

REVIEW OF ARTICLE

PALLIATIVE CARE IN NIGERIA: CHALLENGES AND PROSPECTS

***Iornum Hembe Shambe**

**Department of Obstetrics and Gynaecology, Jos University Teaching Hospital*

Email : iornum@yahoo.com

Phone number: +234-7033011234

ABSTRACT:

Background: Health workers seek to cure ailments with surgery, medication and occasionally radiotherapy. In resource constrained settings such as that prevalent in Nigeria however, patients often present with late stage diseases where it is not practical to expect cures. Palliative care seeks to ease the suffering of the many patients who cannot be cured against the backdrop of late presentation of patients with life limiting illnesses. It is a relatively new concept in medical practice in Nigeria and has yet to be fully integrated into patient care while encountering limited successes and impediments by health practitioners, policy makers and occasionally clients.

Method: This is a review article on of various policies and publications concerning Palliative care in Nigeria using different search engines such as Pubmed and Google.

Conclusion: Palliative care implementation in Nigeria is still a work in progress with limited availability in health facilities in the country.

Key words: Palliative care, Pain relief, Oral morphine

INTRODUCTION

Palliative care is an approach that improves the quality of life of patients and their families facing the problems 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 spiritual¹. There continues to be an enormous need for palliative care based on the following statistics.

- over seven million people died from cancer in 2007²
- two million people died from the Acquired Immunodeficiency Syndrome (AIDS) in 2007³
- Over 70% of people with advanced cancer or AIDS experience severe pain⁴
- Thirty -three million people are currently living with HIV worldwide³
- 100 million people worldwide could benefit from basic palliative care⁵

Chronic medical diseases including malignancies are becoming of increasing public health importance in developing countries and although the burden of common cancers like cervical cancer is on the increase worldwide, its' burden appears higher in developing than developed countries⁶.

Patients in developing countries often present with advanced disease and require relief for their suffering and improving on their quality of life. Palliative care therefore does not seek to lengthen or shorten life but to improve quality of life⁷. This form of care is neither in competition with alternative models of care nor does it seek to replace them but should be part of a comprehensive health care system in patients suffering from HIV/AIDS and cancer where the patient is viewed holistically as an individual with physical, psychological, and social needs⁷. The World Health Organization (WHO) has named palliative care as one of four strategies to cancer control, with other three being cancer prevention, early detection and diagnosis, and treatment⁸.

Palliative care is meant to be provided as a continuum of care from the point of diagnosis of any incurable disease until the end of life using a team approach. Typically the team will consist of a physician and nurses trained in palliative care, a counselor, and a pharmacist. There are various models for palliative care delivery and they include day care support, Hospital palliative care team, palliative care clinic, in patient care and palliative care within in Home Based Care (HBC). All of the models are hinged on impeccable assessment and

treatment of distressing symptoms such as pain and its alleviation using the WHO analgesic ladder and use of oral morphine and adjuvant medication for patients with severe pain⁷.

Modern hospice and palliative care started in England in the 1960s principally with cancer patients and the Human Immunodeficiency Virus (HIV) epidemic focused attention on the need for palliative care⁷. The pioneering work of Anne Merriman working in Uganda in 1993 lit the palliative care fire that has been carried to University College Ibadan by Professor Soyawo and her co workers across a few centres in Nigeria.

CHALLENGES

The introduction of palliative care to medical practice in Nigeria has not been without its challenges some of which are shared with other countries in Africa and beyond are peculiar but a few of which appear peculiar to the Nigerian environment, There is an evident gap in knowledge occasionally in a health care workers who are providing palliative care, This is shown in a few studies in the South West of Nigeria. Elumelu working in University College Ibadan reviewed prescription patterns of Oral morphine solution over a 6 month period which showed only 1.1% of all prescriptions conformed to international guidelines of oral morphine prescription that emphasize dosage by the mouth, at four hourly intervals with a double dose at bedtime with prophylactic use of laxatives to combat the often troublesome side effect of constipation that oral Morphine causes⁹.

There also persists a reluctance by doctors in Nigeria and beyond to prescribe Morphine where it is available because of fear of addiction and it's supposed lethality even with appropriate use, this has been demonstrated by other workers even in developed countries with under prescription of pain relief for cancer patients because of fear of diversion of prescribed Morphine^{10,11}.

Knowledge gaps have also been identified even among health care practitioners that provide palliative care in terms of their understanding of the goals that palliative care seeks to achieve. This was demonstrated in a study in a tertiary centre in Ado Ekiti about the perceptions of nurses regarding palliative care with over 71% perceiving it to refer to solely control of pain¹². The lack of a nationwide population based cancer

registry in Nigeria has made it difficult for researchers to estimate the national burden of cancer and by extension, palliative care needs in Nigeria. This may provide a challenge in terms of planning and policy making. Even at that, smaller hospital based registries indicate that the incidence of cancer in Nigeria is on the increase. The Ibadan Cancer Registry recorded 1093 cases in 2001, with a steady increase to 1576 by 2005¹³. This scenario stretches a workforce in the health sector that already does not have adequately trained people in the area of palliative care.

PROSPECTS

The articulation of a National Cancer Control Plan in 2008 by the Federal Ministry of Health sought to reduce the mortality and morbidity from cancer as well as improve the quality of life of people suffering from cancer. It involved building capacity of health care workers in many areas including the provision of skills to provide palliative care and easing hitherto stringent restrictions on the supply of morphine powder^{14,15}. It is pertinent to note however that a criticism of the strategic plan is that the process by which the goals of the national cancer control plan are to be achieved have not been defined and its funding has remained a challenge¹⁶. This may however be considered a step in the right direction.

Introduction of palliative care into the curriculum of medical and nursing schools as well as Diploma and degree programs has been done in Uganda which is considered a success story of palliative care in Africa. This is an example that can be replicated in Nigeria and has begun in University of Ilorin Teaching Hospital.

CONCLUSION

A public health approach and advocacy will ease the path of providing palliative to those suffering from life limiting illnesses in Nigeria. This along with advocacy and continuous training of and retraining of health care workers using conferences and continuing medical education programs will make palliative care accepted among medical practitioners and patients. In the words of Archbishop Desmond Tutu; ' This is an issue that affects literally everyone on the planet. We would all like our lives , and the lives of those we love, to end peacefully and comfortably.'

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