

HEALTH AND CARE DEVELOPMENT:AN EXPLORATION OF FACTORS THAT HAMPER BETTER PALLIATIVE CARE IN SUB-SAHARAN AFRICA

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ABSTRACT: *Palliative care is a special care for patients with active, progressive, advanced disease where the prognosis is short and the focus of care is the quality of life. It is a basic human right to provide comfort, assistance and relief. Its principles are not peculiar to the care of the dying but are the integral features of all good clinical care -freedom from pain and the alleviation so far as is possible, of all physical, psychosocial and spiritual suffering; the preservation of dignity; the utmost respect for honesty in all our dealings with these patients and their relatives. Palliative care remains significant in health care but its recognition in most sub Saharan African countries is low. Therefore, to help widen and sustain the scope of palliative care, this article aims to identify the factors that are impeding its development in Ghana. The research employed the use of interviews and questionnaires to retrieve information from a cross-section of health practitioners and general public across the country. The data showed that, many respondents from the general public had little or no knowledge about palliative care even though a similar method of care is provided for terminally ill relatives mostly in their homes. Respondents indicated factors such as; religio-cultural attitudes towards the death and dying, high cost of health care services and lack of funds for the provision of special care, as hampering palliative care in Ghana. As a result, this article prompts that palliative care must be a public health priority and there must be a merger of the general (Western) palliative care concept into that practiced in sub-Saharan Africa (which must adapt to the needs and context of care in Africa).*

KEYWORDS: Palliative Care, Medical Treatment, Health and Human Development, End-of-Life, Terminal Illness and Factors

INTRODUCTION

It is hard to live with a terminal illness and lots of people die from such illness with their death likely to be needlessly painful and indecorous. With a focus on quality of life and a holistic approach to caring for patients suffering from terminal illness, palliative care seeks to relieve the suffering of such patients. Palliative care, according to Richard Harding, is an essential part of treatment and such treatment, while not curative, yet prolongs life for considerable periods of time and restores quality of life.¹ The importance of these tasks has prompted assertions that palliative care is a fundamental human right.² Thus, all persons have a right to palliative care. However, Barbara Reville and Foxwell have observed that the global progress in developing

¹Richard Harding, *Palliative Care In Sub-Saharan Africa: An Appraisal*. (Kings College; London, 2004).

² F. Brennan, "Palliative Care as an International Human Right". *J Pain Symptom Manage* 2007;33:494-499

palliative care across the world is in fluctuating.³ This is made evident by statistics (emanating from international health research programs) showing the growing demographics and epidemiology of life-limiting diseases across the world.⁴ A 2011 study by the Worldwide Palliative Care Alliance (WPCA) found that 74 percent of countries have no palliative care services, or services that reach only a small percentage of the population. This has created an urgent and growing need for palliative care development⁵ that will seek to the needs of terminally-ill and dying patients.

The World Health Organization (WHO) defines palliative care as a medical specialty that addresses physical, psychological, social, legal, and spiritual domains of care by an interdisciplinary team of professional and lay health care providers.⁶ In Africa, for instance, palliative care -initiated by the African Palliative Care Association (APCA) and ably supported by funders such as; The Diana, Princess of Wales Memorial Fund, World Health Organisation (WHO -Africa Project on Palliative Care) and the Open Society Foundation International Palliative Care Initiative (IPCI), among others –have helped in the progress of integrating palliative care in the main health care service of some countries in Africa⁷. However, the impact that the withdrawal of such supports -especially by the Diana, Princess of Wales Memorial Fund from Africa in 2012 -will have on the continued development of palliative care in the region is so far unidentified. In 2012, twelve public hospitals in Kenya, seven public hospitals in Tanzania, seven public hospitals in Malawi and Uganda's main referral hospital were in the process of incorporating palliative care into their services. By 2012, palliative care was being taught in five medical schools and eight nursing schools in Kenya. In Malawi, palliative care became an examinable subject at all of its 13 nursing schools and was being taught at the Malawi College of Medicine.⁸ Significantly, such Palliative Care Initiatives have also supported several distance learning diplomas for health care staff particularly in sub-Saharan Africa, which enabled health workers to work and study, concomitantly. This has ensured the production of more than one thousand (1,000) graduates with expertise in palliative care.

Indeed, it is to be acknowledged that the provision of care for terminally ill patients is not a new phenomenon. Globally, diverse cultures have different approaches to helping people who have reached the latter stages of their lives of which sub-Saharan Africa is no exception.

³ Babara Reville and Anessa M. Foxwell, "The Global State of Palliative Care-Progress and Challenges in Cancer Care", *Annals of Palliative Medicine*, Vol. 3, No 3(2014).

⁴ World Health Organization. Strengthening of palliative care as a component of integrated treatment within the continuum of care. (Available online: http://apps.who.int/gb/ebwha/pdf_files/EB134/B134_R7-en.pdf: 4/13, 2014).

⁵ Human Rights Watch, *UN: WHO Boosts Hope on Pain Relief, Palliative Care. Board Position Should Improve Access for Patients with Life-Threatening Illness*. (Available from: <http://www.hrw.org/news/2014/01/24/un-who-boosts-hope-pain-relief-palliative-care>)

⁶ World Health Organization. *Strengthening of Palliative Care as a Component of Integrated Treatment Within the Continuum of Care*. (Available online: http://apps.who.int/gb/ebwha/pdf_files/EB134/B134_R7-en.pdf: 4/13, 2014).

⁷ Based on the report of Worldwide Palliative Care Alliance (WPCA): The Mapping Levels of Palliative Care Development: A Global Update 2011. Uganda is part of the countries where hospice-palliative care services are at a stage of advanced integration into mainstream service provision.

⁸ <http://www.dianaprincessofwalesmemorialfund.org/who-we-supported/palliative-care-initiative> (10/16/2014)

However, the concept of palliative care, in particular, is not well developed in sub-Saharan Africa. All the same, the slow development of palliative care in sub-Saharan Africa can also be attributed to the different perceptions and attitude towards the dying. This diversity in perception is informed by several cultural and traditional factors which have interrupted the formal development of the concept of palliative care in this area. Notwithstanding, the existing models of palliative care approaches in developing countries are primarily aimed to respond to the needs of people with terminal illness such as cancer and Human Immunodeficiency Virus (HIV).

Indeed, quality end-of-life care is a universal public health problem, but a fundamental issue which is going to be addressed in the slow rate in sub-Saharan Africa, particular Ghana. With palliative care being perceived as a fundamental human right for everyone it is unavailable to most in the developing world. Ghana, as a country (developing nation) has limited resource with respect to the provision of better hospice and palliative services. The relevance of palliative care has not been fully appreciated in the quest to addressing the needs of terminally-ill patients and near-death individuals. In view of this, the article addresses the context of palliative care in sub-Saharan Africa while researching into the factors that are impeding its development in order to help widen and sustainable the scope of palliative care with Ghana as the case study area.

UNDERSTANDING PALLIATIVE CARE

Regarded as a response to suffering⁹, palliative care can be seen as a holistic approach to care and support; it takes into account physical, emotional, social, psychological and spiritual needs. Palliative care¹⁰ is the active total care of patients and their families, usually when their disease is no longer responsive to potentially curative treatment, although it may be applicable earlier in the illness; it provides relief from pain and other symptoms; it aims to achieve the best possible quality of life for patients and families; and even extends as necessary to support in bereavement. According to the World Health Organization (WHO), Palliative care refers to “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”.¹¹ Primarily, palliative care is aimed at providing the best possible quality life both for people approaching the end of life and for their families and care

⁹Eric L. Krakauer. Just “Palliative Care: Responding Responsibly to the Suffering of the Poor”. *Journal of Pain and Symptom Management*, Vol. 36 No. 5 November, 2008; (http://www.massgeneral.org/palliativecare/assets/pdf/Just_Palliative_CareResponding_Responsibly_to_the_Suffering_of_the_Poor.pdf)

¹⁰ *The Palliative Care Handbook: Advice on Clinical Management* (7th Ed), October 2010. In association with Wessex and Avon, Somerset & Wiltshire Cancer Services Specialist Palliative Care Units. (http://www.ruh.nhs.uk/For.../Palliative.Care/.../palliative_care_handbook.pdf)

¹¹World Health Organization, *Definition of Palliative Care*. (<http://www.who.int/cancer/palliative/definition/en/>) Accessed 8th October, 2014.

givers.¹² Providing quality life for beings in this state of life is to be understood as a vital process in the development of their human status. Palliative treatment, by its process and nature, provides a special and renewed moment for development. It is essential to improving the individual's quality and sanctity of life, well-being, comfort and dignity.

On January 23, 2014 in Geneva the Executive Board of World Health Organization adopted an innovative declaration urging countries to ensure access to pain medicines and palliative care for people with life-threatening illnesses.¹³ In the report, palliative care services are required for people with a vast range of health conditions, ranging from cancer, heart disease, and HIV, and tuberculosis.¹⁴ It is recommended for all persons (children, adult, aged, both males and females) who are engulfed in such situations. As an ethical responsibility and medicine's moral imperative¹⁵, it is the ethical duty of health care professionals to alleviate pain and suffering, whether physical, psychosocial or spiritual, irrespective of whether the disease or condition can be cured, and that end-of-life care for individuals is among the critical components of palliative care.¹⁶ It is almost impossible for a health care professional to avoid being called upon to care for people getting frailer as life ebbs away, to care for them at their dying and to have to help and support their loved ones afterwards. Derek Doyle¹⁷ therefore writes that at point of death, who can be insensitive to their pain, their breathlessness, their weakness and their fears? Who can forget how helpless they have felt at these times, how lost for words, how unskilled and unprepared. Doctors and nurses, whether generalist or specialist, can no more avoid these professional and personal challenges than they can deny or avoid death itself.

The emergence in 1987 of palliative care as a medical sub-specialty (mentioned in the Preface to the first edition of this book) has brought about improvements in care, research, professional education and training, and in the understanding by the public and the politicians of what needs to be done and what can be done for those at the loneliest time on their life journey. It has also had a downside. Many have come to suspect that providing palliative care requires unique people to do justice to this demanding work, unique skills to do it well, and more time than today's doctors and nurses ever have.

SIGNIFICANCE OF PALLIATIVE CARE

¹² Sue Lucas, *Palliative care: Issues and challenges*. (http://who.int/3by5/en/palliativecare_en.pdf)

¹³ UN: WHO Boosts Hope on Pain Relief, Palliative Care . Board Position Should Improve Access for Patients with Life-Threatening Illness. Available from: <http://www.hrw.org/news/2014/01/24/un-who-boosts-hope-pain-relief-palliative-care>.

¹⁴ *Strengthening Of Palliative Care as a Component of Integrated Treatment within the Continuum of Care*. (Available at: http://apps.who.int/gb/ebwha/pdf_files/EB134/B134_R7-en.pdf. Accessed on 11/10/2014).

¹⁵ *Ibid.*

¹⁶ *Ibid.*

¹⁷ Retired Consultant in Palliative Medicine; Vice President, National Council for Palliative Care; Founding Member and Adviser, International Association for Hospice and Palliative Care.

Palliative care is a distinct care approach which helps people with life-limiting conditions to live life as long as possible. Numerous studies have shown that palliative care services improve patients' symptoms, lead to better patient and family satisfaction, and significantly reduce long-lasting misery and posttraumatic stress disorder among family members who are bereaved. This contributes to both the quality and cost of overall health care.¹⁸

Though results from researches concerning the advantages of palliative care originate from countries with abundant health care resources, evidence is showing that the same benefits are derived with developing countries. Thus the significance of palliative care can be summarised as follows:¹⁹

- ✓ Provides relief from pain and other distressing symptoms.
- ✓ Affirms life and regards dying as a normal process.
- ✓ 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 patient's illness and in their own bereavement.
- ✓ Enhances the quality of life, and will also positively influence the course of illness.

PALLIATIVE CARE IN SUB-SAHARAN AFRICA

Findings from researches estimate that about half a million people die of terminal illness (cancer) in sub-Saharan Africa every year²⁰. Regardless of the importance of providing palliative care and recognition from the World Health Organization (WHO), studies show that the service provision in Africa remains erratic and incoherent.

The Global Atlas of Palliative Care at the End of Life, published by the World Health Organization and the Worldwide Palliative Care Alliance (WPCA), found that almost 80% of the global need for palliative services is in low- and middle-income countries²¹. Most of the sub-Saharan African countries were found in the group which had no known activity of

¹⁸*The Strategic Importance of Palliative Care within the Irish Health Service: Perspectives on Future Service Delivery* IHF Perspectives Series: No. 1. (Available at: <http://www.hospicefoundation.ie>) Accessed on: 10/7/2014

¹⁹ *Hospice Philosophy*. (Available from: http://www.hospice.co.za/pages/32341_hospicephilosophy).

²⁰ Richard Harding and Irene Higginson, *Palliative Care in Sub-Saharan Africa*. (<http://www.ncbi.nlm.nih.gov/pubmed/15936427>).

²¹ World Wide Palliative Care and World health Organisation, *Global Atlas of Palliative care at the end of life*. (Available from: http://www.who.int/nmh/Global_Atlas_of_Palliative_Care.pdf)

palliative care²², capacity building activity²³, isolated palliative care provision²⁴ and a generalised palliative care²⁵. Sub-Saharan African countries that had palliative care preliminary integrated in their health care systems²⁶ were few with only one sub-Saharan African country having an advance integration of palliative care²⁷.

Although there is the need for palliative care in the sub-Saharan countries due to chronic ailments such as HIV and Cancer, based on the mappings by the Worldwide Palliative Care Alliance, the current provision of palliative care in sub-Saharan Africa is at best limited, and at worst non-existence.

FACTORS HAMPERING BETTER PALLIATIVE CARE IN SUB-SAHARAN AFRICA

Studies from researchers on palliative care in sub-Saharan Africa bring to light numerous factors hampering the development of palliative care. Key among these factors includes little insight on palliative care (education), medical unavailability, and financial, psychological, social and religious barriers.

According to Harding R. Et al²⁸, most of the health professionals have little or no knowledge of the principle or practices in palliative care. In Ghana for instance, due to limited understanding, patients and health care professionals alike fear opioids and addiction. There is a fear amongst the people of Ghana that opioids symbolize the end-of-life²⁹. This fear has also led to resistance to properly treat pain and consequently influences pharmacies to limit supply of opioids available³⁰.

²² **Group 1** includes countries with no known activity of palliative care service. The sub-Saharan countries present there include Benin, Burkina Faso, Central African Republic, Guinea, Guinea-Bissau, Liberia, Togo, and Somalia.

²³ Countries in this group (**Group 2**) showed wide-ranging initiatives designed to create the organisational, workforce and policy capacity for hospice-palliative care services to develop, though no service has yet been established. Democratic Republic of Congo is the only sub-Saharan African country present in this group.

²⁴ **Group 3 a:** Sub-Saharan countries here include Angola, Cameroon, Ethiopia, Mali, Mozambique, Namibia, Nigeria, Lesotho, Gambia, Sierra Leone and Ghana.

²⁵ Generally referred to as **Group 3b**, Cote d'Ivoire is the only sub-Saharan country present in this category.

²⁶ These countries were present in **Group 4a** and they are Kenya, Malawi, South Africa, Tanzania and Zimbabwe.

²⁷ Uganda is the only sub-Saharan country with an advance integration of Palliative care in their health care system as at the survey. Thus, present in **Group 4b**

²⁸ Richard Harding, Kathleen M. Foley, Stephen R. Connor and Ernesto Jaramillo, "Palliative and End-of-Life Care in the Global Response to Multidrug-Resistant Tuberculosis", In: *The Lancet Infectious Diseases*, 2012; 12(8): 643-6.

²⁹ M. J. Fisch, Palliative Care Education in Ghana: Reflections on Teaching in West Africa. *J Support Oncol*, 2011;9:134-5

³⁰ *Ibid.*

Also, many countries cannot provide effective medical treatment to patients with life-threatening illness due for financial constraints. One other factor which seems to be a worldwide problem affecting palliative care treatment is the limited provision of pain relieving medications. Controlling or relieving pain is an essential part of palliative treatment, thus essential palliative care medications, especially opioids, are required for the delivery of quality palliative care. However, access to pain relieving medications is limited.

Mostly, in sub-Saharan Africa there exist various attitudes towards death and dying which are generally informed by cultural beliefs. Thus the arrival of palliative care as an end of life care remains a whole new thing to most of the countries and turning to that implies turning away from some beliefs and practices.

METHODOLOGY

Basically the paper relied on published articles and reports from researches made by scholars on Palliative care in Sub-Saharan Africa. Ghana being part of the sub-Saharan countries with palliative care services on the low, the research work gathered views from health professionals (65) in 7 hospitals and clinics as well as from a section of the general public (50) all within the regional capitals. Among health personnel were; nurses, midwives, medical doctors (pediatricians, gynecologists, general practitioners and psychologist) physician assistants, pharmacists in addition to health and ward assistants. Also, amid the general public were; teachers, traders, pastors, accountants, legal practitioners and students. The researchers employed the method of random sampling in selecting respondents from the general public and health institutions. Moreover, relevant data were accessed electronically from the Ghana Health Service, World Wide Palliative Care Alliance, Global Partners in Care (formerly Foundation for Hospice in Sub-Saharan Africa) and African Palliative Care Organization.

FINDINGS AND DISCUSSION

Demography

Data obtained from the field in this paper are both descriptively and graphically analysed. Respondents included 73 males and 42 females of different age groups. Respondents within the age group of 18-30 years had a majority of 61 respondents followed by those in 31-40 years (27), 41-50 years (18) and 51-60 years (9). However, there was no respondent within the age group of 60 years and above. While 9 respondents were separated in marriage, 48 and 58 respondents were single and married, respectively.

Among the 65 health personnel, 26 of them had been in their respective professions for less than 5 years, 15 were within 6-10 years, 13 within 11-20 years and 11 above 21 years. As per their profession and its obligation, it is believed that these respondents had received formal education in various health institutions in the country. On the other hand, respondents (50) from the general public had obtained diverse levels in education. The research revealed that respondents either had secondary or tertiary level of education. This is to say that the educational level of all respondents was above basic education (secondary -24, tertiary -19 and post-tertiary -7).

Perceptions on Palliative care:

Almost all respondents shared their views and knowledge about palliative care and its place and role in health care. 79 respondents indicated their awareness and knowledge about palliative care as against 36 who had no idea. Respondents gave the following explanations in respect of what palliative care entails. They stated that it is the care for people who have reached their old age and want to be treated as a child; special care for aged people; giving proper care to the aged or those who are almost dying, allowing them to enjoy the last moments of their lives as well as giving special care to people who have few days to live. Others stated that, palliative care is giving extra care and attention to people who have few days to live due to sickness and the process whereby near death patients are kept in a 'VIP' condition for the remaining part of their lives. Some respondents referred to it as a specialized medical care given to chronic and terminally-ill patients to help them feel better. It involves the care to treat emotional, social, practical and spiritual problems. Palliative care was also understood as a specialized area of health care that focuses on the relieving and preventing of the suffering of patients. They stated that palliative care relieves persons from symptoms, pain and stress of a serious illness whatever the diagnosis. Respondents added that people at this stage of care need and want everything to be done for them. However, many respondents were of the view that if any special care is to be given to any patient, it should be done immediately the sickness is noticed and not when they are close to death. When all respondents were asked whether or not they are aware of palliative care in health care in Ghana, 27 respondents said they were aware, while 99 said 'no'. This indicates the fact that palliative care is on the low in Ghana, perhaps many sub-Saharan states. It is to be added that respondents' understanding of palliative care provides a fairer knowledge and perception of the treatment and for that matter its relevance and purpose to persons who suffer due to ill-health and old age.

Among the 65 health personnel, 59 of them were of the view that palliative care is relevant in modern health care. Some respondents indicated that they were aware of few persons who have been given palliative care in Ghana. Among these respondents were 17 health personnel (out of 65) and 9 (out of 50) from the general public. These respondents mentioned not many patients and relatives as obtainers of palliative. They, however, indicated that they neither knew exactly all what the process entailed nor its system of care. Significantly, indicating their awareness of persons who are likely to receive palliative care, 40 respondent mentioned chronic/terminally-ill patients as major receivers of palliative, while 36 respondents mentioned people in old age (aged) as major receivers of palliative care, a number of 12 respondents mentioned near-death persons. It was however, realized that 27 respondents shared no idea in respect of the major receivers of specialized palliative care in modern health care.

Also, respondents (46); particularly health personnel indicated that aside palliative care, terminally-ill persons obtained other forms of specialized health treatment. They, however, failed to indicate whether or not this treatment can as well be classified as palliative care. However, further indications and responses proved this kind of health treatment not to be palliative care. This was termed by some medical practitioners as special attention for terminally-ill patients (during prognosis). The remaining 19 health personnel, on the other hand, did not indicate any awareness of a possible specialized care either than palliative care for terminally-ill patients. Respondents (the 45 health personnel), again, indicated that for patients with chronic/terminally diseases, the only special treatment which was offered them was by treating symptoms and pain via giving out drugs and injections (like anti-retroviral

drugs, analgesics, opioids) to patients and proper intensive attention/care. They indicated that the kind of special treatment at this level was necessarily ailment specific (thus, ailment type determines treatment/care).

Also, on the part of the general public, 43 respondents indicated that ‘yes’ people with terminal disease requires special treatment before their death, 5 respondents thought otherwise (who gave no reason for taking that stand), while 2 did not know of any special care. Among the 43 respondents, 16 of them mentioned palliative care, 12 mentioned home care and 15 traditional medicinal treatment. According to the general public, terminally-ill relatives were likely to receive treatment in health centers, church/spiritual homes, mosque, prayer camps and traditional healers. A majority of 22 respondents mentioned health centers (for general medical care, with no reference to palliative treatment) while a minority of 4 respondents mentioned prayer camps.

Table 1: Places of Treatment for terminal disease –General Public

Places Of Treatment For Terminal Disease	Frequency	Percent	Valid Percent	Cumulative Percent
A	22	19.1	44.0	44.0
B	5	4.3	10.0	54.0
C	2	1.7	4.0	58.0
D	3	2.6	6.0	64.0
E	3	2.6	6.0	70.0
A,B	6	5.2	12.0	82.0
A,E	4	3.5	8.0	90.0
A,C,E	1	.9	2.0	92.0
A,C	3	2.6	6.0	98.0
A,D	1	.9	2.0	100.0
Total	50	43.5	100.0	
Missing system	65	56.5		
Total	115	100.0		

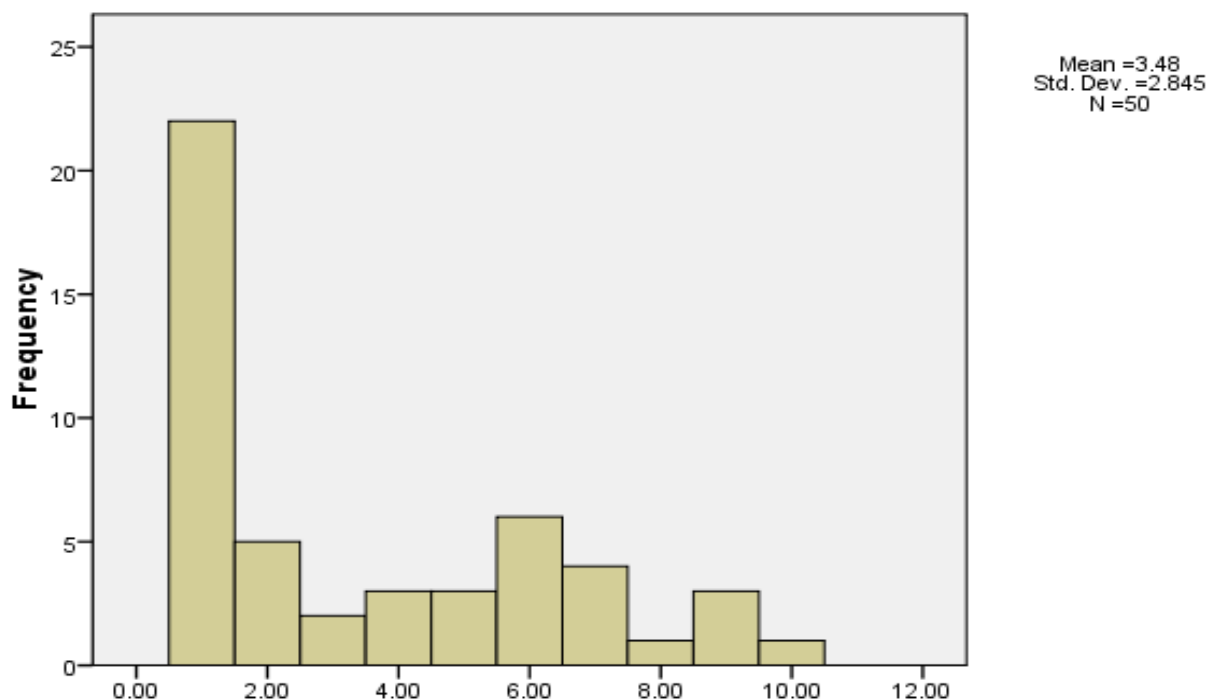
A=Health Centre

B=Church/Prayer Campsites

C=Mosque

D=Spiritual Homes

E=Traditional Medicine Men

Figure 1: Places of Treatment for terminal disease –General Public

Source: Opoku J. K., Addai-Mensah P. and Manu E. (October, 2014)

From the above table and figure, it is evident that respondents have diverse choice concerning treating terminal illness in the absence or lack of knowledge/awareness of palliative treatment. They indicated that they send people to these places due to the following reasons; less cost involved, effectiveness, religious beliefs and cultural/traditional responsibility. However, 33 respondents added that they will seek palliative care any time appropriate for their relatives and for themselves when the need arises, while 14 of them resented. The remaining 3 respondents failed to comment on this. This gives the implication that respondents who are members of the general public have little or no knowledge about palliative care and its practice in the communities or places for receiving health care.

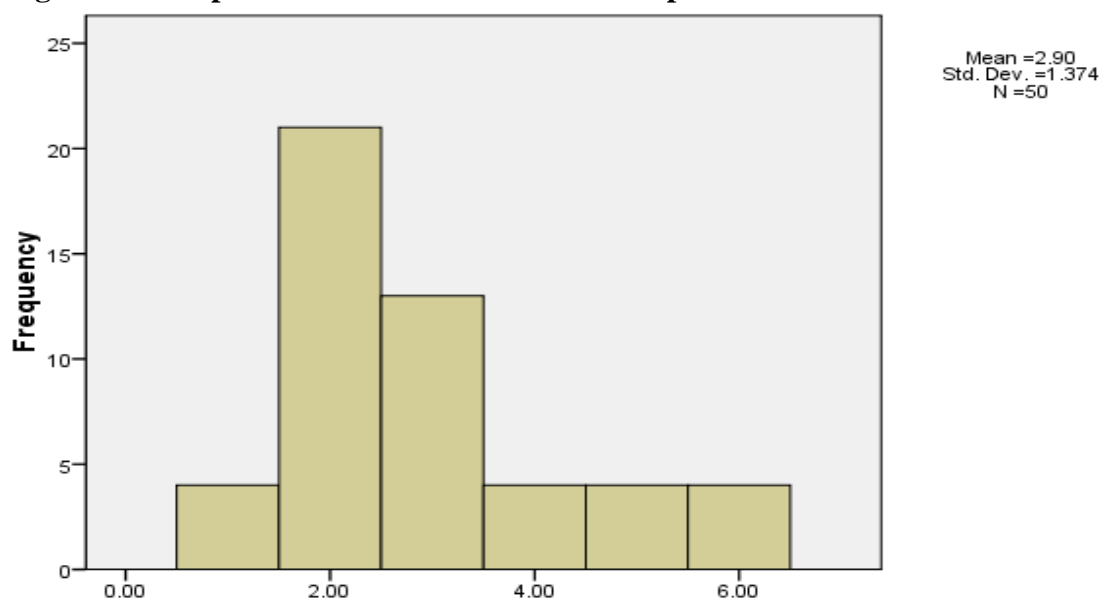
Factors hampering palliative care:

In addition, respondents believed that the presence/existence of palliative care in modern health care in Ghana will go a long way to influence interests in this form of specialized medical care. Respondents (general public) believed that the following factors were liable to influence/motivate their personal quest for palliative care. They included; treatment due to severe/terminal pain/symptom, emotional, social, psychological and spiritual support, holistic support for family members and existence/availability of the treatment. On the other hand, health professionals also indicated their reasons that may influence their quest for palliative care. The distributions of all responses by both groups of respondents are indicated below.

Table 2a: Reasons for palliative care -General Public

Reasons for Palliative Care -General Public	Frequency	Percent	Valid Percent	Cumulative Percent
Treatment due to severe or terminal pain/symptom	4	3.5	8.0	8.0
Emotional, social, psychological and spiritual support	21	18.3	42.0	50.0
Holistic support for family members	13	11.3	26.0	76.0
Existence/availability of the treatment	4	3.5	8.0	84.0
Death	4	3.5	8.0	92.0
Others	4	3.5	8.0	100.0
Total	50	43.5	100.0	
Missing System	65	56.5		
Total	115	100.0		

Figure 2a: Graphical distribution of reasons for palliative care -General Public

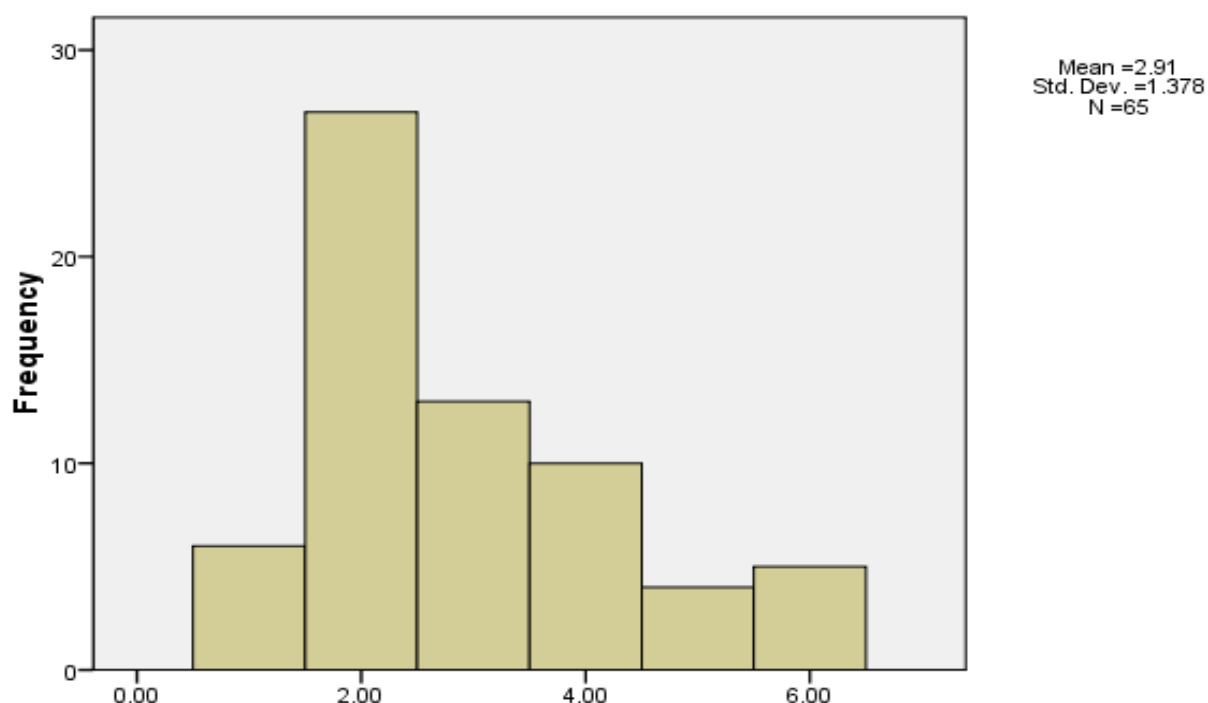


Source: Opoku J. K., Addai-Mensah P. and Manu E. (October, 2014)

Table 2b: Reasons for palliative care -Health Personnel

Reasons for Palliative Care -Health Personnel	Frequency	Percent	Valid Percent	Cumulative Percent
Treatment due to severe/terminal pain/symptom	6	5.2	9.2	9.2
Emotional, social, psychological and spiritual support	27	23.5	41.5	50.8
Holistic support for family members	13	11.3	20.0	70.8
Existence/availability of the treatment	10	8.7	15.4	86.2
Death	4	3.5	6.2	92.3
Others	5	4.3	7.7	100.0
Total	65	56.5	100.0	
Missing System	50	43.5		
Total	115	100.0		

Figure 2b: Graphical indication of reasons for palliative care -Health Personnel



Source: Opoku J. K., Addai-Mensah P. and Manu E. (October, 2014)

The tables and figures above clearly indicate that in one way or another, respondents are likely to go in for palliative treatment. The diverse reasons or factors cited gives the indication that

when available, there is the likelihood that respondents will opt for palliative care when the need arises.

Furthermore, from the data earlier discussed, it has been realized that the number of respondents (Ghanaians) who believed that palliative treatment is less/not practice is greater than those who believe that it is in existence. Respondents stated some factors as major elements that affect the provision of palliative care in Ghana. Among these factors, patients' inability to pay for palliative care (high rate) when instituted was mostly cited by respondents, while personal religious belief was of minority. Significantly, respondents believed that more than one factor were also responsible for hampering better palliative care. Respondents' views in respect of the factors that hamper palliative care in Ghana are indicated in the table and figure below.

Table 4: Factors affecting the provision of palliative care

Factors	Frequency	Percent	Cumulative Percent
A	7	6.1	6.1
B	16	13.9	20.0
C	29	25.2	45.2
D	22	19.1	64.3
E	7	6.1	70.4
F	10	8.7	79.1
A,C	3	2.6	81.7
A,C,F	4	3.5	85.2
B,C,D	2	1.7	87.0
B,C,D,F	3	2.6	89.6
B,C,F	8	7.0	96.5
C,D,F	1	.9	97.4
No idea	3	2.6	100.0
Total	115	100.0	

A=religious belief system

B=high rate of health care

C=patients' inability to pay for palliative care

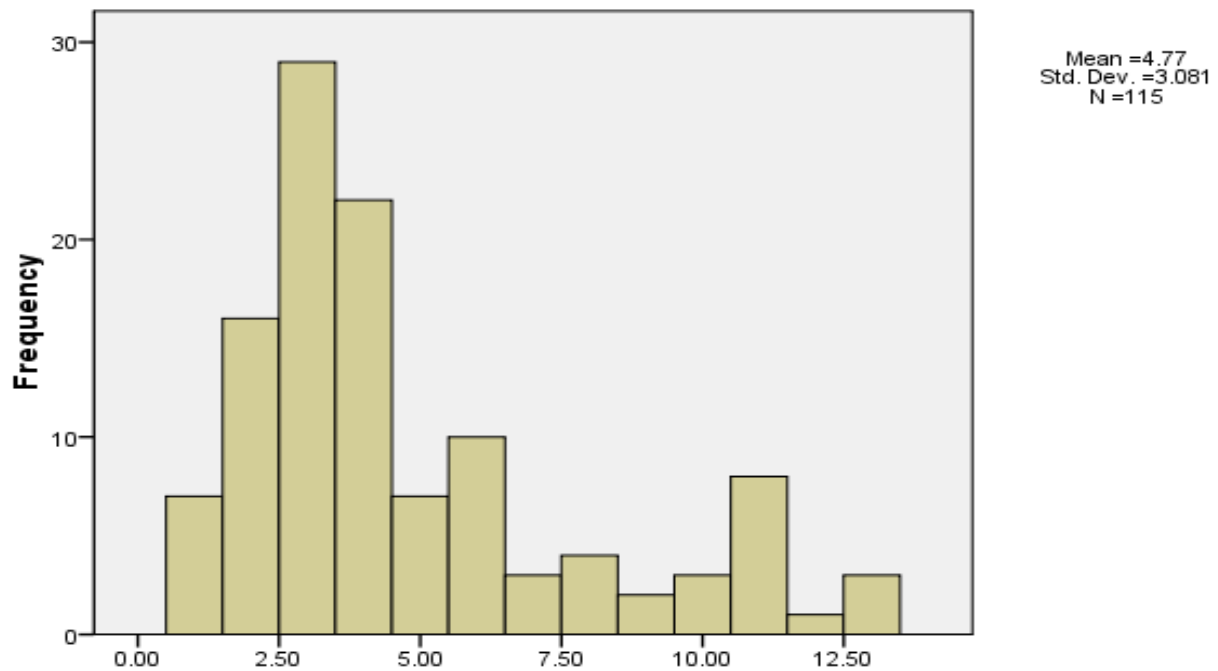
D=unavailability of treatment/drug/ procurement

E=socio-cultural background

F=lack of knowledge/education

G=No idea

Figure 4: Factors affecting the provision of palliative care



Source: Opoku J. K., Addai-Mensah P. and Manu E. (October, 2014)

In view of the above, 102 respondents stated that the above-stated factors can be eradicated in health care to ensure palliative care. However, 13 respondents believed that these factors cannot be eradicated to ensure palliative care. In the view of the 102 respondents, palliative care as a specialized medical care for dying and terminally-ill patients can be ensured when the following suggestions are guaranteed.

- Government should take full responsibility of palliative care.
- Proper establishment of palliative care should be available to terminally-ill persons.
- Public sensitization and education on the need and relevance of better palliative treatment for sick, dying and aged persons.
- If available, the care should be made accessible to everyone, both the poor and rich; young and aged.
- Proper funding of care by private organizations, national and international donors to support its establishment and continuous existence of the program.
- Proper sustenance of existing health facilities to make an introduction of palliative care and its sustenance, if absent, a possibility.

SUGGESTIONS AND CONCLUSION

In order to overcome these constraints in the development of palliative care services in most sub-Saharan African countries, several approaches should be taken. Firstly, there must be a definite policy for the implementation and delivery of palliative care in all countries. Most of the countries in this area do not have clear policies for the provision of palliative care in health care system. Judging from the survey of Worldwide Palliative Care Alliance Report (2011), on the whole, most of sub-Saharan African countries had no laid down policies for the provision of palliative care in their countries with few others in their preliminary stages and just one country in sub-Saharan Africa who had advanced the integration of palliative care in their health care systems. Governments of various countries should therefore set up a framework, implement policies that will fuse palliative care in the various health care systems and also organize programmes to deliver palliative care.

Findings from the study showed that most people including health practitioners had little or no knowledge about palliative treatment/care. Most medical schools in this part of the continent do not extensively teach about the provision of palliative treatment as compared those in Western societies. As result, all medical professional schools should endeavour to include basic training on palliative care for all health professionals. Those offering home-based care basically due to some beliefs (religious and cultural) should also be educated on specialized palliative treatment. This will help them to know that seeking proper (palliative) care is not only in the interest of the patient but the care giver, as well. An integral concept in the practice of palliative care is pain management, and that lack of essential medications needed to deliver palliative care should be addressed, although limited access to opioids seems to be a global problem of palliative treatment. This problem stems from the fear that these pain relieving drugs will be abused by people. These extreme regulations may not only cause unwarranted distress to patients, but to families and health care providers³¹. As a result, governments and countries must take up the initiative to accept responsibility to improve access to pain relieving medication. Since palliative care in most sub-Saharan countries has been door-driven, funders should support and sponsor activities.

Relieving suffering is a key obligation in health care practice. In view of this, palliative care - an approach to caring for people with terminal illness and to improve quality of life for aged individuals and family members affected by life-threatening illness -has become an approach in response to such suffering in health care. In order to overcome all these constraints and improve the development of palliative care services in the sub-Saharan region, both the governments of countries and the people in this region must develop the will to recognize and advance the course of palliative care, hence the absence of palliative care leads to needless misery for the vulnerable (patients and family). As a right needed to be enjoyed by every person, palliative care should be provided for all without any constraints in Africa and sub-Saharan Africa, in particular.

³¹ N. I. Cherny, J. Cleary, W. Scholten, et al. "The Global Opioid Policy Initiative (GOPI) Project to Evaluate the Availability and Accessibility of Opioids for the Management of Cancer Pain in Africa, Asia, Latin America and the Caribbean, and the Middle East: Introduction And Methodology". *Ann Oncol* 2013; 24 Suppl 11:xi7-13. [PubMed]

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