to be made of few inspired individuals that contributed and still contribute positively to the progress of palliative care in Nigeria. As literatures in palliative care in Nigeria show, these inspired individuals have continued to create awareness and champion the cause of palliative care in Nigeria mostly through self-effort.\textsuperscript{108}

The history of modern palliative care in Nigeria dates back to 1993 when Hospice Nigeria, a home care program was established in Lagos. At its inception, this non-governmental organization in Lagos provided home based care to the terminally ill. This service is often utilized by Cancer/HIV patients returning from abroad to Nigeria. The director of the program Olusola Fatummbi, a nurse by profession, had the intention of operating a model similar to St. Christopher’s Hospice. To embark on the project, she took many courses in palliative care including a course at St. Christopher’s Hospice and another one in Uganda.\textsuperscript{109}

Another effort in establishing a modern palliative care program in Nigeria was undertaken by Olaitan Soyannwo, a professor of Anesthesia who founded Palliative Care Initiative Nigeria now known as Center for Palliative Care Nigeria. Filled with compassion for the extensive suffering of cancer patients in Nigeria, and interest in pain management, she started off by attending the World Pain Congress of the International Association for the Study of Pain (IASP) in 1996. Thereafter, she formed a palliative care team at the College of Medicine at University College
Hospital (UCH), Ibadan in 2003. In 2005, the team commissioned a pain and palliative care clinic in the hospital. The team continues to provide support for cancer patients and other patients with chronic pain. The activities of the center have led to many educational and advocacy programs in Nigeria, including the establishment of Society for the Study of Pain. The name of the center was changed from ‘Palliative Care Initiative Nigeria’ to ‘Center for Palliative Care Nigeria’ because it is hoped that it will act as the coordinating center for all other palliative care activities in Nigeria. Currently, Olaitan Soyannwo is the president of the Center.

The first hospital based palliative care was founded in the south-wester part of the country by Folaju Oyebola who had a vision that palliative care could be integrated into an existing hospital service. He took the initiative to form a multidisciplinary palliative care team in his hospital (The Federal Medical Center Abeokuta-FMCA) after obtaining training in pain and palliative medicine. The activities leading to foundation of the program started in 2002. By 2008, the first independent hospital based palliative care department in Nigeria was born.

Information from the institution’s website shows that though the department of Pain and Palliative Medicine is the youngest department in the institution, it is also the first of its kind in any Nigerian hospital in terms of the services it provides. It offers education, training, and research in palliative and pain medicine. It also runs HIV clinic and provides hospice care facility for patients who require palliative care. In addition, it maintains a day care hospice, home-based palliative care, grief and bereavement care, family support, and community outreach.

Other tertiary institutions in Nigeria are trying to follow the example of the Federal Medical Center Abeokuta (FMCA) by adding palliative care programs in their hospital units. For instance, in September 2008, University of Nigerian Teaching Hospital, Enugu opened a
palliative care Unit. The Center is a Multi-disciplinary oncology unit. Tonia Onyeka, one of the outstanding champions in the promotion of palliative care in Nigeria is a staff from the institution. She has through her many works/writings contributed much in creating awareness in the challenges involved in the practice of palliative care in Nigeria.

All the above mentioned palliative care activities reflect the efforts of individuals in providing palliative care services. In spite of the numerous challenges on ground, these individuals commit their personal efforts with determination in developing palliative care in Nigeria. They put in a lot of efforts with very little or no government support. Their commitments and the services they render are their motivation. Their activities are merely supplemented by few other palliative care activities that operate in obscurity in the country. The lack of government support is one of the factors that cripple palliative care activities in Nigeria. Not much advancement has been made in palliative care in Nigeria.

Generally speaking, there is only a slight improvement in what palliative care in Nigeria used to be. This was revealed by a review of progress of palliative care in Africa conducted in 2004 by a team of researchers at International Observatory on End of life Care. The research reviewed the level of palliative care activities in Africa and found palliative care in Nigeria so underdeveloped. In actual fact, the team that conducted the research only accepted Nigeria for review based on exception criterion. The report considered that strictly speaking what was on ground in Nigeria could not be considered as palliative care because of the lack of certain palliative care concepts, including opioids, holistic approach and lack of coordination.
Consideration was given to Nigeria only as a resource poor nation with palliative care services in the process of development.118

But there are some good sides to the review. The researchers might not know it but making the exception for a poor resource nation like Nigeria with ‘palliative care services in the process of development’ became a great moral boost and a foundation for greater improvement. As things stand now, there are indications that the palliators on ground have made some improvements since then. When the research was conducted in 2004, only two palliative care centers were on board.119 Today that number has increased as seen above. Again, the review exposed the lack of coordination among the palliators. At the time of the 2004 research, lack of a national coordinating body among the palliative care practitioners was noted as a great hindrance to palliative care promotion in Nigeria. Some palliative care literature in the country show that the initial attempts to form a national association of palliative care in the country failed.120 But today palliative care in Nigeria can boast of a national association body. The challenge was over with the establishment of Hospice and Palliative Care Association of Nigeria (HPCAN) in January 2007 through the assistance of Dr. Anne Merriman.121

There is no doubt that the action of making exception for a resource disadvantaged nation such as Nigeria has helped palliators on ground to double their efforts. As significant as the improvements and as encouraging as the efforts of the palliators, the truth is that the situation of palliative care in Nigeria is still bad. What is on ground currently in Nigeria as palliative care is not enough considering the alarming burden of illness and urgent need for palliative care in the nation. Again, there is no national policy on palliative care yet. Government is yet to shift from offering erratic responses to giving constant and sustainable responses. The end result is that many patients continue to suffer and die with unattended pain in Nigeria.
Palliative care in Nigeria is still minimal and inadequate. Considering the huge population of Nigeria and the great palliative care need in the country, the few palliative care activities on ground are not enough. This is a hindrance to achieving the basic goal of palliative care for the patients and their families. The overwhelming number of patients needing palliative care are too much for the very few number of palliative care facilities and personnel currently in the country. Not just that they are few and inadequate, they are also poorly distributed. They are mainly concentrated in the urban areas and in the south-western part of the nation in particular. By concentrating provisions in cities access becomes difficult to poor palliative care patients in rural areas. Bearing in mind that poverty and sickness has been shown to be more in rural areas, it makes sense to say that majority of palliative care patients in the rural areas are poor. Poverty as already established limits mobility. This makes it impossible for the greater number of poor palliative care patients who reside in the rural areas to access the palliative care services in the cities. Hospice Nigeria, Center for palliative Care Nigeria, and the Institute of Palliative Medicine are all in the western regions of the country. They are in the south-west cities of Lagos, Ibadan and Abeokuta respectively. Only UNTH, Enugu is in the eastern part of Nigeria. There is none yet in the northern part of the country. In fact, the future of palliative care in the northern region is not promising, especially with the insurgence of Boko-haram. The few palliative care activities in Nigeria are in the cities and are mostly in hospital settings. These make them out of range for the poor who mostly live in the rural areas. More-so, the palliative care programs have cancer and HIV patients as their focus. But there are patients with other serious life threatening conditions. They should be included in the palliative care focus in Nigeria. The implication from the current structure of palliative care in Nigeria is that not all patients who need palliative care get it. In other words, current palliative care structure in Nigeria
benefits only a few, mostly the rich. In as much as the contributions made by these palliators are vital, for a greater outreach to all those who need palliative care Nigeria needs a grass-root palliative care program as well. This is yet to be achieved. Palliative care in Nigeria must be structured to avoid the contradictions that trialed the eradication of diseases, namely, success in cities, flaws in rural and suburban areas.

Again, government erratic and nonchalant responses to the issues of palliative care in the country are not encouraging. There are so much government can contribute to the promotion of palliative care in Nigeria by being involved. As observed from the experiences of those developing nations with progressive palliative care, their government’s positive involvement in their programs was part of their success story. Nigerian palliative care need government positive involvement. This will create conducive environment for palliative care operation that is currently lacking. In Nigeria, government can help put in place a national policy on palliative care, allocate more funds to health and palliative care, help put infrastructures in place for easy access to the remote areas, of the nation, help revitalize moribund health facilities and structures in the rural areas, help facilitate inclusion of palliative care education for the training of young physicians in the nations education system, etc. All these and more will go a long way in creating conducive and stable environment necessary for expansion of palliative care to the levels of coverage and quality needed for the country.

Currently, there is no national policy on palliative care in Nigeria. Scholars believe that national policies are the cornerstone in facilitating the implementation of any serious program in a nation. Both policies, (including socioeconomic policies) and programs are needed in Nigeria to safeguard the needs of the poor and to promote and encourage the activities of palliative care. Currently, palliative care in Nigeria is experiencing great drawbacks that emanated from lack of
national policies on pain relief and palliative care. Absence of a national policy on palliative care has contributed to the inability of some of the individual practitioners to get grants, to access opioids, or to partner adequately with local and foreign corroborators. It has also deprived patients access to opioids.\(^{129}\)

It is an essential goal of palliative care to provide relief from pain and other distressing symptoms. This is why World Health Organization recommends that essential medicines should be available to patients at all times and at a price the individual and the community can afford. This recommendation has not been met in Nigeria. Nigeria for one has no law that makes morphine available to palliative care providers.\(^ {130}\) Generally, there is a major problem with the availability of opioids in palliative care practice in Nigeria. Opioid consumption in Nigeria is very low because of government bottlenecks and bureaucracy. The average opioid coverage rate between 2008 and 2010 was 0.2%. This results to many dying annually in untreated pain.\(^ {131}\) One common complaint among the palliators in Nigeria is lack of opioids for pain management. They are frustrated with the lack of adequate care for palliative care patients as lack of opioids undermines the quality of care received by patients.\(^ {132}\) The truth is that no model of palliative care can achieve the goals of palliative care in relieving pain without access to morphine.

The ugly situation of palliative care in Nigeria is summed up by Olaitan Soyannwo, one of the palliators in Nigeria. According to her:

> Patients with terminal illness on the word are referred to us, but one major problem is the availability of opioids. We don’t have oral morphine in the country: we have injectable opioids, but even that was not available for about four years. We had to do a lot of advocacy because some years back there was a regulatory problem and opioids were banned because they were grouped with narcotics. So although it’s on National Drug Formulary, we don’t have the oral form - even on the formulary- so we are doing a lot of advocacy to get that in now for palliative care and management of ill patients.\(^ {133}\)
The ugly situation has not changed. It is not just that there are serious restrictions on the essential drugs, government bureaucracy makes distribution of the procured ones difficult. The situation is such that even when these drugs are available in the Central Medical Stores, they are not used due to government bottleneck and bureaucracy. The system in the country that allows only a low prescription rates by doctors compound issues resulting in the expiration of morphine powder in the central Medical store.134

But Nigeria cannot afford such waste of resources considering the present hardship in the country. Advocacy is really needed to get the Nigerian government involved. Government has to step up to make palliative care a national necessity. The current erratic and fire service approach by the government to the issues of palliative care is not only discouraging but not needed. Government of Nigeria is consistent with poor annual budget allocation to healthcare with zero budget to palliative care. The existence of strict regulation on the importation of opioids is still a great setback. Thus even with the few palliative care programs on ground, lack of national policy, opioids availability and accessibility to patients are part of the major issues still bugging palliative care practice in Nigeria.

The implication is that currently there is extensive suffering resulting from high incidence of incurable and chronic diseases in Nigeria because of lack of effective and corresponding palliative care. Many patients in Nigeria still die without good pain management and without effective palliative care. The hope for advanced pain management in Nigeria is far from being realized, especially in light of its distinctive situation of having little palliative care activities.

In sum, Nigeria is a developing nation with peculiar palliative care needs that make the provision of palliative care in the country an urgent necessity. Unfortunately, Nigeria has not considered
palliative care a human health priority. It tends to devote so much effort in the fight against communicable diseases to the neglect of palliative care. Nigeria's effort on palliative care is left at the mercy of few individuals. These individuals are overwhelmed by the enormous palliative needs because of the vastness of the country and other factors. Their palliative care activities are considered minimal and fragmented considering the huge size and population density of the nation. Equally, they are not enough considering the urgent and enormous palliative care need in the country. One thing is clear, palliative care needs in Nigeria cannot adequately be addressed with only incidental and fragmented palliative care activities, as is currently practiced. The approach must be holistic. Such an approach is still too far from vision.

The hope for advanced pain management in Nigeria is far from being realized, especially in light of its distinctive situation of having minimal palliative care activity. Currently, the extensive suffering resulting from a high incidence of incurable and chronic diseases in Nigeria begs for effective palliative care. Many patients in Nigeria die without good pain management and without effective palliative care. This is a call for action.

**Conclusion**

Nigeria is a distinct developing nation with many unmet palliative care needs. The nation has so many advantages that have not factored in positively in the general living conditions of the people. Instead, the country suffers from a lot of social and economic deficiencies that give rise to poverty, diseases, sufferings, and deaths. These simultaneously create huge and urgent palliative care needs. The socio-economic poverty string is a real issue in the way Nigerians live because it affects the way they die. The socio-economic deficiencies in the country give rise to poverty and poverty induced conditions that account for poor hygiene, poor environmental sanitation, poor living conditions. These lead to diseases, greater sufferings and high death rates.
Fighting diseases alone has not changed the situation of health care needs. Instead it consumes a lot of effort and resources to the neglect of other needs, including general health care services and palliative care. The distinctive situation in Nigeria makes palliative care a public health priority that requires urgent humanitarian responsibility and action. To bring about this there is need for an approach that incorporates both how the people live and how they die. This requires political will on the part of the government so as to see palliative care as a national priority. At present such an approach remains on the level of desire and thinking. It must be admitted that the current palliative care practice in Nigeria is ethically unacceptable. The current practice and structure make palliative care very expensive, scarce and difficult to access. As such, many patients continue to suffer extra burdens of pain and neglects in their sickness such that many often end in agonizing deaths. Hence a new palliative care structure is needed if effective and robust palliative care aimed at resolving the peculiar palliative care needs in Nigeria is to be achieved.


10 WHO Regional Office for Africa 2009, 6; Federal Ministry of Health 2010, 5.


14 WHO Regional Office for Africa 2009, 2.
15 WHO Regional Office For Africa 2014, 4.
17 WHO Regional Office For Africa 2014, 4.
18 Onyeka, et al. 2013, 599.
19 WHO Regional Office For Africa 2014, xii, 16.
20 Federal Ministry of Health 2010, 6.
24 WHO Regional Office For Africa 2014, 11.
26 WHO Regional Office For Africa 2014, 6, 9.
30 WHO Regional Office for Africa 2009, 6.
31 WHO Regional Office For Africa 2014, 9, 10.
34 Saheed 2010, 351.
35 Onyeka, et al. 2013, 599.
36 WHO Regional Office For Africa 2014, xii, 4; WHO Regional Office For Africa 2009, 4.
39 Alubo 1985, 324.
40 WHO Regional Office For Africa 2014, 4.
83 WHO Regional Office For Africa 2014, 17.
85 F. Oyebola, A combined Perception and Needs Assessment Study of Home Based Palliative Care among Patients with Life-threatening Diseases Attending the Federal Medical Centre Abeokuta, Nigeria. (Cape Town: University of Cape Town, 2009, 2; 6); Onyeka, et al. 2013, 600
87 F. O. Oyebola 2009, 6.
88 WHO Regional Office For Africa 2014, 16, 17.
91 WHO Regional Office For Africa 2014, 13, 14.
93 Adejumo 2009, 16; Federal Ministry of Health 2010, 125.
94 WHO Regional Office For Africa 2014, 4, 14; Alubo 1985, 324.
95 Stock 1985, 473
96 WHO Regional Office For Africa 2014, 14.
97 T. C. Onyeka, Palliative Care in Enugu, Nigeria: Challenge to New Practice 2011, 131; Stock 1985, 473.
98 Alubo 1985, 325; WHO Regional Office For Africa 2014, 7.
99 WHO Regional Office For Africa 2009, 5; WHO Regional Office For Africa 2014, 10.
100 T. C. Onyeka, Palliative Care in Enugu, Nigeria: Challenge to New Practice 2011, 132
103 WHO Regional Office For Africa 2009, 9-8.
105 WHO Regional Office For Africa 2014, 22.
110 Wright, et al. 2006, 313.
111 Wright, et al. 2006, 310, 314.
112 Center for Palliative Care Nigeria Newsletter, Pep-Talk. Newsletter vol.2 no.1, (Ibadan, Center for Palliative Care Nigeria, 2013, 1), http://hospice-africa.merseyside.org/pdfs/CPCN%202013%20NEWSLETTER.pdf.
Chapter 5: Sociocultural and Religious factors in Nigeria

Having explored the circumstance of palliative care in Nigeria, this chapter discusses the sociocultural and religious factors in Nigeria that can foster the development of palliative care in the country.

Nigeria has sociocultural and religious institutions that can be helpful in the practice of palliative care in the country. Values found in the cultural institutions like family support system, religious and faith institutions, traditional medicine/healers, burial/funeral rites can be helpful. Such cultural values include caring for the sick and the aged, safeguarding and protecting life, health care, hard work, courage, integrity, community living, and sharing, etc. These can be tapped, harnessed and blended with modern practice for palliative care in Nigeria. It is not enough that the people have these cultural values. It is equally important that the values be harnessed and put to use for effective palliative care practice in the country.

The need for the integration of such cultural/religious values in the palliative care practice is heightened by the effects of psycho-spiritual burdens and the effect of socio-economic deficiencies of the country on patients. As already observed in the previous chapters, palliative care patients experience compounded burdens of pain: physical pains that can be handled with medicines and; the experience of other pains that can be emotional, psychological, spiritual and social in nature which medicine alone cannot resolve. Unfortunately, both the drugs and other resources needed are either scarce or not affordable to palliative care patients in the country.

Again, the dearth in the Nigerian health care system arising from the shortcomings of Nigeria as a developing nation makes access to health care needs an issue and a source of hindrance in palliative care practice and provisions in Nigeria. Coupled with socio-economic deficiencies, is the psycho-social issues which medicine alone cannot resolve. For Nigerian patients, the
psychosocial aspect of sickness can be more complex because of complexity in culture and religion. Culture and religion, especially in the mix with Christianity, Islam and modern civilization can make the experience of emotional, spiritual and other psychosocial aspect of sickness more complex. Palliative care must attend to these. Though these issues could be overwhelming both to the patients and care providers who operate in such cultural environment, palliative care must find a meaningful way to navigate.

The good news is that Nigeria has sociocultural and religious institutions in place. Such institutions as will be seen later can be of immense help in the practice of palliative care. They can help mitigate some of the shortcomings. Tapping from such cultural values and incorporating or integrating them with the modern palliative care practices will go a long way in boasting palliative care for the country. It will make palliative care more accessible, more affordable, and more meaningful to the people in their situation. A holistic approach to the needs of palliative care patients in Nigeria will not be complete unless cultural values and sensitivities are given serious attention in the overall health and palliative care practices. Thus cultural values are relevant for any model of palliative care to be effective in Nigeria.

The importance of incorporating relevant cultural values is not peculiar to Nigeria. Palliative care in general favors cultural sensitivity. Cultural sensitivity was first advocated by Saunders as part of the holistic approach to palliative care. As the founder of modern palliative care, she argued that the patients need to be studied and understood in their situation in order to care for them adequately. This implies that effective provision of palliative care involves the study of the individual patient in his or her situation which includes cultural/religious situations. This position is affirmed by other scholars. Such scholars have maintained that palliative care, in general, does
not overlook cultural context that influences the way people approach illness and death. For Africans, culture is a truism.

For many writers on palliative care in Africa, cultural consideration is not an option but a must. They argue that cultural values support palliative care in Africa and emphasize that neglect of cultural sensitivities is an invitation to doom. Clark et al. (2007), maintain that a good understanding of the culture and cultural sensitivities are required to offer psycho-spiritual, emotional and social support needed for African patients. They argued that those who ignore culture in Africa are actually doomed to fail.

A similar observation was made by Anna Merriman, a palliative care practitioner who worked for decades in many African countries including Nigeria. She insisted that being culture conscious is the first consideration when it comes to practicing palliative care in Africa. She emphasized the fact that there are cultural aspects to sickness and deaths in Africa. For her, tapping on these is the beginning of wisdom in offering palliative care assistance to patients from such nations.

There is no doubt that the advice was taken seriously. In 2005, African Palliative Care Association (APCA) set up its headquarters in Uganda with the full backing and support of the government of that country. As a non-governmental organization registered in 2003, two years after it was registered, it was entrusted with a regional mandate to promote and scale-up culturally appropriate and affordable palliative care for people with progressive, life-limiting illness.

Again, Hospice Uganda today employs a cultural approach both in practice and in training to meet the cultural and practical needs of the people. In the same vein, the importance of culture in palliative care is expressed in a study carried out among some selected palliative care providers in Southern Africa. They express the view that local spiritual and cultural customs of
dying, death and bereavement, as well as indigenous knowledge, are important when providing healthcare services in Africa. The point is that culture is a serious issue palliative care must not neglect in African societies including Nigeria. This necessity is also derived from African worldview.

Mbiti (1970), presented a vivid picture of African worldview when he noted that it is very densely populated with spiritual beings, spirits and the living dead that permeate the peoples’ their concepts of reality. African cultural/ religious ethos and philosophical perceptions are formed through those lenses. Inevitably, unless taken into consideration, this type of conception can create a very big gulf between the culture and thought of the people and palliative care providers if they are ignorant of the cultural realities. It makes sense then that modern palliative care in any African society including Nigeria must not overlook cultural realities when providing services in the regions. It, therefore, follows that like in most African societies, palliative care in Nigeria cannot determine and prescribe care without due consideration of the worldviews of the patients.

Culture is a serious issue in Nigeria like in most African societies. Many writings from Nigeria and scholars interested in African traditional cultures and religions attest to this. They indicate that Nigeria like many African societies has a complex cultural and religious/spiritual belief system. This complex belief system permeates all aspects of the peoples’ daily lives. A typical Nigerian, like the average African, is deeply religious. He believes in the existence of supernatural being(s), who controls different aspects of life for both good and bad. He believes that religion makes a difference in life and he carries his religion with him through all his activities.
For good ten years Leonard Arthur Glyn, a British colonial officer and a major in the British army, patiently studied native life and thought of some tribes in Nigeria. Writing about some tribes in Nigeria, he observed that their culture and religion permeate their entire way of life. On the Igbo tribes, he writes: “The Igbo people are in the strict sense of the word a truly and deeply religious people of whom it can be said, that they eat religiously, drink religiously, bath religiously, dress religiously, and sin religiously. In a few words, the religion of these natives is their existence, and their existence is their religion.”

Religion plays important roles in their daily activities. What is true of the Igbo tribes is also true of the rest of Nigerian tribes.

In Nigeria, sickness is viewed from cultural, social, and religious lenses. Cultural factors, can, in conjunction with other factors (factors like economic situations, availability/accessibility or otherwise of the needed support) can determine the level of support or lack of support a patient receives from the family, community and the society in general. They can also determine where and from whom they can seek such support (as will be discussed). Writers have shown that even in the midst of modern medicines and hospitals, many Nigerians continue to patronize traditional medicines and faith clinics for various reasons, especially for cultural and religious reasons.

For some of these patients, it is also a matter of necessity and ‘can’t help’ (because they cannot afford the means to the hospital). Their normal approach then is to seek help first from their traditional healers and faith clinics. Writing about cancer patients in Enugu, in the Eastern part of Nigeria, Onyeka et al. (2013) pointed out that many patients who thought their sickness was spiritual continued patronizing traditional healers and faith clinics. They maintain that such patients present late to the hospital. Such scenario is also common in other parts of the country. For instance, in the Northern Muslim area of the country, patients patronize traditional healers for multiple reasons. Some do so out of necessity because they lack access to the hospitals or that
they cannot afford to pay for hospital services. Some equally patronize them because of the belief that their sicknesses cannot be treated in the hospitals. Culture and religion have significant roles in the lives of Nigerians. For this reason, some scholars advocate for the integration of traditional medicines and collaboration with faith-based originations in Nigerian health care system. This needs to be considered in determining effective palliative care in Nigeria. Since culture influences the way Nigerians conceptualize and approach issues of sickness, death and dying, any approach in attending to palliative care patients need to include consideration of the patients through their cultural lenses.

Nigeria has cultural and religious values and institutions that can be of immense help in approaching Nigerian patients through their cultural lenses. Values found in their family care system, in their funeral/burials that follow death, in their religion, and other belief practices are relevant. These cultural/religious institutions and values in Nigeria can contribute much to the promotion of palliative care in the country. Home care can be boosted with family care system already in place. Grieving families can be supported with a cultural system already in place. Patients who lack access to western medicine could be supported through the local and traditional medicine/healers that are easily accessible in both rural and urban areas. For effective and wider coverage of palliative care, Missions/faith-based organizations (FBOs) can be utilized. They wield a significant level of cultural, political, social, educational, and economic influence. Most importantly, they are found in nearly all communities in the country and can be utilized to access hard-to-reach communities. In spite of their shortcomings, the inherent values in these structures must not be overlooked. Palliative care practitioners should study and understand the culture in order to tap the appropriate values for effective palliative care in the country.
Knowing a bit of the peoples’ world view especially as it concerns sickness, death, and dying is one way of understanding the people and their culture. It will throw more light on why they view things through cultural/religious lenses. It will also show why palliative care must meet them on their cultural level by understanding and tapping into their cultural contexts for the benefit of their palliative care needs.

A. Nigerian Traditional/ Cultural Worldview and Attitude Towards Sickness, Death, and Dying

Although the advent of Christianity and Islam is a mix that makes the spiritual belief system of vast majority of modern Nigerians more complex, the belief system of the Nigerian people still consists of individual’s relationships with nature, the spirits/gods, and the community. According to many writers, Nigerians share in belief in the existence of supernatural being(s). They believe in the idea that one supreme God created the world and is supposed to have active control in its everyday affairs. Good relationship must be maintained with God through prayers, sacrifices and good conduct to attract blessings, support, sustenance of life in all its aspects, and protection from untimely death, etc. Prayers and offerings can be made to him directly or through his intermediaries – the smaller gods/spirits who are equally influential in daily life and can even be mischievous in nature. In all, they believe these spiritual beings have powers and forces that support or impinge human life in every aspect. These beliefs permeate and play out in all aspects of the daily lives of Nigerians, including how they conceptualize sickness and death. For most modern Nigerians who have come in contact with the western way of life and foreign religions (like Christianity and Islam), the cultural belief system is not erased. Instead in most cases, it makes their situation more complex.
Nigerians incorporate in their worldview beliefs in the invisible spirits/divine beings and the visible beings. They also believe like most African societies, in the existence of two-world orders - the spiritual world for the invisible spirits and the existential world for visible beings. These beliefs affect their ideas about sickness, death and dying because they believe that the world order exact great influence in their daily lives.

The work of Chigere, (2000), on the Foreign Missionary Background and Indigenous Evangelization in Igboland, and other literature on Nigerian cultures are windows to understanding the belief system of Nigerians that form their ideas on life in general and death and dying in particular. The Igbo cosmology, for instance, holds that the invisible spirits are comprised of one Supreme God and two kinds of intermediary spirits (small gods and Ancestors). This means that for the Igbos there are three levels of divine beings. There is one Supreme God who is also referred to by many names (e.g. Chiukwu -the great God, Chukwuokike -God the Creator). There is the small gods/spirits (chi), and there is the ancestors (Ndi-Ichie- the spirits of the dead people). These divine beings have different abodes in the spiritual world. The spiritual world consists of Elu-Igwe (Heavens above or sky), the abode of the Supreme God or God the Creator from where He excises His dominion; and Ala mmuo (world below -the abode of the spirits or the dead). The spiritual world is always differentiated from the existential world which consists of Ala-mmadu (the land of the living -the physical world or existential world of human beings). Though the divine beings have their abode in the spirit world, some of them can operate freely in the world of the humans- the existential world. This means that both the Supreme God (Chiukwu) and the intermediary spirits (small gods and ancestors) have levels of influence in the existential world of the humans- (Ala-mmadu).
The Supreme God keeps watch over his creatures (in the existential world of the humans) from His distance heaven above. Though He has great influence in the affairs of human beings, He seldom interferes. His involvements in the affairs of the creatures is more often through the intermediary gods namely the small gods and ancestors. Approach to Him is more often through the numerous intermediary spirits. This is the reason some tribes in their cultural, religious practices do not offer direct sacrifices to God the Creator. However, good relationship must be maintained with him to avoid unnecessary misfortunes like sickness or even death. Such good relationship has to be maintained through worthy life (compliance to His moral order in good conduct), sacrifices and prayers/worship made through the intermediary spirits.

Among the numerous intermediary spirits are the small gods. Though they belong to the spirit world, they are seen to be everywhere and are very influential in the daily life of the people. When in the existential world of the humans, they can have domains in natural objects like trees, water, rocks, rivers, or mountains. Some of them are localized as deities. They receive sacrifices from human beings on behalf of God the creator who is regarded as the final receiver of sacrifices offered to the small gods. Interesting thing about the minor gods is that they are generally subject to human passions and weaknesses. They may be kind, hospitable, and industrious. At other times they can even be mischievous in nature. They can be treacherous, unmerciful, and envious. In other words, they are seen to hold the goods that can sustain life and the bad that can destroy it. According to Chigere (2001), the average person “must tend towards God or the deities on whom he must depend for both life and wealth.” Winning their friendship is very important to avoid their troubles. To establish and maintain this friendship, one has to appease them through prayers and sacrifices and must be compliant to the moral order of the supreme God.
Ancestral Spirits are another important kind of intermediary spirits. These are the spirits of the dead members of the family who lived good and exemplary lives while in the existential world. Ancestral belief consists of the idea that when someone dies, he or she starts a new life in the spirit world. In other words, for them, there is life after death. This belief in life after death is seriously connected with the idea of reincarnation as observed in other African cultures. The philosophy here, according to Nzewi (2001), is that the invisible (spirits), and the visible (persons) form a vital union joining dead and living beings. Death is the process through which the living is born in the spirit world. Birth completes the process through which the dead is reborn. This is the reason marriage institution and procreation are very sacred and very important for the people. Both the birth process and death process form the string in the bond of family relationship that produce the process through which the dead (from the spirit/invisible world) can become reborn (in the visible/human world). The implication from this belief is that death is not always a bad thing among the people. It is not the end of existence. There is life after death. In this context, death becomes a transition phase between life and the spirit world. This means that when someone dies, a new life is started in the spirit world. The belief is that once in the spirit world, two things can happen. The spirit of the dead can either remain as an ancestor or choose to be reborn in reincarnation to continue a new life in the existential world. A dead person would either choose to be reborn as a new person to continue the cycle on reincarnation, or to remain an ancestor. In whichever way, the dead still maintain a relationship with the living especially the family members. As ancestors, they enjoy a new life in the spirit world with supernatural powers. They are ever-present and influential among the living. Together with the living, they form the bond of family relationship as they are still considered members of the family. They abhor bad behaviors. Ancestral spirits are always
ready to intercede on behalf of any family member to the supreme God. All it takes is maintenance of a good relationship with them through good behaviors, prayers, sacrifices, or obedience to laws/observance of (social, religious, and cultural norms). There is always some amount of vigilance in the maintenance of good relationship with the ancestors. The reason always is to ensure a continual bond with and constant assistance from them.

Joining the ancestral-spirits is not automatic. It depends so much on how one lived and died. This belief is equally shared in many African societies as observed in the works of some writers.54 Like most African societies, Nigerians have great attachment and interpretations to how one lived and died.55 This is because how one lived and died determines his/her ability to joining the ancestors. The determinants of one’s ability to joining the ancestors are most often measured by individual’s relationships with the gods/spirits and the community, as well as the nature or manner of death. From the point of view of the determinants on how one lived and died, a distinction is made between ‘good death’ and ‘bad death.’56 A good death guarantees one the privileges of ancestral spirit, while a bad death denies one those privileges. Detailed implications of good and bad deaths will be discussed later.

The study of these beliefs and many more are beyond the scope of this project. However, it is important for our purposes in this project to understand that these beliefs also form the lenses through which life is viewed in general by Nigerian society. Their cultural, religious, psychological, emotional, aspirational, values and attachment to life, sickness and death take into account these relationships. They can create some psychological and emotional process in the mind of any Nigerian patient. Some of the emotions can be positive bringing strength, happiness and joy to the sick and dying patients if the patient views his/her death as a happy one. Or they can be negative bringing pain, anguish, and suffering to the sick and dying patient if the
impending death is viewed as bad one. Awareness to these cultural facts could be very helpful in palliative care practice in Nigeria.

1. Concept of Sickness and, Attitude Towards Death and Dying

Sickness and death for any society are serious issues because they are generally viewed in relation to life. Life is always exposed to the dangers of sickness and death. Sickness expresses an unhealthy state of life, and death expresses the absence of life. In this way, life can be weakened through sickness, and eventual consequence could be death. Because health is a state of balance in life, any disruption to the balance is sickness and sickness can lead to death.

Sickness can prevent life from running its normal course. In traditional African societies, life for a person is expected to run its natural course from birth to death into a new life in the spiritual world. In that context birth for a person is a process that starts with physical birth, through naming ceremonies, puberty and initiation rites, and finally marriage (or even procreation). A person is not considered a fully born until he has gone through the whole process. More importantly, if a person dies before he is ‘fully born,’ his death is premature, it is considered a ‘bad death’ which may not be related to a bad life. For the Africans, sickness is a serious issue not just because of the stress that goes with it but more so because it can lead to premature death which prevents life from running its normal course. This notion of sickness thrives in Nigeria just as in the rest of Africa.

Among Nigerians, there is still some deeper cultural and religious connotations to sickness in relation to life and death. In Nigerian world-view, life is not just about existence in this physical world; it involves a connection in the supernatural world. This means that a ‘healthy life’ in the physical world can lead to a continuation of life in the spiritual world after a ‘good death’ (life is supposed to have a natural end through death) in the physical world. Again, because of this dual
relationship of life to physical and supernatural worlds, life could be attacked, disrupted, interrupted, threatened and at times be exposed to danger by both physical and spiritual elements that can lead to sickness and death. This means that sickness in the Nigerian context has both physical and serious spiritual dimensions. Sickness tends to interfere in something sacred and invaluable.

For Africans, the value of life is derived first from its origin to God. Secondly, life is itself a value on which other values depend as it sustains other activities of human existence – "Ndu bu isi." It is the highest gift/good from God. Life belongs to God who is the creator, the author, and sustainer of life. For this reason, life is valued, cherished, and respected among African societies. On the other hand, sickness and death are the enemies of this life in all its ramifications (physical and spiritual). They (sickness and death) exact hostile influence on life. Sickness embodies and optimizes all the agents of the impingements to life. But for its value and its origin life must be enhanced, preserved and protected from the harms of sickness.

Life must not be allowed to be overrun by the agents of impingement. There is a sense of obligation to protect, care and respect this gift to man from God. Africans believe that one way to enhance and sustain this life is by maintaining a bond with the creator through vigilant prayers and sacrifices to him or through his agents - the small gods and spirits. Observance of moral norms, good and orderly life, peaceful living with gods/ancestors, neighbors, kith and kin, and maintenance of good name are all parts of maintaining harmony with God. Doing so attracts God’s favors and blessings that enhance life. Not to do so attracts misfortunes that can lead to sickness and death. Note that sickness draws its spiritual connotation from this context. Cordial relationship with the gods enhances life and push back on those agents that impinge life while lack of good relationship can attract the opposite. In other words, maintenance of a good
relationship with the gods ensures healthy life - attracts fortunes that help to protect, maintain, and enhance life such as bumper harvest, possession of adequate wealth, safeguard from calamities and epidemics, etc. Not to do so attracts, in the same way, God’s wrath and punishment which diminishes life through the agents of impingement leading to sickness and death. With good and orderly life, one can rightly face other challenges of life-sustenance because he is in harmony with his creator, the gods, and the community. Anything that affects this harmony diminishes life and anything that diminishes life is unhealthy. This means that life being a gift from God is a value on which other values depend.

Life is valued in itself because it is the highest gift from God as well as the center of all other values. As the center of all other values life in the Igbo context is synonymous with health. According to some Igbo writers, there is no sharp distinction between life and health in the Igbo worldview. Life actually depicts strength, power, and dynamism with which one endures and overcomes the challenges of life. In this sense, to live is to be healthy. As such to be healthy implies to be lively. The essence of fighting sickness is to be healthy, and to be healthy is to be lively. Health is not just about physical state or condition of the body and mind. Health includes the well-being of the individual, the community, and the natural environment. Generally, health is viewed as a balance in life - a balance that reflects harmony with the creator, the gods/ancestors, the community at large and the natural environment. This understanding is deeper than the definition of health given by World Health Organization or that given by AMA which depicts physical state or condition of the body and mind. In 1948 WHO defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” The definition of health attributed to the American Medical Association (AMA) on the other hand is that health is “a state of physical and mental well-being.” Though
these definitions certainly infer health as a state of balance in life authors believe they are not as deep as the understanding in Nigerian/African context.70

Writers on the African traditions and cultures maintain that health for Nigerian societies is all encompassing. It is not solely about bodily or mental fitness.71 For the Igbo, the desire to enhance life means the desire for sound and integral health which goes beyond a person’s physical health to include harmonious relationship between the physical and metaphysical worlds.72 Integral health also implies perfect harmony with self, others, nature, and spirits. The writers maintain that integral health also implies the presence of water. “Among other things, the continuous presence of water, either in a spring or stream, rich harvest of the crop (absence of famine and other natural disasters such as: cyclone, flooding, and storm; successful conception or childbearing, abundance of male offspring, progress in business, ability to find a suitable husband or wife, absence of family quarrels), in more modern times, success in examinations, easily obtaining a good job and promotion in the same”73 imply integral health. These are reasons why in the Nigerian cultural context sickness is all inclusive. Both sickness and death exact hostile influence on life. In effect, Nigerians have concept of sickness and attitude to death and dying that reflects their worldview.

i. Concept of Sickness

Nigerians have a concept of sickness that reflects their worldview. As observed above the Nigerian society like other African societies has cultural worldview that consists of individual’s relationships with the spirits and gods and the community. Similarly, both life, sickness, and death have cultural and religious connotations that reflect all these relationships. Writers agree that sickness as a mode of ill-health is understood differently in different cultures.74 The
implication here is that sickness as what attacks life or human health in general is understood and interpreted differently in Nigerian cultural context.  

Again many writers have shown that Nigerians have an understanding of sickness that is so inclusive. Good life we observed means good health. However, *being in good health* is more than *simply bodily fitness*. It also entails being in perfect harmony with self, others, nature, and spirits. In the same way sickness as the enemy of this integral health –(life) is all inclusive. It is not just a problem with the physical health of the individual body and mind. Rather sickness in the Nigerian cultural understanding is seen and conceived as a disruption or an evil opposed to life and health but which is more than the malfunctioning of an organ of the body. Sickness in Nigerian cultural context has both physical, spiritual, social and mystical dimensions and interpretations.

Research carried out by Henry and Kemp (2002) on the culture and end of life among Nigerians showed that Nigerians have a concept of sickness/ill health that is both personal, physical, as well as social, spiritual and moral predicaments. In effect, their health beliefs reflect their cultural worldview that is typically so inclusive. Here sickness is not always just about the individual. Sickness is viewed in the totality of the individual’s relationships with the gods/spirits, family, society and the moral order of existence. This means that health is more than just physical functioning and sickness more than biological malfunctioning of the body and mind. Also included in this mix is the proper order, balance, and well-being of the individual and the individual’s relationships in society. Because of these cultural and religious connotations to sickness, a typical Nigerian considers the nature, causes, process /development, consequences and the reasons behind his/her sickness, and seeks help/remedy based on the inclusive
relationship with the spirits and gods, community, and nature. This is necessary because causes of sickness are many just as the nature, process and consequences.

The nature of sickness could be natural or un-natural, normal or abnormal depending on the cause, process and response to treatment. A natural and normal sickness is expected to respond to medical treatment. The root causes for such sicknesses fall within the realm of normal biological malfunction of the body and mind. For instance, when one is threatened with malaria, fever, cough, colds, headache or pain, etc., he/she is expected to get better by normal treatment. However, if the sickness defies treatment or the nature or process of the sickness is different from what is considered normal the cause and reason behind the sickness changes. Such sickness is considered abnormal and could be attributed to different causes and agents. In his writing, *African Traditional Medicine with Reference to a Wholistic View of Sickness and Health Care*, Ityavyar (1990) enumerated some cultural understanding and causes of illness among Nigerian societies. They include bewitchment, broken taboos, offending of the gods and ancestral spirits, debts, lack of respect for elders, adultery with neighbor’s wife, incest, quarrels, jealousy and culturally unacceptable marriages. Violators are often visited with sickness or other forms of misfortunes. The Nigerian interpretation of the causes of illness is a reflection of their worldview. For instance, writing about the Igbo tribe of Nigeria, Mbieri (2014), observed that Igbo understanding of sickness is clouded with human agents, supernatural forces, spiritual influences, and mystical/occult powers. Nigerians strongly believe that these external factors bring health hazards to the individual and in some cases to the entire community as well. There is no doubt that such understanding is different from the Western understanding of what causes ill health. Yet the fact remains that most African societies including, Nigeria, believe in their reality and seek remedy based on what is culturally meaningful. For this reason, it is
meaningful to underscore the point that Western medicine alone cannot address all sickness issues for a Nigerian patient. Alternative therapy that is cultural and indigenous is also required. In the same way, modern palliative care devoid of cultural balance would not do much for a palliative care patient in Nigerian. It is therefore imperative that the Nigerian patient must be studied through the same cultural lenses that form his/her worldview, including death and dying. This is necessary if the goal is to provide adequate, affordable and culturally relevant palliative care to such patient.

ii. Attitude Towards Death and Dying

Death like sickness has cultural and religious connotations. As already noted, death is always viewed as a transition from the physical world to the spirit world. Like sickness, it is viewed in relation to life because both can be hostile to life as already demonstrated above. Chigere (2001), observes that among the Igbos, there are two aspects to death namely- a gradual aspect of death, and the climax aspect of death. The gradual aspect of death sets in once life is not in a very good order. This includes conditions such as in biological malfunctioning of the body or as in poor health, lack of life-sustenance or wealth, infamy of name and character, disorderliness and quarrelsomeness in the family and the surroundings. In this way, sickness becomes the dying aspect of death. The individual gradually through different forms of sickness approaches the climax of death which is reached by cessation of breath and all human metabolic activities. This is the physical death of the individual person which is the end of human terrestrial existence. In all, death is seen as a transition from the human world to the ancestral world as the existence is not annihilated but continues in the spirit world of the dead.

Among many African societies, including Igbo of Nigeria, death is viewed as a complex journey because it can come in different manners and circumstances. In other words, all deaths are not
the same. Some deaths usually start gradually with sickness. Other deaths happen suddenly, with or without sickness. Again, death starts for different people of all ages and all sexes at different times. While some deaths are natural and explainable, others are termed untimely, premature or even mysterious too. For some societies, the journey is not completed when the individual ceases to breath. For such societies (e.g. Nigeria) funeral ceremonies must follow to complete the journey. All these and the thoughts of the mystery that follows death make death and the process of dying a complex one. It needs to be noted that because of the complex nature of death, attitudes to death and dying are also complex. Different manners and causes of death elicit different interpretations and meanings and define the attitude of the people towards them. For instance, death can be perceived as good or bad, fearful or hopeful, welcomed or unwelcomed, painful or endured. The perception and interpretation depend on the circumstances surrounding a particular death and the particular individual’s level of commitment or lack of commitment to the observance of the community’s societal norms.

The circumstances and manner of a given death determine the attitude towards it. Death like life is expected to run its normal and natural course from birth through ripe old age. The natural course for death should be a gradual death with a known and explainable sickness at a very old age after one is considered fully born. (As noted earlier, birth like death has a gradual process among many African societies. A person is not considered fully born until he/she undergoes all the necessary processes of physical birth). To die before the attainment of such cultural statues is to die prematurely. Though premature death is usually a bad death (as will be discussed later) not all ‘gradual deaths’ are good death. Lifestyle is always a factor. Gradual natural death must have a relationship with good lifestyle (i.e. one must have lived good and exemplary life) for it to be a good death. An individual who died as described above with good life is said to have died a
natural and good death. His or her death is normal, fulfilled and peaceful if the individual is at peace with himself, his family, his community, his ancestor, deities/spirits and gods. This kind of death is welcomed. The death is considered a good death. The attitude of the dying individual towards it is not fearful but hopeful that he/she is ready to join the ancestors for a new life in the ancestral world. Also, the family members have no reason to cry because their loved one lived a fulfilled life ready to join the ancestors. This understanding is depicted in the first Igbo published fiction in 1933 *Omenuko*. This biographical novel was based on actual events in the life of the hero ‘Omenuko.’ The novel presents a man who after committing an offense also had the opportunity for expiation and reconciliation. He was not afraid to die. The reconciliation secured him peace with himself that he was not afraid to die. His decision to consciously go against the tenets of communal life resulted in a turbulent life that saw him ostracized, alienated and exiled from the rest of the community. His eventual repentance through genuine reconciliation with the community was sealed with sacrifice for atonement to appease the angered deities. His confession at the end of the expiation that “If death comes to me now, I shall not be afraid” shows how fulfilled, welcoming and acceptable a good death could be among the Igbo of Nigeria.93

Good death, therefore, includes maintenance of good relationship and harmony with the community and gods/spirits through good and exemplary/worthy life plus a favorable manner of death. The manner of death such as ripe-age (adult age) and natural death (death from natural cause- explainable death) projects a given death as a good death if such a person was in harmony with the gods and humans (expressed through observance of societal norms). Such individual has the capacity to join the ancestors.94 His/her death is celebrated. Befitting burial/funeral
ceremonies follow such death to complete the transition for the human world to the ancestral world.

Bad death, on the other hand, is determined by individual’s unworthy life style. Bad life style emanates from lack of good relationship with the gods and humans. This is expressed in the neglect and contravention of social norms as noted in the case of Omenuko. Omenuko would have died a bad death if he did not repent, did expiation and did reconciliation with the community and the land/gods. The manner of death can also make such a bad death. Examples of bad manner of death are untimely or premature death (e.g. infant, child or youthful death), death viewed as a punishment from the gods (usually from a mysterious/unexplainable illness), violent death- (e.g. suicide), and death resulting from accidents. However, one who lived long life- ‘gradual death’ -but had a bad/unworthy lifestyle surely died a bad death. These are not just bad deaths but curses and tragedies. Any individual who dies under any of these circumstances dies a bad death. He/she lacks the ability to join the ancestors. Such death is not welcomed and not celebrated.

While good death is easily welcomed and happily anticipated, bad death is always unwelcomed. Actually, bad death is a double loss. It denies the individual the ability of transiting to the ancestral world and denies the community the ancestral privileges that the individual dead could have been to the family/community.

The belief system, therefore, attaches different meanings and interpretations to different manners and circumstances of deaths. All these circumstances and the interpretations combine to make a given death good or bad, fearful or hopeful, welcomed or unwelcomed, painful or endurable. Again, determinants of a given death as good or bad is reflective of one’s level of commitment/lack of commitment to the observance of societal norms that constitutive worthy
and unworthy life. All these can form part of the struggles of a Nigerian patient irrespective of the level of the stress of medical condition. What is he/she suffering from? Is it natural or unnatural? Will the end be a good death, Is he at peace with himself, his community and the gods? Will his life be celebrated? What kind of funeral will he be given? Will he be welcomed in the ancestral world? etc. These make patients prefer a gradual dying process. Gradual dying process allows the dying time and opportunity to make sure he is at peace with himself, community and gods, and that the living/feels the same. Nigerians prefer a dying process that is prolonged or gradual to allow time to address some of these issues. This allows the dying time to make peace, give final instructions and say farewell to the living. This understanding is very critical in fashioning a healthy palliative care system in Nigeria.

iii. Burial/Funeral Rites

The journey to the ancestral-spirits world is not really easy. It requires the diseased part and the family/community part. It is not ‘either-or scenario.’ It demands both. The journey is complete only when both the individual and the community play their part well and full. Joining the ancestors is not automatic upon achieving the status of good and peaceful death. The achieving is only a part of the passage. There is still another rite of passage that will complete the journey. This rite is the burial/funeral rites. The transition is incomplete without burial/funeral ceremonies. Even when one is sure of a worthy life, he/she can still worry about the actual completion of the transition process in burial and funeral ceremonies. This is something he/she cannot do for him/herself. Family members are relied upon to complete this segment of the journey for the dead. It is the onus of the living to help the dead to secure the new status in the spirit world.
The journey to the ancestral world is completed through burial and funeral rites. However, burial and funeral rites are more than a transition rite. They are equally a grieving process as well as a moment of readjustment and reestablishment of new bonds. Every death creates a vacuum in the social and spiritual relationships that hold society together. Through burial/funeral rites that follow death, this bond is reestablished as the dead is ritually incorporated into the wider family of both the dead and the living. Almost every culture in Nigeria observes burial/funeral rites after the death of a loved one. Every dying patient will like to die with the assurance of a befitting burial and funeral so as to complete his/her journey to the spirit world.

Funeral as a rite of passage for the diseased assures both the dying and the family of a peaceful transition to the spirit world. It is the function of enabling the dead on the onward journey to the spirit world that makes the rite of passage assumes another meaning. It becomes not just funeral rite but also a source of relief from the pains of loss. Therefore, funerals, burial and other ritual ceremonies that follow after death are performed equally for relieving the pains and emotions associated with the death of a loved one. This clearly situates funerals and their rites with palliative care.

Burial or funeral ceremonies continues to be a public event and must be performed for every dead member of the family who merits it. Inability to observe this for any dead member is itself a cause of grief and pain. On the other hand, it is a great source of fulfillment and relief to give a loved one a resounding funeral. This is one great desire and aspiration of every Nigerian. This informs their attachment to funeral ceremonies. The cultural attachment to funeral ceremonies is so deep that funerals continue to remain a public event even when there are limited resources to sponsor the burial and funeral.
According to Ifeanyi (1989), “Nigerians traditionally believe that when a person dies, befitting funeral ceremonies must be performed for him to enable him have easy and quick access to the land of the dead. Failure to do this would make life unpleasant for his relations on earth with various forms of afflictions which very often include sickness.”

Befitting funeral for the dead is a must among Nigerians. No family wants their loved one to be stranded on this mysterious journey of life, and no family wants to experience the unpleasant afflictions that might befall them for not giving a befitting funeral ceremony to their dead. Even the influence of Christianity and Western way of life have not changed this attitude.

In summary: The idea that when one dies, he will live in the spiritual world as ancestor is deeply rooted in the minds of many Nigerian people. To join the ancestors because one lived a worthy life and still participate in the activities of the living is a status no dying patient wants to lose after death. It is being in harmony with the spirits. Worst still, if one is not in harmony with the spirits, his troubles continue even after death. Such a person will never be able to join the ancestors. This makes the thought of one’s status after death always a factor in the emotional struggles of the dying. These cultural factors resonate with palliative care.

Palliative care practitioners in this culture should be aware of things like these to be able to offer the right and appropriate palliative care assistance. Offering the dying assistance that will assure him or her of a good status in the spirit world will be a huge relief for such a patient. The fear of loss of the right status in the spirit world is a disaster a dying patient will not like to entertain.

Being at peace with the community and gods is always a source of a happy and welcomed death. The provision to help patients achieve this objective will be good for palliative care.

In addition, the idea of maintaining a relationship with the family and bond with the ancestors informs the desire of most patients to die at home surrounded by family members. The fear
that one’s death might occur in the hospital (i.e. not bonded with the family/community) equally explains why some detests going to the hospital. Home care can be an option for such patients especially in a culture that values family care for the patients. (This will be discussed later).

Knowing that a Nigerian sick patient could be struggling with the thoughts about status after life, and knowing how to address it relying on the same cultural context readily available to the patients should be an added advantage in offering palliative (assistance) -care services- to such patient. A model of palliative care in Nigeria will be one ready to consider cultural sensitivities of the people bearing in mind that such sensitives can generate positive or negative emotions depending on how they are handled.

2. Positive and Negative Aspects of the Culture for Patients

Although culture is important for palliative care in Nigeria, researchers have shown that certain aspects of the culture also constitute hindrances to the work of palliative care in Nigeria. However, the very aspects of the culture that constitute setbacks to palliative care are part of the very reasons understanding peoples culture is important to palliative care in Nigeria. As already seen, many constructs can be made from the worldview of Nigerian traditional cultures as it concerns the sick and dying patients. Culture influences society’s way of evaluating reality. Some of the evaluations and constructs could be positives others negatives. Some of the positive aspects are helpful in the practice of palliative care and some of the negatives constitute problems to palliative care. Some of the negative elements of the culture can complicate situations of the patients if not handled properly. Understanding the constructs and how they affect a sick/dying patient is vital to palliative care practice in Nigeria.

Values to protect life and to care for the general wellbeing of others, family structure that revolves around extended family system, attitude towards death, burial and funeral that follow
death, and some cultural and religious institutions are some of the positive aspects in the culture. Institutions like family structure have inherent care values that could be beneficial to palliative care as they make care for the sick easier. Patients' religious, traditional and faith institutions can be tapped into. These institutions are most often the first contacts for most people when they become sick. Palliative care can utilize these institutions in many ways such as information dissemination and outreach to the patients. Family members, religious leaders and tradition healers share the same cultural/religious worldview as the patients. They can be trained and involved in the multidisciplinary team of palliative care. They have so much to offer in palliative care especially in providing care to the sick and helping family deal with grief and other psychosocial issues involving sickness and death.

On the other hand, there are certain constructs from the same culture that can produce misconceptions and negative attitudes and behaviors towards the sick and the dying in Nigeria. Scholars have observed that misconceptions arising from the belief system influence negative behaviors. Such negative behaviors come in the form of stigmas. They not only affect the welfare of the sick patient but also weaken effort in providing palliative care. Misconceptions give rise to stigmatizations. This happens when particular features or behaviors of a person or individuals are interpreted or evaluated negatively by the society. The negative evaluation is made to rhyme with the society’s cultural realities concerning such behaviors. When a person is stigmatized, several inappropriate reactions are elicited from the society towards his or her physical flaws. The patient is identified and treated in some negative forms. This makes provision of palliative care difficult as people are less willing to help a patient with a stigmatized condition/s. The patient might have many constraints in following up with treatment /care. For instance, if a sickness is considered as a punishment from God, it is less likely that such a patient
will receive much sympathy from the people. The patient might be reluctant to seek help or even might reject help as he or she believes his/her situation has no remedy. If a stigma is attached to a sickness, the patient is likely to be avoided and rejected. Even in death such patients might be denied funeral. HIV/AIDS is one sickness that can be considered a punishment from God because it is viewed as a sickness of immorality. When a person is sick with HIV/AIDS, it is not only the physical pains that is involved. There is also a feeling of emotional and psychological pains arising from a perception of rejection by people and God, rejection from ancestors, and the guilt and fear of ‘permanent death.’

Some cancer patients equally suffer the same fate. A case study presented by one of the authors Onyeka (2010) shows the ugly fate of the stigmatized patient and how difficult it is to provide care to a stigmatized patient in Nigeria. The case study was on a patient with Neurofibromatosis type 1. The 40-year-old patient had multiple large cancer tumor that grossly disfigured her face, facial trunk, and limb. Providing care to this patient was made impossible because of mobility. The patient could not follow up her appointments because of rejection from the public. Because of her conditions commercial drivers would not take her to appointments. She could not make it on her own as the place of appointment was not a trekking distance (a three-hour drive). Even if it was a trekking distance people could stare at her, or even jeered at her.

The issue with stigma as a negative product of culture is that it makes provision of palliative care difficult and makes the patients suffer more and makes their situations more complicated. Stigmatized patients tend to feel isolated. They are also usually depressed. Their self-worth is affected. Their interpersonal relationships are displaced and misbalanced. The patient might tend to withdraw from family and community. Society most often reject or abandon them giving rise to social morbidity. Sometimes, in trying to seek a solution to their situation, they consult
alternative medicine practitioners who in this situation have nothing to offer but rather increase their frustrations and despair. These situations increase the psychological, emotional, spiritual and physical pains and distress of the patient. In stigmas culture portrays its ignorance about certain diseases, sicknesses and illnesses. Some cultural evaluations ignorantly label and stigmatize patients. It is not just that the constructs from such beliefs are wrong but also that the stigmatizations they produce are so telling on the victims. Stigmas increase and complicate the sufferings of patients. They lead to neglect and abandonment of patients. Some patients who feel their sickness is a curse from God/gods or who fear they will be stigmatized if their sickness is known usually do not show up in the hospitals. Some resort to self-medication, others end up in churches, healing ministries or with traditional healers. Such stigmatization is more prevalent with cancer patients and HIV/AIDS patients in Nigeria. As a result, such patients suffer more because provision or reception of care is made more difficult. Palliative care practitioners in Nigeria have to be aware of these social aversions towards some kind of sicknesses.

Another negative element from the Nigerian culture that stands on the way of palliative care is obnoxious taboos. In the past Nigerian societies were replete with so many cultural taboos. Thanks to religions, especially Christianity and contact with the Western world many obnoxious cultural taboos have been eradicated. It was Megasa (1998), who observed that taboos traditionally play a significant role in the ethical duty of transmitting and preserving life. As observed in the previous section, because many things can attack life and cause sickness or harm measures are put in place to preserve and sustain life and the health of the society. Maintenance of life is done through good living, observance of social, religious and cultural order. These include the Do’s and Don’ts of the cultural, religious and social orders. Not to
observe them accordingly might spell serious doom / bad omen for the entire community. It is believed that any breach of taboos endangers the health and well-being of the entire society.\textsuperscript{116}

Culturally, taboos are not just about actions. They also include sicknesses. Sicknesses or misfortunes suspected to be as a result of a breach of the cultural, social or religious norms are considered taboos. The affected individuals are stigmatized and treated differently and negatively. In olden days the way such individuals are treated are many - ranging from simple ritual to serious punishment, like death. Other ways included simple apology, doing some work to appease the anger and assuage the feelings of the person wronged, selling into slavery, ostracism, propitiatory sacrifice, neglect, abandonment, rejection, ejection and banishment from the community.\textsuperscript{117}

Cultural taboos included both sicknesses and actions and objects. The list of cultural taboos included any sickness of deformities such as retardation and handicap, or abnormalities and strange situations (e.g. if a child did not cry after birth, a child bearing of upper teeth first, a child not walking after three years of birth, death of a mother during child bearing, a child coming out with leg or hand during birth, a baby having six or more fingers, giving birth to twins or more); or as in objects and things regarded as totems; or in actions such as in incest, adultery with neighbor's wife, and killing of fellow human being. Also regarded as taboos were mysterious sicknesses and sicknesses that defile medical treatments. Examples are swollen stomach, chickenpox, smallpox, and leprosy. These were regarded as bad omens and punishment from God.\textsuperscript{118} These victims were stigmatized and treated differently so that their cursed situations will not affect others. Because some of the sicknesses were infectious diseases the society applied cultural measures of prevention known to them at the time such as banishing the affected individuals to 'evil forest.' The victims were banished so that they would not be able to have
contact with healthy people and so would not infect the entire community. Such patients were abandoned to die in solitude in the evil forest.

The good news is that most of these taboos and sanctions have been relegated to history due to the influence of Christianity, modern civilization and enlightenment in education, medicine, and social life. However, it is also a fact today that patients still suffer the effects of the residues from such taboos. It is because of such residuals from taboos that many Nigerian patients are stigmatized. The residual taboo construct in the culture is the reason most cancer and HIV patients are stigmatized. HIV/AIDS makes the list not just because it defiles treatment but equally because it is regarded as a sickness of immorality. In other words, it is understood as a bad disease - not necessarily about the medical nature of the sickness but on moral grounds. Residues from taboos cultural construct produce stigmatization fears that make it very difficult to test healthy people for HIV. This means that most HIV (AIDS) and some cancer patients are subjected to neglects, abandonment, rejections, fears, loneliness etc. Such situations weaken efforts in providing palliative care.

There are other constructs from the cultural context that can also lead to psychological tendencies that can hinder provision of palliative care. For instance, some seriously ill patients can detest going to the hospital because they do not want to die in the hospital. They want to die at home. Again some patients are too afraid or too concerned to die not because they fear death but because they are concerned about how their funeral will take place. This is something they cannot do for themselves. They depend so much on the assistance of the family members to achieve this final ritual that will secure them ancestor status. These and many more are some constructs from the culture that can produce psychological, spiritual or emotional issues for dying patients.
Though these cultural aspects generate some psychological tendencies and fears, there is good news. The good news is that with a cultural sensitive palliative care, extract can be made from the rich values of the culture to attend to their psychological and spiritual needs. For instance, a simple assurance of befitting funeral could change the mood of a fearful dying patient to a joyful dying patient. For patients who detest hospitals because they want to die at home, ‘Home Care’ could be fashioned out of the cultural context that revolves around the extended family system. Such care system as already tested in Uganda that has similar culture with Nigeria has been shown to be cost effective and easier. Involving family members in palliative care team makes care for the sick easy. Religious leaders and traditional healers can help patients resolve some of the unresolved spiritual and cultural issues. Patients who lack access to Western medicine could be supported through the local and traditional medicine/healers that are very widely dispersed/distributed in both rural and urban areas. With these, effective and wider coverage of palliative care will be ensured. It also shows that though traditional healers can ignorantly constitute to the predicaments of the patients, there are other ways they can be of important help to palliative care. Engaging them with palliative care workshops and training will be helpful making them more useful to palliative care. Such measures will help reduce some of their ignorance and misconceptions about certain sicknesses. Integrating them and other Faith Based Organizations (FBOs) providers as part of the palliative care multidisciplinary team will boast the activities of palliative care in Nigeria. Together, they wield some significant level of cultural, political, social, educational, and economic influence among the people. Also they have solid grassroots base that can be utilized as they can be found in nearly all communities in the country. They can provide access in engaging hard-to-reach communities with social mobilization, advocacy and other palliative care services to the patients.
This shows that there are positive aspects in the same culture that has negative aspects. The positives can be extracted from the same culture that attaches values to life in all its ramifications. Effective palliative care in Nigeria therefore, will include an approach that knows how, when, and where to apply the positive values from the culture in attending to the psychological and emotional needs of the patient. The approach must also know how to handle negative psychological and religious issues/beliefs that could complicate situations. Knowledge of what constitutes stigma, allows practitioners to identify it. Identifying stigmas during diagnosis will help initiate counseling together with the treatment of the primary condition. Family members can participate in the counseling segments. Even workshops could be organized for all the support groups (family, religious and traditional leaders and healers) as they form part of the first contacts of patients when they become sick.

In general, a good understanding of the positive and negative cultural/religious connotations to sickness and death is important to palliative care practice in Nigeria. The knowledge is important as it helps palliative care providers understand the connotations that are involved when a patient is concerned about the source/cause of his/her illness. It provides clue to why people are afraid or happy dying, why they chose traditional medicine in place of hospital, why they choose to die at home and not in the hospital, why some sick patients refuse any medical attention at all, why some sick patients are discriminated against, why family members or community will be reluctant to attend to the needs of a patient, when a patient has the need for priests, for diviners, for traditional healers or any other form of faith clinic etc. These negative issues and concerns can be handled appropriately with good knowledge of the culture of the people. Both the positive and the negative aspects of the culture has to be understood properly and handled appropriately and effectively to meet the psychosocial needs of palliative care patients in Nigeria.
B. Role of Family in the Care of the Sick

1. Family as a Site of Care

The importance of family in palliative care cannot be overemphasized. Authors have shown that the role of family as a site of care is not out of place in palliative care, especially in Africa where extended family system is still practiced with great commitment. As already discussed, family care is one of the early concepts of care carried over to modern palliative care practice. It has led to the formation of models in palliative care with family orientations and values in mind. As already seen, such approaches applied respect and provides the hospitality of a good home to patients. The practice has continued to form part of bedrock in palliative care practice. As such, palliative care is noted to have enjoyed favorable culture in developing nations through family and community care. For instance, in India and some Africa countries palliative care enjoys this kind of family and community care responsibility. It is noted that most often the chronically ill “who need continued supportive care spend their lives not in the hospital but in the community, among their family and neighbors.” Also, the high number of patients with chronic and incurable illness in nations like Nigeria, definitely highlights the need to involve the support of the family and community in palliative care as professionals alone cannot bear the enormous weight of care by themselves alone.

Sociocultural contexts have always been the driving force in support of family care in developing nations. Authors agree that family care is very important for palliative care especially in developing nations, including Nigeria where there are poor health care systems and cultural contexts that support family care, or that make patients prefer to be cared for and to die at home instead of hospital. The point is that family is one cultural institution that stands to benefit palliative care practice in Nigeria as a developing nation.
Many developing nations, as already observed, lack modern amenities that support palliative care. Nigeria is one of them. The nation lacks social infrastructure and this adversely affects coverage of health services. In such circumstances it is family care that stands the chance to offer palliative care providers grass root assistance to the patients. Apart from this, cultural context supports family care. For instance, a need assessment survey carried out among palliative care patients in Uganda shows that many patients consider home to be a safe place to be sick and to be cared for. They believe it is therapeutic because it allows them a comfortable place to express their distress freely. Home for them is not just a building. Rather it houses relationship between patient and family. Talking of relationship and care by family members in Africa, Livingstone (2013) observed, “In private homes mothers, aunts, daughters, brothers, fathers, and even entire families might wake in the night to stay with and provide solidarity and comfort to relatives whose pain was intense enough to prevent or interrupt their sleep.” This shows that family is a strong support system. A similar observation was also made that cultural context of Uganda revolves around the extended family. Patients prefer to die at home. Home care is also less expensive. This makes home care suitable for a nation with poor patients, like Nigeria. Some other writers agree with the idea that family context supports home based care and is less expensive. They argue that it is easier to meet cultural and practical needs of the people through home care. In this way they can meet their desire to die and to be buried at home. Some writers and palliative care practitioners from Nigeria also observed that most patients in Nigeria prefer to die at home. Some of their practical desires include to die and be buried at home, to make their peace, to say farewell and give final instructions. For them home instead of the hospital is the safest place to achieve their final desires in life.
2. Kinship, Nuclear Family and Extended Family

i. Kinship System as the Force of Family

Nigeria like most African countries has a rich cultural context that support family care. Studies show that family is one of the strongest forces in traditional African life.\textsuperscript{139} Family relationship in Africa is very unique.\textsuperscript{140} What makes African family traditional life so unique is contained in the explanation offered by some writers on kinship system in Africa in general\textsuperscript{141} and Igbo of Nigeria in particular.\textsuperscript{142} According to one of these writers, family is among the African traditional concepts connected with human relationship which can only be understood and interpreted through the kinship system.\textsuperscript{143} Kinship system is noted to represent or infer the strongest force in the traditional African life. The system is the force and backbone that largely binds the entire life of the community. It governs the behavior, thinking, and whole life of the individual in the society he (the individual) belongs to and shares membership. The force and strength of the bond of family unity is derived from the same concept surrounding kinship:\textsuperscript{144} This is the force that drives respect for the elderly, care of the sick and the needy members of the family. It is the force that enables solidarity, stimulates commitment, and enhances hospitality. It is this force that makes the individual understand that he is simply part of the whole, that is, to exist is to live with the group.\textsuperscript{145} Igbo, like most African peoples, tend to define a person in terms of the group to which he belongs, to exist is to belong to a family, live in the group or community, to see and do things with the group, that he exists for others as others exists for him.\textsuperscript{146} This is the force that inputs the consciousness that what one member of the family suffers others suffer. It is the force that ritually incorporates the dead into the wider family of both the living and the dead and makes the surviving members to understand they must respect and not offend the departed to avoid misfortune.\textsuperscript{147}
In sum, it is the force that provides and drives the bond of family unity and love. With all these great values there is so much love, care and support to go around in African family system. The love and connection individuals experience in the family inform why many patients prefer to die at home, among their family and in the midst of their loved ones

ii. Extended Family and the Care for the Sick

The family system described incorporates both nuclear and extended structures. Extended family is a family unit that extends beyond the nuclear family to include other relatives such as “aunts, uncles, cousins, parents and grandparents.” Of course some African traditions have no such names as ‘uncles, aunts, and cousins.’ They regard these aggregates of relatives as ‘brothers and sisters.’ This way of viewing each other tightens the bond of commitment that exists between them. The key characteristic of the extended family is that there are multiple adults in the family. These adults may not be the parents of the children, but they participate in the sustenance of the extended family in many ways including financial support. The power of the bond of family system is very active in the extended family structure. The operational strength of this bond in extended family can be seen in the story recounted in the previous chapter about a woman caring for her nephew. She sacrificed the needs of her own children to be able to take care of her dying nephew. A woman caring for her sick nephew was ready to forfeit the education of her children in order to provide medical care for her nephew. That is the power of the bond of extended family. Based on these qualities and values researchers observed that before modern palliative care found its way into developing nations that African people have always valued life and had a way of caring for the sick and relieving the pains and emotions associated with the death of a loved one (family member).
Extended family is a great care resource system for its members. It stands to offer different types of solutions to different kinds of problems for her members. In addition to the bedside support and provision of the essential needs for the sick, it makes provision for the emotional and psychological healing of the surviving members of the family in a substantial way. Burial and funeral that follow the death of a loved one are important ways of dealing with bereavement grief. Extended family system bonding supports performing the transition rites for the dead - something the dead cannot do for themselves. The bonding in the family system provides the assurance that makes their members feel comfortable in the way they live and die as something paramount. It is therefore important to encourage and promote such family support, in the face of poverty and hunger that limit the capacity of caregivers in providing for the needs of the sick.

In sum. Caring for the sick is part and parcel of the cultural practice of Nigerian family system. It is a care that stems from the strong force of the African family system. There is remarkable commitment and solidarity in the extended family. Among the Igbo of eastern Nigeria, the members of the extended family are bonded by solidarity in seeking the physical, social, moral and general well-being of all her members. This is helpful to palliative care. Palliative care in Nigeria should include a model of care that can properly harness and utilize the values of the family system already on ground. In this way, palliative care can reach the sick at their homes through the solidarity and support of the extended family members who owe it as a duty to care for them.
C. Religion and Alternative Beliefs

Having considered what constituted sickness in the traditional worldview of Nigerians, religion (modern and traditional), traditional medicine and healers continue to be sources of alternative health care and spiritual wellbeing for many Nigerians. It is common knowledge in Nigeria that the presence of modern health care delivery is not able to stop some of the Nigerian patients from seeking alternative care as solutions to their sickness. In some cases, modern scientific health care plan run side by side the religious and traditional cares. In Nigeria, just as religion and religious institutions abound exceedingly, so all the traditional health specialists are found all over. In many instances, these others are given prior over modern scientific health care. Some palliative care practitioners and writers observe that some Nigerian patients prefer religious faith clinics and traditional healers as an alternative to modern medicine. This is usually the case if they consider their ill health as spiritual. The practitioners and some writers see this as a setback in (their) palliative care work.

Though the practice might be considered as such (setback) it still remains part and parcel of the people’s culture. Instead of lamenting the setbacks in the practice the values inherent in them could be extracted and channelled into providing the patients with what is culturally meaningful to their palliative care needs.

1. Religion

Religion is part of the culture of the people, and their culture is part of their religion. Their traditional religion incorporates all aspects of their worldview many of which has not been erased by their new found religions or modern way of life. Before the advent of Christianity or
Islam, Africans traditionally is said to have what is called “lived religion.” What this means is that one is born into it. He/she learns it from childhood as it requires no formal indoctrination or induction. The religion needs neither proselytizers nor converts. Rather it is a religion that accepts, cherishes and integrates foreign practices as well as allows individuals to retain their own religious practices.158

Two things are clear. First, traditionally their religion involves whole life. Many writers have characterized the traditional religion of the Africans and Nigerians in particular as a religion that involves the whole life.159 Meaning that whatever one does or thinks has religious connotation or interpretation.160 This is understandable in an environment already described as “densely populated with spiritual beings”161 and among the people already described as truly and deeply religious because their religion is their existence, and their existence is their religion. People who “eat religiously, drink religiously, bath religiously, dress religiously, and sin religiously”162 will definitely view everything including their sickness religiously.

The second thing that came out clearly is that Nigerians by tradition are prone to accommodating and integrating alternative beliefs. When these two things are brought together, they present a vivid understanding as to how aspects of traditional worldview /religious or spiritual beliefs enter and become a part of modern belief that makes alternative belief common especially during sickness and moments of great need.

Religion /culture is a factor to why many Nigerian patients believe in alternative solutions instead of hospitals because they believe their sickness is spiritual. They choose faith clinics, prayer houses and traditional healers and medicines as an alternative to hospital or modern medicines most often because they believe their sickness is spiritual. Traditionally, the belief in
divine beings or spirits implies also the belief that these divine beings have great influence in their daily lives. The belief in spirits and spiritual forces explains why a sick patient can easily believe his/her sickness is spiritual. The implication is that hospital is not the solution. Solution has to be sort from the alternative beliefs. The belief also explains the existence of different types of traditional healers in Nigeria and why many Nigerian patients resort to traditional healers and faith clinics that are found in nearly all communities in Nigeria.

2. Alternative Beliefs

The alternative beliefs mask the complex ways in which a sick patient can be drawn to seeking solution from faith clinics and traditional healers instead of the hospital because he believes his sickness is spiritual or metaphysical. In this mix a person who considers himself a Christian and believes in Christian practices or one who is a “devout Muslim” may feel his sickness has ‘non-medical explanations.’ So what is the point going to the hospital if medical aid is not a solution. He may resort to prayers and expectations of miracles from his faith group or he may also follow or be influenced by indigenous/cultural beliefs and practices. Even some traditionalists in moments of sickness as described patronize and seek miracles from the churches, mosques or traditional healers without recourse to hospital. Whichever way, hospital is not considered as an alternative if the sickness is judged spiritual. Faith clinics and traditional healers must supply if the sickness has ‘non-medical explanations.’ It is for reasons like this that writers have advocated that traditional healers be trained in care roles. It is therefore not surprising that this proposal is even contained in the Nigerian current national health care bill as mentioned in Chapter 4. Cultural friendly palliative care in Nigeria will ensure the implementation of that bill for the benefit of palliative care patients.
Undoubtedly, traditional healers have good knowledge of local traditional practices. Traditional healers could collaborate with palliative care providers to meet the spiritual and cultural needs of patients. A traditional healer could also be of benefit in a palliative care team as they can dispense traditional medicine and have an in-depth knowledge of patients’ psychological needs, which could supplement and complement the work of nurses and home-based care volunteers. Resort to churches, traditional healers or faith clinics is common among many Nigerian patients. Nigerians patronize faith clinics in search of what is culturally and religiously meaningful to them. Alternative healers are often the first and last port of call for many patients. A typical case presented by Stock (1985), shows that Hausa people in the Muslim northern part of Nigeria believe in spiritual forces for which reason they usually resort to the services of traditional healers if they believe their sickness is spiritual. A hospital based case study and descriptive field work carried out at Lagos University Teaching Hospital, Nigeria from 1984 to 1987 show a similar belief and attitude among other Nigerian tribes like Yoruba, Ishan and Igbo.

Authors are divided on the implications of seeking alternative care when it comes to palliative care in Nigeria. According to some writers, many Nigerian patients seek help with spiritualists and churches before getting proper medical care. This leads to late presentation to hospital. For these authors the issue is not whether Nigerians resort to churches and miracle churches in time of sickness because they do. The issue is with the implications such attitude has for the patient and for palliative care. They argue that the problem of palliative care in Nigeria is not getting palliative care as a discipline to recognise, research and discuss spirituality. Their concern is that participation in certain aspects of organised religion may prevent people from seeking palliative care services.
However, some palliative care practitioners in Nigeria have a different opinion. O.A. Soyannwo, an anaesthesiologist who founded the Centre for Palliative Care in Ibadan, did not agree entirely with this line of argument. She, like some others, argue strongly that patients patronize churches and traditional healing places in search of what is culturally and religiously meaningful to them. She maintains that the hope patients have in miracle and prayers should not be discouraged, diminished or ignored. She sees the works of the alternative faiths as offering social and psychological supports to the patients. She maintains that churches, faith groups, and traditional healers should be encouraged and made to understand the importance of palliative care through advocacy, collaboration, and palliative care education. Patients’ hope for healing does not prevent patients from seeking medical help.

On his part, Ityavyar (1990), argues that traditional healers are holistic in their approach and versatile in cultural norms and values. Though scientific medicine provides good medical care, it is deficient in health care. Traditional healer does not only treat a person’s disease. He attends to the whole person. He not only treats the patients’ disease but goes above and beyond to employ his cultural knowledge and community’s norms and values to explain the cultural, social, magical and physical environment of the patient. A therapy that involves socio-cultural analysis of the patient’s situation goes a long way in cementing fragmented relationships between individuals or between individuals and offended spirits. A traditionalist uses his versatility in cultural /traditional and religious knowledge to treat a whole spectrum of illnesses for which hospital treatment shuns. Ityavyar’s argument is that the ability of the traditional healers to understand patients’ values is part of what attracts most patients to them. Patients go to them because they are from the same culture as the patients, employ the same language and share the same worldview as the patient. They also prescribe cures which are familiar and valued by
Religion is not the only reason patients patronize alternative healing centers. Social, psychological, economics and cultural reasons are equally factors. Another factor that endears patients to alternative medicine is their accessibility. Great number of Nigerians out of necessity rely on traditional healers and faith clinics for their health issues because they are more accessible and affordable. The truth is there are many and different types of traditional healers, churches and faith clinics in nearly all communities in Nigeria. On the other hand, hospitals are found mainly in big cities. While modern hospitals are hard to access, churches and traditional healers are common place. Traditional health specialists are found in every village and patients find it easier seeking their services than going to towns to access hospitals. Their services are equally cheap and in some cases free. Compared to the huge expenses in transportation and medical services involved in accessing hospitals for treatment, it appears more convenient for patients to rely on what is readily available.

Though there are dangers with alternative beliefs there are also serious reasons not to sweep them aside. They are easily accessible and Nigerian patients hold them dearly. Alternative beliefs also accommodate the various worldviews of the Nigerian people. They provide psychological, emotional, and social supports and views familiar to patients and their families. Patients find them culturally and religiously meaningful in their sick situation. They can be utilized in rural areas where road access to facilities is difficult. Actually, they could be seen as necessary avenues to reaching out to the patients who find it difficult accessing the hospitals. Their shortcomings could be improved upon. For instance, palliative care could engage traditional healers, churches, and other faith groups /leaders through advocacy, collaboration and palliative care education. In this way, their excesses could be curtailed and their values extracted through adequate training for the good of the patients.
D. Positive Contribution of Church Missions

Churches are part of the faith based organizations providing prayers and healings to patients as discussed above. While they share in that category in meeting patients psychological and spiritual needs, they have other enormous qualities that help enhance social, health and economic wellbeing of Nigerians. They wield not just religious and spiritual powers among the people but equally a significant amount of influence in the areas of education, health, cultural, social and economic advancement of Nigeria.

These aspects of their contributions will be discussed in this section. The contributions of the churches as faith based organizations operating in Nigeria are singled out to be discussed here because of the enormous strengths they wield in Nigerian sociocultural setting/structures.

According to some authors, faith based organizations in Nigeria are known for their strengths in efficacy, commitment, knowledge, networks, and influence. Churches are not just part of the alternative beliefs that provide faith healing to patients. As organized institutions, they have many other ministries that have contributed so much in the positive shaping of Nigerians. They have contributed and are still contributing in the areas of schools, hospital management, and charitable works, not just in the cities but also in the rural areas. Their strength could be tapped in many ways to enhance palliative care in Nigeria.

Part of the major hindrance of health care delivery in Nigeria is accessing the rural areas. As discussed in the previous chapter, many communities in Nigeria are hard-to-reach. By extension, it is equally a problem for palliative care.

On the other hand, church missions have presence in most interior communities. They have grass-root structures that could be utilized in the provision of palliative care. Most of the privately owned health care delivery in Nigeria today are owned by church missions or faith
based organizations. These institutions are more dispersed and can be found not just in cities but even in the interior and hard-to-reach communities/ rural areas where government presence are not felt.\textsuperscript{179}

The resilience of the Nigerian churches mostly the Christian churches in providing social services among communities especially hard-to-reach communities has been tested and can be said to be trusted. The history of the churches show that they travelled tough and difficult terrains and were found worthy. The story of the advent of the churches are replete with all kinds of difficulties and setbacks as well as adjustments that helped them through. The hurdles were material, social and environmental. The Christian missions first came to Nigeria in the 1880s (the Presbyterians in 1846 and the Catholics in 1885). Almost everything was hostile and foreign to them. The people were uneducated and unwelcoming. The language was foreign. The climate and weather were harsh. Diseases were common place - malaria-carrying mosquitoes were everywhere. Hospitals and medicines were unknown and unavailable. The entire place was undeveloped, and the people were described as not civilized. There were no roads and no cars. Travelling was hazardous, and sailing appeared more like death traps. Some of the very early arrivals survived only for days. These and more were the many challenges the churches' missionaries overcame in order to establish their missions.\textsuperscript{180}

Their first attempt in evangelizing the people through visitation and apostolate of slaves and outcasts did not work out well.\textsuperscript{181} The background of the early missionaries was that of ‘compassion and sensitivity to the horrors, misery, inhumanity and the indignity of the slaves and inhuman social taboos and crude cultural practices.\textsuperscript{182} The Catholic church was the first to discover that rescuing slaves by buying them back from the slave traders and giving refuge to the outcasts were not the most effective way of achieving their objectives. They figured out that
grass-root approach through medical apostolate and school apostolate were the surer way to get to the people and correct the inhuman practices. By 1889, the first dispensary in the east of the Niger (current eastern part of Nigeria) started functioning. Three years later, (1892) a hospital was established.

The hospital apostolate helped the missionaries gain the people's confidence. They approached the people easily and the people came to them with ease. Sick children were brought to them for healing and for baptism. In general, the people trusted their activities and their new gospel message. Medical Apostolate proved that through healthy body and mind, healthy souls could be secured for Christ. The success recorded in Nigeria through catholic medical apostolate was replicated in other places. By 1956, the Spiritans were said to be operating about four hundred and twenty-one dispensaries and hospitals in Africa.183

However, the greatest converts were made through school apostolate which they considered as a lucrative approach to evangelization and civilization.184 The church believed strongly that education of the children will store up a perpetual positive factor and influence for the benefit of the church and the society at large. With this conviction, grassroots education with children through primary school schemes was started. About thirteen Roman Catholic primary schools were established in Eastern Nigeria by 1902 with estimated attendance of 800 pupils.185 This was eventually followed by establishment of secondary education scheme. Evangelization through Hospital and School apostolates thus was started by the catholic mission in Nigeria. The approaches were later followed by protestant missions in Nigeria because they found them to be rewarding. Both approaches were lucrative not just for evangelization but for the general wellbeing of the people. This missionary strategy saw to the establishment of many mission schools in many parts of the country.186
The resilience of the churches has continued to sustain their influence among the people. Their apostolate through hospitals, schools and parishes in rural and urban areas gives them grassroots structure and platform in reaching out to the people easily more than any other organization in the country. The government of Nigeria and palliative care promoters in Nigerian can collaborate with the churches. They can utilize the advantages of the grassroots structures and platforms in place to pass on important government/palliative care programs and activities.

Not only that the churches have solid grassroots, they are also very disposed for collaborative engagements. With solid grassroots, collaboration is another key factor. As far back as 1902, the British colonial administration has discovered the grassroots platform in the church missions. They partnered and collaborated with them in many aspects to achieve their own goals. They supported the church schools with grants and educational programs. Recognizing that the church has earned the trust of the people through education and hospital apostolate, the government promoted the apostolates and involved the church in most of their expeditions, especially where both parties have common interest. For instance, the church was interested in religious transformation aimed at eradication of the obnoxious cultural and traditional practices through education and hospital apostolate. The government on its part was interested in social and political transformation through subjugation of the people. They needed each other to achieve their objectives. The churches needed both financial and political support of the government, and the government needed the cordial relationship and the trust the church has built among the people. Both the church and the civil authority owe the success of their transformation agenda to the collaboration they had with each other. This is a good indication that government’s goodwill and support of the mission institutions can go a long way in the transformation of the nation. This approach will be of great advantage to the Nigerian government of today. There are many
mission structures and Faith Based Organizations with schools and hospital structures considered to be most stable and most extensively dispersed. Currently the government have no serious policy that recognizes the great impact of the missions in the nation building.

The darkest period in education in Nigeria started in 1970 when the government took over all mission schools and expelled foreign missionaries. That singular attempt in expelling of foreign missionaries and seizing mission schools resulted in fall in academics and rise in crime. Nigeria has not recovered from that. Though the Churches have built more schools after that, attempt must be made to return the seized schools back to them. The return of the schools can help build trust and stimulate collaborations between missions and the government. It can also improve performance in academics and reduction in crime.

In sum, Churches and many Faith Based organizations have solid platforms and grassroots in Nigeria. They have the platform and the ability to influence behavior and impact knowledge even in the remotest parts of the country. Government support and collaboration with missions that have acquired a long lasting grassroots in the communities will go a long way in creating an enabling environment that can sustain a lot of government programs including health and educational programs. Palliative care promoters in Nigerian can also tap into the missions’ and other Faith based organizations’ structures on ground to offer a grass root based services to the needing patients and families.
Conclusion

Palliative care in Nigeria must not overlook sociocultural and religious context in the country. Values that are found in the cultural institutions like family support system, religious and faith institutions, traditional medicine/healers, burial/funeral rites can be helpful in palliative care promotion. This project notes that though cultural values are important for palliative care promotion in Nigeria, certain contents from the same culture could hinder palliative care. Knowledge of those negative contents and sensitivity to the cultural contexts is important to navigate the shortcomings.

That culture and cultural sensitivity are important in the practice of palliative care are attested to by many writers. It is both a necessity and a big help. Tapping into them in Nigeria is not out of place. The practice of tapping cultural contexts in palliative care is already in practice in some other African nations, like Uganda. The support given by different authors for cultural sensitivity in palliative care in Africa favor Nigeria because of her cultural values which beg to be tapped. These encourages the effort to study the people and their culture.

Understanding the people begins with understanding of their traditional/cultural worldview. It is the key to a proper understanding of the people and their culture. Cultural and religious beliefs abound in Nigeria just like in many African societies and they affect how the people view reality. In effect, their cultural and religious attachments have so much influence on the life of the people in general and how they conceptualize sickness and death in particular. In moments of sickness and death the people’s belief system plays significant role in their attitudes towards sickness, death and dying. Knowledge and understanding of the cultural worldview of the people highlight some inherent cultural values and institutions that must be integrated in the specific model of palliative care for Nigeria.
Integrating such cultural values and incorporating them with the modern palliative care practices will go a long way in boosting palliative care for the country. It will make palliative care more accessible, more affordable, and more meaningful to the people in their situation. Holistic approach to the needs of palliative care patients in Nigeria will not be complete unless cultural values and sensitivities are given serious attention in the overall health and palliative care practices. Thus cultural values are relevant for any model of palliative care to be effective in Nigeria.


8 Merriman and Heller, Hospice Uganda- A Model Palliative Care Ininitiative in Africa: An Interview with Anne Merriman 2002.


11 Campbell and Amin 2014.


13 Mbti 1970, 97.


16 Leonard 1906, 429.


21 Stock 1985, 480.
23 Stock 1985, 472.
25 Stock 1985, 472.
36 Froiland 2016.
38 Ilechukwu 2007, 240.
44 Every Culture 2016
46 Magesa 1998, 41.
49 Adewole 1990, 161.
50 Nzewi 2001, 1404.
51 Iweadighi 2011, 43.
52 Froiland 2016.
58 Iweadighi 2011, 65.
59 Mbiti 1970, 32.
60 Iweadighi 2011, 50, 67.
61 Mbiti 1970, 55.
63 Chigere 2001, 90, 97.
64 Chigere 2001, 97.
65 Mbiere 2014; Iweadighi 2011.
69 Iweadighi 2011, 67.
70 Ityavyar 1990; Mbiere 2014; Iweadighi 2011.
72 Iweadighi 2011, 67.
73 Mbiere 2014, 25.
74 Boyd 2000, 10; Iweadighi 2011, 68.
75 Iweadighi 2011, 68.
77 Mbiere 2014, 25.
80 Iweadighi 2011, 102.
81 Ityavyar 1990, 236.
83 Ityavyar 1990, 233.
85 Magesa 1998, 144.
86 Chigere 2001, 97.
87 Mbiti 1970, 32.
88 Iweadighi 2011, 43.
89 Lee and Vaughan 2012, 163.
91 Lee and Vaughan 2012, 161; Iweadighi 2011, 43.
92 Mbiti 1970, 32.
94 Iweadighi 2011, 43.
96 T. C. Onyeka, Palliative Care in Enugu, Nigeria: Challenge to New Practice 2011, 133; Onwumere 2013.
98 Mbiti 1970, 141.
100 Chigere 2001, 97.
102 Ifeanyi 1989, 56.
147 Mbendi 1970, 139-144.
150 Gysels, Pell, Strauss, Pool, & Robert, 2011, p. 5.
152 Chigere, 2000, p. 97.
153 Chigere, 2000, p. 41.
155 Ityavyar 1990, 236; Stock 1985.
156 Onyeka, et al. 2013, 600.
158 Magesa 1998, 60.
159 Magesa 1998; Mbendi 1970; Leonard 1906.
160 Magesa 1998, 60.
162 Leonard 1906, 429.
163 Ityavyar 1990, 234-5.
165 Ityavyar 1990, 234-5.
167 Federal Republic of Nigeria. 2014. *National Health Bill.* Abuja: Nigerian Senate 1, 2a
168 Campbell and Amin 2014.
170 Stock 1985, 469-484.
171 Ilechukwu 2007, 234-244.
173 Gerety 2013.
174 Ityavyar 1990, 243-5.
175 Ityavyar 1990.
176 Stock 1985, 480.

183
Chapter 6: Evaluation and Conclusion - (The Suitable Model)

Palliative care is both possible and very important in Nigeria. As a distinct developing nation with many unmet palliative care needs, Nigeria is blessed with untapped sociocultural and religious institutions that can help palliative care. In light of these, this Chapter presents a specific model of palliative care for Nigeria. The model especially emphasizes the need to embrace the sociocultural and religious traditions and institutions to address the distinctive palliative care needs in Nigeria. The model being presented, is designed to deliver care in any setting (rural or urban, in hospitals, palliative care units, or residential care homes). Basically, the model will be able to penetrate hard-to-reach communities of the country. To achieve all these and more, the suitable model of palliative care for Nigeria will be driven by what this project prefers to call the New Integration Strategies for palliative care in Nigeria. The concept is adopted because this proposal seeks to integrate new approaches to the already existing practice to suit Nigerian context. This is how the model is constituted.

A. Constitution and Application

1. The New Integration Strategies

The new integration strategies for the suitable model of palliative care for Nigeria embodies three major integration strategies. The first will be a Shift-in-Approach Strategy, the second will be Extensive Collaboration Strategy, and the third will be the Ultimate Goals Strategy. The strategies support and complement each other. These strategies will be integrated to the WHO basic principle that is already in place. The strategies allow for candid integration of different components that have been adjudged to be beneficial in the provision of basic services to the people. These integration strategies will be the life-wire of the suitable model of palliative care
in Nigeria. The three strategies can be called or be referred to in this work as the *New Integration Strategies for palliative care in Nigeria*. Thus specific model of palliative for Nigerian is one that can apply these three *Integration Strategies* to the WHO basic principle to address the distinctive palliative care needs in the country.

2. **WHO Basic Principles**

The general strategy for establishing palliative care in a country was stipulated by World Health Organization in 1990. The stipulation formulated and outlined three foundation measures with basis on policy, education and drug availability. 3 With this three foundation measures palliative care will focus on the relief of suffering and pain in the face of life threatening illness, and attend to physical, social, psychological, and spiritual issues accompanying such sickness; use multidisciplinary team work and partnership strategies for services education and research.4 With developing nations in mind, this strategy was adjusted. The adjusted strategy recommended integration of public health approach to the foundation measures.5 The simple understanding is that- it is impossible to establish and practice modern palliative care in developing nations without the involvement of the governments of those nations for the obvious reasons of poverty and its effects in developing nations. One of the easiest ways to meet the urgency of the needs of palliative care patients in poverty ravaged developing nations was to engage the government and use the government structures on ground. For this reason, WHO added public health approach to its basic strategy for developing nations. The directive is that palliative care in developing nations be integrated into the existing individual countries healthcare system. This now becomes the Basic Principle of palliative care for developing nations. The aim is to have robust outreaching in palliative care provision that can provide services through government health care system.
Health care system is the channel through which government and all its agencies reach out to its citizens to provide them with basic needs and services of life. Such provisions include medical care but goes beyond that to include economics, political and social services such as good water, shelter, food, education, employment, sanitation, eradication of disease, etc.\(^6\) These are basic services that promote the general living conditions of the people. It is a system that takes care of how the people live through public health.\(^7\) Such services support prevention of diseases, prolongation of life, and promotion of the health of entire populations.\(^8\) Having the services of palliative care integrated within this system is good for practice of palliative care in Nigeria where poverty puts the people in great disadvantage. Having a palliative care model that is sensitive to how the people live and not just how they die is important.\(^9\) The WHO Basic principle makes sense for developing nations where attention to the issues of how the people live is heightened. Connecting palliative care to the system that provides these basic services that support and prolong life is important in developing nations. However, Nigeria has poor healthcare system that makes difficult the provision of the basic services. Hence a consideration of new approach in palliative care in Nigeria as proposed in the three Integration Strategies.

**B. Soft-Spot Approach (Shift-in-Approach Strategy)**

This project advocates for a model of palliative that can accommodate a *shift-in-approach strategy* as part of its operating principles. Basically, it is a strategy that allows the integration of a soft-spot approach to already existing principles of palliative care as operated in developing nations. This move is sustained for by two reasons.

First by the common practice in palliative care that allows change.\(^10\) Historically, from the evolution of palliative care to its establishment in various developed nations, the practice has been consistent.\(^11\) Palliative care demonstrates a capacity to adapt, transform and extend across
cultures, nations, and situations in time and history. This inherent capacity in palliative care is relevant in Nigerian context. The practice that allows palliative care assemble unrelated demands and bring them together “in a new pattern or synthesis” is still important for the task in establishing a specific model of palliative care appropriate for the future of palliative care in Nigeria. It is not enough that such capacity exists. Effort is needed to utilize it for the benefit of palliative care in Nigeria. Based on these, this section argues for a shift in approach. The shift will allow for integration of a soft-pot approach in palliative care practice in Nigeria especially as it is in line with the general practice of making exceptions for rural areas.

The second reason for advocating for the shift is the need factor. Rural communities abound in Nigeria with most Nigerian patients in poverty trap. Again they have peculiar cultural views on sickness, death and dying. All these present complex pain and discomfort to Nigerian patients. The current palliative care activities in Nigeria has not been able to address these issues, thus the need for a shift to a suitable approach in palliative care that can address such practical and peculiar issues.

The shift-in-approach strategy as being proposed will allow for a soft-spot approach, and be positioned to accommodate other relevant approaches that can address the actual needs of the people. The proposal here is that these operating principles of palliative care in developing nations be disposed to allow a soft-spot approach for Nigeria. Having palliative care that retains the modern approaches as stipulated in the general practice of palliative care, and integrates a ‘soft-spot’ approach to the WHO’s Basic Principles is the ideal for palliative care promotion in Nigeria. This shift-in-approach strategy will serve as part of the life-wire connecting in-and-around the specific model of palliative care in Nigeria. As part of the life-wire of the model, it will allow for possible integration of other components of the model as will be discussed in
Extensive Collaboration Strategy and Ultimate Goal Strategy. In other words, this strategy, as part of the New Integration Principle of palliative care for Nigeria will allow palliative care model in Nigeria to make other accommodations. The approach will allow for the use of socio-cultural values and can also allow the model to overcome and navigate the shortcomings of Nigeria as a developing nation. The approach will also make it possible to mobilize and utilize all affordable resources necessary in attending to the needs of the sick.

1. Soft Spot Approach

Soft-spot approach is based on the principle that allows exception for palliative care in resource poor nations. But soft-spot is not just about making exceptions; it goes further to give a humane base to the practice of palliative care. It is an approach that overlooks certain shortcomings in the actual practice of applicative care as it allows the use of what is readily available (in the absence of what the normal practice permits) to attend to the specific needs of the patients. It can be integrated and applied in the practice of palliative care in Nigeria to address additional issues arising from poverty, dis-functional health care system, culture context and religious preferences, etc.

The principle that allows an exception for developing nations was first implied in WHO’s 1990 directive.17 It recommended a public health approach for palliative care services in developing nations because of evidence of unmet needs and suffering.18 With this gesture, the scope of palliative care was expanded to include extending quality of life to the poorest people through public health model.19 Though this change is important for palliative care in developing nations to address issues of poverty and suffering, relying on it alone is not enough in Nigeria because of other factors. The situation with Nigeria’s broken health care system could not sustain nor implement the WHO recommendations. The result of which was a stunted palliative care in the
country despite WHO’s recommendations. Soft spot approach has to be activated to address the additional issues of poverty, broken healthcare system, and issue of cultural context. Support for soft spot approach is implied in the arguments of many palliative care scholars for alternative forms of engagements to address the concerns raised by the additional needs in developing nations.20 The forms of engagements put forward by these scholars include discussions and practical actions of engagement. Some of the scholars would want a discussion in palliative care for developing nations to include considerations on what constitutes quality end-of-life care in non-industrialized countries.21 Others want discussions on palliative care that will include how the people of the third world live not just how they die as is currently the case. They equally want such discussions to address how the practice of palliative care should be carried on in developing nations with political content.22 On the practical considerations, some believe that the appropriate and feasible models of care must respond to cultural variations and preferences.23 To this end, others suggested that in addition to institutionalized healthcare system, government and nongovernmental agencies, that other cultural and traditional institutions such as family system, community support, spiritual, and socioeconomic support system must also be engaged in palliative care. Some equally suggested that research for developing nations be focused on collaborations that can address specific needs of patients within their geographical needs and socio-economic and cultural contexts.25 These show that the consideration can come in different forms. The practice of making this kinds of exceptions and the reasons behind them is what this project choose to call soft spot-approach. It is called soft-spot approach not just because exceptions are made, but because the exceptions are based on sensitivity and humane considerations. As an approach that overlooks certain shortcomings in the actual practice of palliative care, it makes sense in Nigeria.
Apart from poverty issues that can result to hunger, starvation, infectious and chronic diseases with their additional burdens to palliative care patients and their families, failed healthcare system stunts palliative care instead of promoting it. Coupled with these are issues of complex cultural synthesis that must not be neglected. Soft spot approach allows the use of what is readily available to help address such issues. Nigeria has ‘things readily available’ that could be used in the absence of what the normal practice permits to attend to the specific needs of the patients. Thus soft spot approach is good for Nigeria to help address additional issues arising from poverty, dis-functional health care system, culture context and religious preferences.

An instance of the use of Soft-Spot approach in Nigeria was in 2004. Some researchers from International Observatory on End of life Care came to Nigeria as part of their research project. The research project was to review the progress of palliative care activities in Africa. They were stunned with the poor level of palliative care program and practice in Nigeria. They found palliative care in Nigeria so underdeveloped that it was unqualified for review. What they found on ground was ‘palliative care’ that lacked certain palliative care concepts, including opioids, holistic approach and lack of coordination. Despite these limitations (absence of what the normal practice permits), they considered Nigerian ‘palliative care for review. The Nigerian palliative care though unqualified for review was accepted and reviewed. The result of the review is part of The Individual Country Report on Nigeria at the International Observatory On End of Life Care website. An analysis of the dramatic decision to consider the ‘underdeveloped palliative care’ in Nigeria for review is revealing. Though the consideration was based on the overall principle of making exceptions for palliative care in resource disadvantaged nations, the decision was more on sensitivity and humane considerations of the practical issues on ground. They could have
rejected Nigeria, after all, what was on ground was not palliative care, to begin with. But they did not. Instead, they overlooked the shortcomings and concentrated on the positives that were readily available. With humane sensitivity, they saw some soft-spot in a palliative care service that is charismatically led by two individuals Olaitan Soyannwo and Olusola Fatunmbi. What was readily available was these two charismatic individuals trying to meet enormous palliative care needs of patients in a very hostile environment. These researchers went ahead to encourage the efforts of these individuals by accepting their ‘under developed palliative care’ activities for review. The moral support and encouragement received by these providers from this consideration resulted in many positives results that are contributing to the progress of palliative care in Nigeria.

In the absence of what the normal practice of palliative care permits, Soft-Spot Approach disregards the shortcomings, identifies the positives of what is available and helpful and applies them meaningfully in meeting the palliative care needs of the people. It is propelled by the ability to be sensitive and humane to the plights and needs of the people and encouraged in palliative care practice of the overall principle of making exceptions for palliative care in resource disadvantaged areas. Integrating Soft-Spot Approach to the WHO’s Basic Principles is ideal for specific model of palliative care in Nigeria as it is supported by the Shift-in-Approach Strategy practice in palliative care.

The soft-spot approach can provide an appropriate form of palliative care in Nigeria because it specifically engages the problems of poverty and other diseases and epidemics relating to poverty where some of the basics that support palliative care are lacking. It can allow consideration of other positive elements in the provision of care in Nigeria especially in the area of cultural contexts. Soft-Spot Approach can provide the basis for alternative engagements in
sociocultural and religious institutions that are helpful in the practice of palliative care in the country.

Having a palliative care model that can combine modern approaches as stipulated in WHO’s Basic Principles with a disposition to make shifts when necessary will be beneficial for Nigeria. Integration of *Soft-Spot Approach* with the modern approaches is what the country needs in order to provide effective and affordable palliative care to the people. Palliative care that is disposed to make changes in favor of the practical situations that have their base in socio-economic and cultural contexts in Nigeria will go a long way in achieving grass-roots delivery in service. With Soft-Spot Approach, Extensive Collaboration Strategy becomes possible as it allows for the inclusion of cultural contents in the promotion of palliative care in Nigeria.

**C. Collaboration (Extensive Collaboration Strategy)**

*Extensive Collaboration Strategy* is the second concept of the *New Integration Strategies* for specific model of palliative care in Nigeria. The strategy allows for expansion of the scope of collaboration in palliative care to include some cultural and local contents for the model of palliative care in Nigeria. This will make possible the integration of traditional/cultural agents and local institutions on ground within the collaboration framework of palliative care.

Collaboration in palliative care has been argued and shown by many authors to be effective in palliative care promotion. However, this section will argue that expanding the constituent bodies to include traditional agents and local institutions on ground will be more beneficial in the Nigerian context. Nigeria has some functioning structures on ground that can be incorporated in the practice of palliative care in the country for effective, wider and cultural sensitive palliative care coverage. *Extensive Collaboration Strategy* makes it possible to retain the common practice
of collaboration and be able to integrate some ‘uncommon contents’ as may be found in the local culture to the overall collaboration practice in palliative care. The reason to integrate the uncommon elements in the collaboration framework is simple. Their services could be utilized to the benefits and advantages of palliative care in the absence of what the normal practice permits. The possibility for the integration is based on the linkage between shift-in-approach strategy and Extensive Collaboration Strategy as part of the live wires in the proposed model. With this linkage, Extensive Collaboration Strategy draws from shift-in-approach strategy the practices and principles that allow exceptions with soft-spot approach. With such support and base, Extensive Collaboration Strategy goes beyond what normal practice in palliative care permits. With humane and sensitivity to the overall poor situation of things in Nigeria, this strategy will allow and include what is readily available and helpful to the advantage of palliative care practice in Nigerian context. What is available in Nigeria includes traditional healers and their medicines and practices, religious/church organizations and their institutions and structures, cultural family settings and other cultural values. These could be helpful in many ways in palliative care practice and promotion in Nigeria if integrated to the overall collaboration practice in palliative care.

The specific model of palliative care for Nigeria will, therefore integrate them through Extensive Collaboration Strategy to address the lack of robust collaboration in palliative care practice in Nigeria. By this, the model will retain the practice of collaboration in palliative but will expand its scope in Nigeria to include some cultural and local contents. When that is done the palliative care providers in Nigeria will include in their team and collaboration stakeholders and contents such as NGO’s (foreign and local), Mission structures on ground and faith-based organizations,
Traditional Healers, family, and other local cultural contents and more importantly the government of the country.

Collaboration is very important in palliative care. It has always been a component part and very effective approach in palliative.\textsuperscript{33} It is a practice that expanded the scope of team work approach in palliative care to include other stakeholders in collaboration. Through it, palliative care engages the multidisciplinary team and encourages partnership. It employs the services of clinicians, of different disciplines in the hospital settings. They include researchers and research institutions, public health planners with their different strategies, policy makers, different organizations and agencies such as government agencies at all levels, non-government organizations (NGOs) in business and academia,\textsuperscript{34} and international bodies such as United Nations and World Health Organization, etc. These work together in collaboration with palliative care providers to ensure a holistic care in relief of pain and suffering of patients.

Collaborative approach in palliative care makes it possible for all these bodies to work together as a team in palliative care practices and service provisions. However, Nigeria is a special case. It lacks the basic system that supports ‘normal’ operations of palliative care including the basic elements that are involved in collaboration. But palliative care cannot function in Nigeria without some sort of collaboration. For this reason, the specific model of palliative care in Nigeria seeks to integrate \textit{Extensive Collaboration Strategy} to the normal practice of collaboration approach in palliative care. The collaboration will go beyond what is ‘traditionally normal’ in modern palliative care to include ‘un-traditional’ bodies/agents. This will be possible because the shift-in-approach strategy approves it and the general principle of palliative care that allows the use of structures on ground allows it.\textsuperscript{35} With this, and bearing in mind the socio-economic situations in Nigeria, \textit{Extensive Collaboration Strategy} for Nigeria becomes imperative. It widens to include
the involvement of foreign NGO’s, local institutions and agencies- including government agencies at all levels, traditional and religious leaders by the palliative care promoters. The collaborative approach will be all-embracing as it equally embraces other cultural values, such as using complementary and alternate medicine, and the Nigerian culture of the family bond. Such move will improve health care education and service provision in the country through grass-root initiatives. Thus, supported by the shift-in-approach strategy, extensive collaborative strategy will not only recognize foreign (NGO’s), and embrace local agencies but will be so extensive as to embrace other cultural institutions and structures on ground.

1. NGO’s (Foreign and Local)

The specific model of palliative care in Nigeria will include in its Extensive Collaboration Strategy NGO’s, both foreign and local institutions and agencies. Such intuitions and agencies will include foreign stakeholders like World Health Organization and other foreign donors (individuals, corporations, and agencies) interested in palliative care as is obtainable in other nations. On the local level will include Nigerian government at all levels, local institutions recognizing the structures on the ground and the contributions of such agencies as missions- engages the role of traditional healers to draw the potential benefits of their service

This Project acknowledges and has equally shown that Nigeria operates better in cities and especially when in collaboration with foreign stakeholders. However, there are not enough of them in Nigeria even for the cities. The situation is worse in the rural or suburban areas with a lot of hindrances. Only the effect of WHO has been felt but not directly with palliative activities. Though there are instances where a few other stakeholders appeared and disappeared, palliative care in Nigeria like in every other nation needs stakeholders that are constant and reliable. There
have been some instances of or cases of foreign collaborations in Nigeria with local palliative care providers. According to some palliative care promoters in Nigeria, there was a time education program was held between the Federal Medical Center in Abeokuta (FMCA) and two UK Hospices. The collaboration was enriching as they longed for more of such because it helps to improve health care education and service provision in the country. Another encouraging collaboration noted is between some of the Nigerian providers and some researchers from the International Observatory on End of life Care came. Unfortunately, the precarious situation of Nigeria is frustrating more influx of such groups to Nigeria.

However, this project is of the opinion that Nigerian environment is not enabling at all for the influx of foreign NGOs who can assist in palliative care as it is in other developing nations. A peep into other nations shows of collaborations with the private sectors, individuals, philanthropic groups, etc. who injected strategically hundreds of millions of dollars in support of the activities of palliative care. It has not been that good for Nigerian palliative care. Nigeria has not benefited from such philanthropic gestures like other developing nations. In some developing nations, for instance, the effects of philanthropic groups/NGO’s and even WHO in direct projects of palliative care are so huge. According to Wright et al.: “WHO is involved in joint palliative care project for cancer and HIV/AIDS patients in Botswana, Ethiopia, Tanzania, Uganda, and Zimbabwe. The Diana, Princess of Wales Memorial Fund, has supported palliative care initiatives in the nine countries of Ethiopia, Kenya, Malawi, Rwanda, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe…The open society institute has grant support program for South Africa.” This type of support is lacking in Nigeria. Largely because of lack of conducive environment. Some foreign agents who attempted to come to Nigeria left as soon as
they stepped foot into the country citing corruption and unfavorable system.\textsuperscript{45} Nigeria needs to earn the trust of foreign donors and NGO’s.

Though WHO is active in Nigeria collaborating with the Nigerian government in other areas, it has lamented the turbulent and insecurity in the country as a hindrance to major activities in the country. \textsuperscript{46} WHO might not be in any direct collaboration with palliative care promoters in Nigeria but it has a lot of positive influence in the country that can benefit palliative care. It can use its good influence to pressure and encourage the government of Nigeria as a major stakeholder to fix its broken healthcare system and create a conducive and enabling environment in the country. This can be achieved through provision of enabling policies and sincere implementations of the WHO MDGs and SDGs as will be discussed in the next section. While foreign NGOs are important in palliative care promotions in Nigeria, their presence and effects are still very minimal. However, even in their absence palliative care in Nigeria can make use of other structures on ground- Mission Structures, and Cultural structures (traditional healers and family system)

2. Mission Structures on Ground and Faith Based Organizations

Churches and many faith-based organizations have solid platforms and grassroots in Nigeria. They have churches, schools, and hospitals in almost every corner of the nation. They engage in a lot of charitable and humanitarian works. This project sees these groups as resourceful palliative care agents especially in the absence of foreign NGOs. The specific model of palliative care in Nigeria need to include these groups in the collaboration scheme/network. Their services are good for palliative care but have not been utilized in a coordinated way for effective palliative provisions. For adequate utilization of their services and base, they need to be directly
involved in palliative care activities in the country. They can participate in palliative care education and training. A serious government can empower them to do more. For instance, their hospitals can be activated and keyed-in in the overall healthcare system. Their hospitals could be used as a channel in reaching out to all corners of the nation with any health care program. Though this is not yet in practice, churches and faith based organizations continue to attend to the people through their missions, schools, and hospitals.

Many Nigeria patients continue to patronize Churches and faith based organizations in Nigeria for many reasons including their spiritual needs and healthcare needs. The patients have great trust in them for their lives. For many of the patients, churches/faith clinics are their first port of call when they become sick. They prefer them as alternative to hospitals. They have both grassroots and outreach.

Religious leaders can be helpful in palliative care promotion in Nigeria. Apart from providing spiritual, psychological, emotional needs to the patients, they could help in dissemination of proper information to the patients. Their services have been shown to be cost effective. The advantages of these groups to palliative care are detailed in Chapter 5.

They have the platform and the ability to influence behavior and impact knowledge even in the remotest parts of the country. They need Government support and collaboration as well through training, government financial support. These groups have acquired a long lasting resilience in grassroots, and trust among the people and the communities that neither the government nor the palliative care promoters can disregard them. Their inclusion in the palliative care activities can see the beginning of palliative care explosion in Nigeria. They can blossom the future of palliative care in the country. The move will go a long way in creating an enabling environment
that can sustain a lot of government and palliative care programs including health and educational programs.

3. Harnessing Cultural Values, Traditional Healers, and Family Care System

A model of palliative care in Nigeria will be one ready to consider cultural sensitivities of the people. Traditional healers and family care system are the main structures on ground that can be tapped in that direction. Traditional healers and family care system will be included in the collaboration framework of the specific model of palliative care in Nigeria.

Both offer the avenues through which cultural values can be tapped for palliative care benefits in Nigeria. They can be included in the palliative care team, and their values can be tapped in various ways. Their services and contributions will boast the overall desire of this model to provide adequate, affordable and culturally relevant palliative care to Nigerian patient. Culturally they share a lot in common in relation to the patients. They accommodate the various worldviews same as the patients. With views familiar to that of the patients’ worldview, they offer them supportive care that are culturally meaningful to them including psychological, emotional, and social supports. Both traditional healers and family care system are part of the cultural/traditional healthcare system that must not be disregarded. They form part of the structures on ground. They must be utilized to fill the gap and complement for the lack being experienced now in palliative care provisions in Nigeria.

i. Traditional Healers

Traditional healers in Nigeria have a lot of cultural potentials and benefits that this project considers their involvement in palliative care provision in Nigeria very important. Collaboration of palliative care providers with traditional healers is important to palliative care in Nigeria to
meet the spiritual and cultural needs of patients in a variety of ways. Traditional healers have knowledge of traditional practices, religion, and medicine. As part of the cultural/traditional healthcare system, they wield much in-depth knowledge of traditional medicine, and patients’ healthcare needs including physical, spiritual and psychological needs. Their holistic approach to treating patients is one of the reasons patients continue to patronize them. Patients find them culturally and religiously meaningful during sickness. Again they are easily accessible, and Nigerian patients hold them dearly. This means palliative care can gain a lot from them in all these aspects. Palliative care can share from their in-depth knowledge of the culture and medicine. As the Nigerian palliative care is having issues with opioids and other pain drugs, traditional pain medicine can serve as alternative. They can also serve as avenues for dissemination of information. More importantly, these services are available in almost every community. They can supplement and complement for the lack of being experienced in palliative care provisions in Nigeria.

They can be utilized in rural areas where road access to facilities is difficult. Actually, they could be seen as necessary avenues to reaching out to the patients who find it difficult accessing the hospitals. The shortcomings of traditional healers could be improved upon. For instance, palliative care could engage traditional healers, just like the churches and other faith groups/leaders through advocacy, collaboration and palliative care education. In this way, their excesses could be curtailed and their values extracted through adequate training for the good of the patients.
ii. Family Care

The nearest healthcare system to majority of patients in Nigeria is the family. Family is the base for love and care. They seek physical, social, moral and general well-being of all her members. When one becomes sick, every family member is involved because caring for the sick is part and parcel of their cultural family system. Even after death, the family still has an obligation to the dead member. This after death responsibility is part of caring for the spiritual well-beings of their loved one. The bond of family relationship is very tight that many patients want to be very close to their family when sick. These and many qualities observed in the extended family system of Nigerians are reasons this project proposes for its integration in palliative care provision in Nigeria. Palliative care promoters can collaborate with family members in meeting the needs of the patients. They can be included in palliative care team and be engaged in palliative care education and training.

Extended Family system in Nigeria supports home-based care. Palliative care in Nigeria should include a model of care that can properly harness and utilize the values of the family system already on ground. In this way, palliative care can reach the sick at their homes through the solidarity and support of the extended family members who owe it as a duty to care for them. Extensive Collaboration Approach is important for the specific model of palliative care in Nigeria. However, in the absence of foreign NGOs, and government support, dependence on the cultural and local contents alone means that collaborative approach has a great setback for the specific model of palliative care in Nigeria. Government serious involvement is very vital. Foreign NGOs cannot come in without conducive environment; the structures on ground (Mission, faith based organizations, traditional healers and family system) cannot do much without government support. The next section is dedicated on a very important integration-
Ultimate Goal Strategy that can help the government revamp its broken healthcare system. In so doing, foreign NGOs could be attracted, and palliative care promotion in the country accelerated.

D. Millennium Goals as Ultimate as Vehicle (The Ultimate Goals Strategy)
The Ultimate Goals Strategy is the third integration strategy of the specific model of palliative care in Nigeria. The strategy argues for integration of the World Health Organization’s Millennium Development Goals as a component in palliative care in Nigeria. It relates mainly to government involvement as a major stakeholder in palliative care promotion in the country. This project observed that involvement of government in palliative care promotion in a developing nation like Nigeria is very crucial. Experience from other successful palliative care promotions in developing nations show that their governments have been great enablers. There are many ways government can help palliative care in Nigeria. Some of the ways include integrating palliative care in its overall healthcare system, policy formulations and enabling environment to ensure adequate supply of palliative care drugs, participation of foreign NGOs, and support and promotion of other contents of palliative care. So far Nigerian government have not lived up to these expectations because of broken healthcare system. There is a serious concern and fear in this project that effective palliative care in Nigeria will be far from being realized. Just like other failed programs in Nigeria, this current effort to meet the urgent needs for palliative care could fail unless there is a serious positive actions from the government.

The positive action can start with Ultimate Goal strategy in place. The positive actions should aim at addressing some of the fundamental issues clogging the wheels of progress in the country. Only when such fundamental issues are well addressed should other issues including palliative care will begin to benefit accordingly. Such fundamental problems are issues of poverty and poverty induced conditions. This objective can be achieved through Ultimate Goals Strategy.
The *Ultimate Goal Strategy* is predicated on the WHO Millennium goals. UN General Assembly in September 2000, adopted eight voluntary development goals. These goals which demanded moral and practical commitments in its implementation were to be achieved by participating countries by the year 2015. The eight developmental goals include actions to- *eradicate extreme poverty and hunger; achieve universal primary education; promote gender equality and empower women; reduce child mortality; improve maternal health; combat HIV/AIDS, malaria, and other diseases; ensure environmental sustainability, and develop a global partnership for development.* On its expiration on 2015, the world body renewed it with Sustainable Development Goals (SDGs). While adopting the SDGs with 17 goals that are broadly centered on economic, social and environmental objectives, the world body (WHO) maintained that MDGs “poverty eradication, health as a basic human right, education, and food security and nutrition remain priorities.”

For this reason, even though the targeted date for achieving the Millennium Development Goals was 2015, it is still relevant for Nigeria where poverty eradication, health, education, and food security and nutrition remain serious and fundamental issues. Government of Nigeria can demonstrate its political, moral and practical wills and commitments by integrating the *Ultimate Goals Strategy* as a driving force of its programs. Achieving the eight goals of MDGs will go a long way in taking care of many anomalies in Nigeria including the issues bugging palliative in Nigeria on both how the people live and how they die. The case of Anambra state that incorporated the MDGs in its governmental programs is a reference point.

Anambra state is one of the 36 states in Nigeria. Before the adoption of the MDGs approach, the state like every other state in Nigeria suffered from the effects of a broken healthcare system that gave rise to poverty and poverty induced conditions. In Anambra, the situation was so dire, and
the State was at the lowest point of its fortunes in every sector. Poverty and unemployment were alarming; movement was terrible as the road conditions were very bad as a result of years of neglect. Social life was terrible as a result of armed robbery and kidnapping— even a sitting governor was kidnapped during the period in question. Education was so bad. (Schools were not in session for over a year because teachers were owed salaries and were on strike. Anambra schools usually were among the last in position in national and west African examinations). In simple term, like Nigeria, everything was wrong with the state. A turning point came in 2006 when a new approach on governance was introduced to reflect WHO Developmental Goals.

The new era in Anambra state started with a developmental program plan called Anambra Integrated Development Strategy (ANIDS). This novel program of action initiated by the government of Anambra state in 2006 was aimed at addressing the anomalies in the state. The initiative was a multi-sectorial model predicated on the internationally acclaimed Millennium Development Goals (MDGs). This program was a turnaround in the life of the state. Not just that sanity returned to the state— everything changed for good.

So many things are working good in the state that Anambra state is today a reference point in Nigeria and even beyond. Today the state is first and best in many things and in many areas. Sanity did not just return to the state, but Anambra state is one of the most secure state to be in Nigeria. It is now the state with the lowest poverty rate and among the first states to eradicate polio. The state with the best network of roads; one of the best states in academic excellence (since 2012 till date the state has maintained 1st or 2nd position in national and West African Exams). Anambra state is the first state to hand over mission Schools back to their original owners— the missions. This exceptional act resulted in a revolutionary partnership between the Church and the State. State government retained the responsibility of recurrent and capital
expenditures of the schools while the church runs day-to-day activities and training of the children and the students for the general good of the state. The achievements were so many that they attracted both national and international attentions.61

Because of the achievements of ANIDS through MDGs, the then Governor Peter Obi was invited to speak at the 69th Session of the United Nations General Assembly in New York on the theme, "Localizing the Past-2015 Development Agenda.62 Anambra state is a living example that Ultimate Goals Strategy as government program63 can work so well in Nigeria. A strategy that worked so well in a particular state in Nigeria can as well work for other states in the country. Integration of this strategy with the other two strategies (shift-in-approach strategy and Extensive Collaborative Strategy) will form the ultimate vehicle that can drive and nurture palliative care in Nigeria.

**Conclusion**

The specific model of palliative care in Nigeria, if implemented as proposed, will be holistic. It will embody palliative care strategies that ensure holistic care for the sick.64 This holistic model will mobilize all affordable resources physical, spiritual, religious, economic and political resources in attending to the needs of the sick.65 The model will utilize the values inherent in the culture to address some palliative care needs that are specific to Nigerian patients. Such practices, values, and capacities as found in the traditional healing care and in the extended family care system will be utilized in withstanding certain crisis (that usually overwhelm care providers, patients, and families) and bringing support and comfort to the sick.66 The model will address the distinctive palliative care needs of patients and families with life limiting conditions during their illness trajectories, regardless of diagnosis. This includes how the people live and
die; not just how they die. The model as presented, is designed to deliver care in any setting (rural or urban, in hospitals, palliative care units, or residential care homes). Basically, the model will be able to penetrate hard-to-reach communities of the country. All these are made possible by a new integration approach. Thus, the suitable model of palliative care for Nigeria will now be driven by a *New Integration Strategies* with live wire connecting three integration strategies—the shift-in-approach, *Extensive Collaboration Strategy*, and *Ultimate goal strategy*. 


21 Manima 2003, 143.


23 Clark, Wright, et al. 2007, 700.


26 Wright, et al. 2006, 300.


30 Oliver, Olupitan and Oyebola 2011; F. Oyebola 2011; Wright, et al. 2006, 7; Clark, ten Have and Janssens 2002, 34, 43; Meier, The Development, Status, and Future of Palliative Care 2010, 36, 37.


35 WHO Regional Office For Africa 2014, 3.


37 Chigere 2001, 42.


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224


