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Do the Clinical Management Guidelines for Covid-19 in African Countries Reflect the African Quality Palliative Care Standards? A Review of Current Guidelines

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Abstract

Context. Palliative care should be a component of COVID-19 management to relieve suffering, improve patient outcomes and save cost.

Objectives. We aimed to identify and critically appraise the palliative care recommendations within COVID-19 case management guidelines in African countries.

Methods. The study employed systematic guideline review design. All guidelines from any country in Africa, of any language, published between December 2019 and June 2020 were retrieved through online search and email to in-country key contacts. We conducted a content analysis of the palliative care recommendations within the guidelines and appraised the recommendations using African Palliative Care Association standards for providing quality palliative care.

Results. We retrieved documents from 29 of 54 African countries. Fifteen documents from 15 countries were included in the final analysis, of which eight countries have identifiable PC recommendations in their COVID-19 management guidelines. Of these eight, only one country (South Sudan) provided comprehensive palliative care recommendations covering the domains of physical, psychological, social and spiritual wellbeing, two (Namibia and Uganda) addressed only physical and psychological wellbeing while the remaining five countries addressed only physical symptom management.

Conclusions. Comprehensive palliative care which addresses physical, psychological, social and spiritual concerns must be prioritized within case management guidelines in African countries. J Pain Symptom Manage 2021;61:e17−e23.

Key Words

Palliative care, COVID-19, clinical guideline

Key Message

- We systematically reviewed palliative care recommendations within COVID-19 management guidelines from 15 African countries.
- Our findings set precedence on current palliative care recommendations for patients who have severe COVID-19 illness in Africa.
- Policymakers must urgently prioritize palliative care within the COVID-19 guidelines and attune the guidelines for Culturally competent care.

Background

COVID-19 was declared a pandemic by the WHO within three months of its emergence.[1] The number of cases and deaths are escalating in African countries. As of 19 January 2021, over 3 million cases and seventy-nine thousand deaths have been officially reported from all 54 African countries.[2]

COVID-19 case fatality rates range from 0•35 to 11%.[3] Risk factors for severe illness and mortality in COVID-19 include being elderly, the presence of pre-

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Accepted for publication: 22 January 2021.

0885-3924/$ - see front matter
https://doi.org/10.1016/j.jpainsymman.2021.01.126

existing health problems, multi-morbidities,[4] and being of black and ethnic minority heritage.[5] In addition to these, severity and case fatality patterns in Africa may also be influenced by the lowered immunity in individuals with existing and undiagnosed conditions such as HIV/AIDS, tuberculosis infections, respiratory, cardiovascular, and metabolic conditions. Approximately 14% of patients have been reported to have the severe form of the disease, and 0•16% to 5% needed intensive care admission to manage severe respiratory symptoms.[6,7] Inadequately resourced health systems in Africa face challenges of providing needed critical care medications and mechanical ventilators for intensive care.[8]

COVID-19 patients and their families report distressing multidimensional symptoms and concerns. These ranges from distressing physical symptoms such as fever, breathlessness, fatigue, cough;[9] psycho-social concerns, and spiritual /existential distress caused by the threat to survival, worry, and clinical uncertainty.[10] WHO recommendations for isolation mean families and patients risk additional distress and poor access to social support.[10]

Palliative care is a core component of Universal Health Coverage and is required by WHA73.3 resolution as part of member state responses to COVID-19.[11] However, the neglect of palliative care among the dying and the resulting unnecessary serious health-related suffering is well established.[12,13] WHO's omission of palliative care from initial COVID-19 response plans has been highlighted.[14] This underscores the general neglect of palliative care within global health response. After wide advocacy,[14,15] this has now been updated.[16] Palliative care must be a component of COVID-19 case management to relieve suffering, improve outcomes for patients and their family members, and save costs.[17,18] Within limited resources, palliative care teams are supporting complex decision making for patients with severe COVID-19 illness.[19] Evidence from previous fatal viral epidemics demonstrates that hospice and palliative care play essential roles including providing protocols for symptom management, training non-specialists, being involved in triage, and providing psychosocial and bereavement care.[20]

Given the low coverage of palliative care services and fragile health systems in Africa, health care professionals should be supported to deliver palliative care through clear comprehensive case management guidelines. This review aims to identify and critically appraise the palliative care recommendations within COVID-19 case management guidelines in Africa. The research questions were;

1) Are palliative care recommendations present within COVID-19 case management guidelines in these countries?
2) What are the specific palliative care recommendations?
3) Are the palliative care recommendations adequate when compared to the African Palliative Care Association (APCA) standards for providing quality palliative care across Africa?

Method

Design

We systematically reviewed COVID-19 clinical case management guidelines from all 54 countries in Africa using systematic guideline review methods.[21] Systematic guidelines review is a design which involves nine systematic steps for the analysis of existing guidelines as part of the process of guideline development and contextual adaptation.[21]

Systematic Search for Guidelines

We searched the Guidelines International Network database for specific guidelines for the management of COVID-19 cases from Africa. In addition, we searched online sources including government agencies and ministry of health websites. In situations where guidelines were not available online or where documents available do not meet our inclusion criteria, key contact persons (ministry of health official, leaders of national palliative care associations, or palliative care champions) were contacted to obtain these documents. The process was coordinated by the African Palliative Care Association (APCA), the regional body that supports and coordinates the development and sustainability of palliative care. We emailed key contact persons in 38 countries.

Guidelines Selection

Inclusion Criteria. We included guidelines for case management of COVID-19 published between December 2019 and 10 June 2020, written in any language. Our search was restricted to Guidelines prepared by a national government ministry or nationally recognized government body tasked with this responsibility. We included only guidelines prepared by the government as we were interested in assessing whether the government is considering and prioritizing palliative care in the delivery of care to COVID-19 patients. Where a country has more than one version of the guideline, the most recent version was used.

Exclusion Criteria. We excluded guidelines that were regional or hospital-based; guidelines that were prepared by NGOs or national associations not commissioned by the government; high-level strategy documents focusing on National Preparedness and

Response Plan; Opinion pieces, commentaries, communique, and editorials.

Data Extraction (Selection and Coding)

A data extraction sheet was designed, piloted, and used to extract the following variables: 1) characteristics of each guideline, i.e., country, title, date, and version of the guidelines. 2) Verbatim palliative care recommendations and content using related terms such as supportive care, supportive treatment, supportive therapy, hospice care, and end of life care. OA and MAO reviewed and extracted all guidelines together. Any guideline for which inclusion was unclear was discussed with second reviewers (AO, EC, EN, and KN). AO, EC, EN and KN also conducted independent checking and verification of all extracted data so that data extracted from each guideline was reviewed by a second researcher, and any disagreement was adjudicated by a third reviewer (RH). Guidelines in French and Portuguese language were independently forward translated by official French (HA and SB) and Portuguese speakers (BG) and their translations were compared for consistency.

Data Analysis

We conducted a narrative synthesis of the extracted data. We analyzed the palliative care-related contents of the guidelines using content analysis. In order to grade adequacy of the palliative care recommendations, we developed a matrix based on Principle 2 of the APCA standards for providing quality palliative care across Africa.[22] The APCA standards document was developed through wide consultation with service beneficiaries and providers to establish a framework for the development of evaluation and performance indicators to facilitate palliative care program improvement and development across Africa. The document contains 37 standard statements grouped under four main principles including organizational management, holistic care provision, children's palliative care, education and training, and Research and Management of Information.[22] As we were reviewing case management guidelines and protocols, we assessed adequacy with respect to Principle 2 (Holistic Care provision) which has 17 standard themes (Standards 2.1- Planning and coordination of care, 2.2- Access to Specialist Palliative care, 2.3- Information and communication, 2.4- Pain and symptom Management, 2.5- Management of opportunistic infections, 2.6- Management of Medications, 2.7- Psychosocial care, 2.8- Spiritual care, 2.9- Cultural care, 2.10- Complementary therapies in palliative care, 2.11- Care for special needs populations, 2.12- End of life care, 2.13- Grief, Loss and Bereavement care, 2.14- Ethical care, Human rights and Legal Support, 2.15- Clinical Supervision, 2.16- Inter-disciplinary team and 2.17- Providing support to care providers) (Table 1). This principle is most relevant to the direct patient and family care and support.

OA and MAO independently graded and checked the adequacy of the COVID-19 case management guidelines assigning fully met, partially met, not met, or not applicable. EN, EC, AO, and KN verified the grading and any disagreement was resolved through discussion. "Fully met" was assigned when a recommendation in a guideline comprehensively addresses the APCA summary statement for a standard. "Partially met" was assigned when a guideline's recommendation addressed some or part of the quality standard summary statement. "Not met" was assigned when a guideline's recommendation was deemed not to have met any aspect of the quality standard. Recommendations were assessed as "Not applicable" where we could not assess a standard due to the complexity of the criteria and where it is not directly involving patient care.

Results

Of the 54 African countries, 31 documents from 14 countries (Nigeria, South Africa, Ghana, Libya, Tunisia, Chad, Cameroun, Djibouti, Equatorial Guinea, Eritrea, Morocco, Cote D'Ivoire, Cape Verde, and Algeria) were retrieved through online searches and 23 documents from responses of 16 Key contact persons (Cote D'Ivoire, Togo, Mozambique, Namibia, The Gambia, Botswana, Tanzania, Uganda, Burundi, Malawi, Kenya, Zimbabwe, Ethiopia, Eswatini, South Sudan, and Sudan). Two responded with no document to provide (Mauritius) or referred us to their website for documents (Rwanda). We had no response from the remaining 20 countries after two reminders were sent and we could not identify a key contact in Niger and Sao tome and Principe. In total, we retrieved 55 documents from 30 countries. Fig. 1 shows the process of retrieval and selection of documents. We included 15 documents (11 in English and four in French) from 15 countries (Algeria, Botswana, Cote D'Ivoire, Eswatini, Ethiopia, Gambia, Morocco, Namibia, Nigeria, South Africa, South Sudan, Sudan, Tanzania, Togo, and Uganda) in this review. 40 documents were excluded with reasons indicated in Fig. 1.

Data extracted from the guidelines are shown in Supplementary File 1. Of the 15 countries' guidelines reviewed, only eight countries (Algeria, Botswana, Namibia, South Africa, Sudan, South Sudan, Togo, and Uganda) had identifiable inclusion of palliative care or supportive care. Of these eight, only one country (South Sudan) provided comprehensive palliative care recommendations covering the domains of physical, psychological, social and spiritual wellbeing, two (Namibia and Uganda) addressed only physical and psychological wellbeing while the remaining five countries addressed only physical symptom management.

Table 1
The adequacy of the Guidelines Against the APCA Standards for Quality Palliative Care in 15 Countries

Countries	2.1: Planning and Coordination of Care	2.2: Access to Care	2.3: Communication in Palliative Care	2.4: Pain and Symptom Management	2.5: Management of Opportunistic Infections (OIs)	2.6: Management of Medications	2.7: Psychosocial Care	2.8: Spiritual Care	2.9: Cultural Care	2.10: Complementary Therapies in Palliative Care	2.11: Care for Special Needs Populations	2.12: End-of-life care	2.13: Grief, Loss and Bereavement Care in Adults	2.14: Ethical Care, Human Rights and Legal Support	2.15: Clinical Supervision	2.16: Inter-Disciplinary Team	2.17: Providing Support to Care Providers
Algeria	+	X	x	+	‡	+	x	x	x	x	x	x	x	x	N/A	x	+
Botswana	+	+	x	+	‡	+	x	x	x	+	+	x	x	x	N/A	x	+
Cote D'Ivoire	+	+	+	+	x	+	+	x	x	x	+	x	x	x	N/A	+	+
Ethiopia	+	+	‡	+	‡	+	+	+	+	x	+	+	+	+	N/A	x	+
The Gambia	+	+	x	+	‡	+	+	x	x	x	+	x	x	x	N/A	x	+
Morocco	+	X	x	+	‡	+	x	x	x	x	x	x	x	x	N/A	x	+
Namibia	+	+	x	+	‡	+	+	x	x	+	+	x	x	x	N/A	x	+
Nigeria	+	X	x	+	‡	+	x	x	x	+	+	x	x	x	N/A	x	+
South Africa	+	+	x	+	‡	+	x	x	x	+	+	+	x	x	N/A	x	+
South Sudan	‡	‡	‡	‡	‡	+	‡	+	+	+	‡	x	x	+	N/A	‡	+
Sudan	+	+	+	+	‡	+	x	x	+	+	+	x	x	+	N/A	x	+
Eswatini	+	X	+	+	‡	+	+	x	+	x	+	+	x	+	N/A	x	+
Tanzania	+	+	‡	+	‡	+	‡	x	+	x	+	‡	‡	x	N/A	‡	‡
Togo	+	+	x	+	‡	+	x	x	x	+	x	x	x	x	N/A	x	+
Uganda	+	+	+	+	‡	+	+	x	x	x	‡	x	x	+	N/A	‡	+

++, fully met.
+, partially met.
x, not met.
N/A, not applicable.

Namibia and Uganda mentioned psychosocial support only when referring to the care of pregnant women with COVID-19.

Other countries (Eswatini, Ethiopia, Cote D'Ivoire, Gambia, Morocco, Nigeria, and Tanzania) have statements of recommendations which are relevant to palliative care within the document. Although Tanzania's guidelines did not have an identifiable section on palliative care, it provides a set of comprehensive recommendations covering the domains of physical, psychological and social wellbeing with culturally specific recommendations. It also covered psychosocial support for families and healthcare professionals and ensuring effective communication with patients and families. Cote D'Ivoire, Ethiopia and Eswatini also recommended some level of psychosocial support. Further details on the palliative care recommendations proposed in the guidelines are in the extraction table (see Supplementary File 1).

All 15 guidelines proposed recommendations on the management of physical symptoms, especially managing breathlessness with oxygen and nebulizer or bronchodilators, secondary bacterial infections with antibiotics, and fever with paracetamol. Reference to sharing information and communication with regard to prognosis and goals of care (Standard 2.3) was only present within Cote D'Ivoire, Ethiopia, South Sudan, Sudan, Tanzania, Uganda, and Eswatini guidelines. Recommendations on meeting spiritual needs (Standard 2.8) were only available in Ethiopia and South Sudan guidelines. In addition, only guidelines from South Sudan, Eswatini, Ethiopia, and Uganda have recommendations on decision making and choice in care; while only guidelines from South Sudan, Eswatini, Ethiopia, Tanzania, and Uganda, made recommendations on supporting families whose relations have severe COVID-19 disease.

Table 1 reveals the adequacy of the palliative care recommendations within the guidelines and protocols when evaluated using standard statements listed in principle 2 of the APCA standards for providing quality palliative care. The majority of the standards were not met. Standards 2.1 (Planning and coordination of care), 2.2 (Access to Specialist Palliative care), 2.4 (Pain and symptom Management), 2.6 (Management of Medications), 2.11 (Care for special needs populations), and 2.17 (Providing support to care providers) were partially met by the majority of the guidelines and only standard 2.5 (Management of opportunistic infections) was fully met by 14 of 15 guidelines. Standard 2.15 (Clinical Supervision) was deemed not applicable and the remaining standards were unmet in the majority of the countries.

Discussion

Our study set out to critically appraise the case management guidelines for COVID-19 in Africa for their

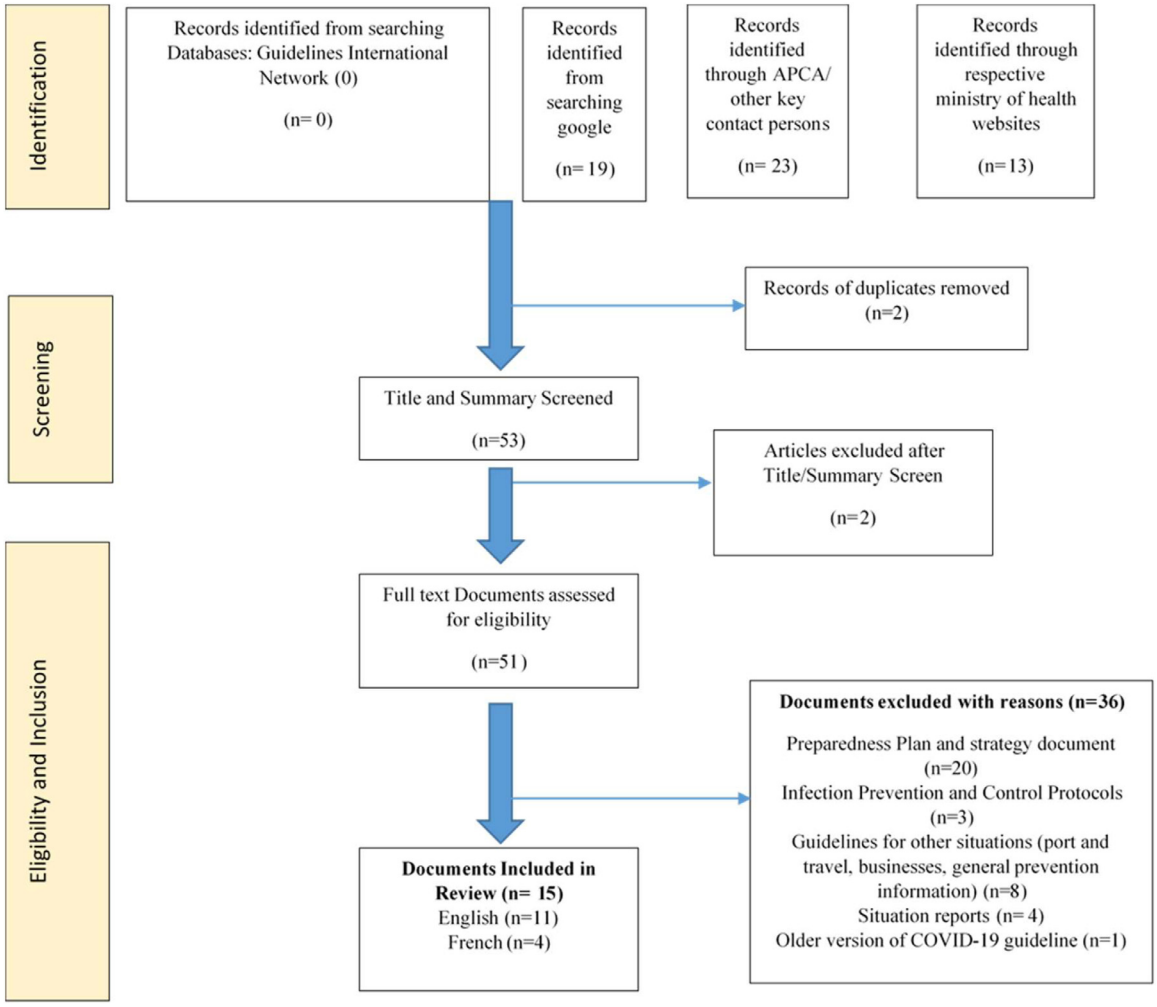

Fig. 1. PRISMA flow chart of guideline selection.

palliative care content and evaluate the adequacy of this against APCA standards for quality palliative care provision across Africa.

The majority of the countries with specific sections on palliative care are in Southern and Eastern Africa. This reflects the development of palliative care in these countries with strong advocacy networks and well-developed services and national policies.[23] Also, these countries named their treatment and therapeutic management sections supportive therapy or supportive treatment to recognize the absence of curative treatment for COVID-19 as against other countries.

While some case management documents made recommendations for some symptoms, there were no recommendations on other palliative care problems that may accompany breathlessness in COVID-19 such as delirium, anxiety, and cough.[24] Also, except for guidelines in South Sudan, Ethiopia, Eswatini, and Uganda, there were no clear recommendations for giving patients and families choices regarding care decisions such as the use of mechanical ventilation. In a continent where healthcare delivery has been known to be paternalistic[25] and palliative care training and education are limited,[23] there is need for explicit recommendations on shared decision making, fostering autonomy of choice, providing psychosocial care, patient-centerd referrals to palliative care, and encouraging adequate communication with the patient and families at a time of high anxiety.

The importance of religious and cultural practices around dying in contributing to the spiritual needs of patients and families has been documented.[26] However, most of the guidelines we reviewed did not meet the standards of spiritual and cultural care (2.8 and 2.9 respectively). While there were sections on managing dead bodies in recommendations from some countries, caring for the dying is omitted in all the case management guidelines. This suggests a lack of priority on supporting the dying phase to reduce distress and suffering.[12] This might also be indicative of the pervasive reticence and taboos around discussing the death and dying in African cultures.[27]

There are limitations which may affect the interpretation of our findings. The wording of the APCA

standard influenced our analysis. The specific wordings within the APCA standard is arguably HIV/AIDS and cancer-focused. For example, standard 2.5 heading and summary statement read, "Management of Opportunistic Infections (OIs): Appropriate management of opportunistic infections, including tuberculosis (TB), improves the quality of life among people living with HIV and AIDS, and those with other life-threatening illness." We applied this by looking at treatment recommendations for secondary/ superimposed bacterial pneumonia infections within the context of COVID-19; although this might not be considered as part of the roles of palliative care in other contexts. We acknowledge that the HIV/AIDS pandemic and cancer have largely influenced the development of palliative care in Africa. However, there is a wider debate that people with other progressive serious illnesses aside from HIV/AIDS and cancer have poor access to palliative care in Africa. This highlights the need for APCA to review and expand the standards to make it more inclusive within the context of wider serious health-related suffering.[28] Our findings are also based on COVID-19 management guidelines that we were able to retrieve online or from key contact persons. We are aware that there might be other documents from government and NGOs which address some of the areas that we identified as weak. In addition, we only did forward translation for guidelines in the French language; therefore some meanings might have been lost in translation.

Furthermore, we applied standard 2.6 (the management of medications) by considering oxygen and other medication recommended in majority of the guidelines as serving palliative care or supportive therapy purposes. In the context of poorly resourced health systems in Africa, even oxygen for the management of breathlessness (which many of the guidelines recommended) may be unavailable, and as such might require rationing. In addition, the detailed criteria for this standard are related to medications commonly used in palliative care such as opioids which require proper training to prescribe and use. Therefore, clear guidance must also be recommended on the use of opioids as an additional line of management for breathlessness in patients dying of COVID-19[24] and systems must be put in place to ensure their availability.

Like the HIV/AIDS pandemic before it, the COVID-19 pandemic might catalyze the development of palliative care in Africa to meet the needs of the non-COVID population. The focus of palliative care is on managing serious health-related suffering[12,28] and this may be the type of care we can offer some patients with severe COVID-19 disease while we conduct further research into developing vaccines and curative treatment. There is extensive palliative care evidence on approaches to managing serious health-related suffering. It is therefore imperative for governments, policymakers, and stakeholders in Africa to prioritize comprehensive palliative care which addresses physical, psychological, social and spiritual concerns in the management of patients with COVID-19.

Role of the Funding Source

No funding was declared for this study.

Patient and Public Involvement

It was not appropriate or possible to involve patients or the public in the design, or conduct, or reporting, or dissemination plans of our research.

Data Sharing Statement

No additional data available.

Conflict of Interest Statement

All authors have declared no conflict of interest.

Acknowledgments

We will like to appreciate the efforts of our French-speaking colleagues who helped with the translation of the guidelines written in the French language- Hamid Benalia and Sabah Boufkhed. We also thank all the key contact persons who responded to our emails with COVID-19 case management guidelines from their respective countries. You have made this possible. Thank you.

Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.jpainsymman.2021.01.126.

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