

COVID-19: time to rethink strategy for palliative care in resource-poor settings

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The Coronavirus pandemic (COVID-19) presents an unprecedented impact on healthcare facilities and health professionals globally, especially in resource-poor settings, including Africa. This article aims to highlight the challenges of providing palliative care in Africa and to forecast what this means in light of the public health issues surrounding COVID-19. According to the Coronavirus in Africa tracker (BBC News, 2020), there are 925,369 confirmed cases of COVID-19 reported in Africa, out of which 19,605 are confirmed deaths as of 31st July 2020. While 577,947 cases are reported to have recovered, there remains a high number of active confirmed cases of 327, 818 in the continent. These numbers could be higher, but are underreported, due to ineffective reporting systems, the capacity to diagnose on a large scale, and people not recognising the symptoms of COVID-19. With the anticipation that COVID-19 will have devastating effects on Africa (Hopman et al, 2020; Nkengasong and Mankoula, 2020), this will cause a surge in the need for palliative care and medical supplies. The World Health Organization (2018) defines palliative care as any support that improves the quality of life of patients and their families experiencing life-threatening illnesses, through the prevention and relief of suffering, whether physical, psychosocial or spiritual care.

In this context, palliative care will mean the care for COVID-19 patients, particularly for those cases where conventional treatment is ineffective and/or life-supporting measures are unsuccessful; that is, the patients whose health conditions have declined to the extent that any life-supporting treatment is failing, and the persons become labelled as terminally ill. Universal health coverage goals consider Palliative care as a critical component; however, palliative care has not been given the needed attention in African countries, and this disproportionate attention results in significant health-related suffering at the end of life (Knaul et al., 2018; Rhee et al., 2018; Sleeman et al., 2019).

During recent times in the COVID-19 pandemic, many people suffering from terminal illnesses may have died in isolation and therefore, palliative care is important, as part of the response to COVID-19. In health resource-poor settings such as Africa, limited state-of-the-art intensive care and life-sustaining equipment and staff, and unavailability of palliative support services for the majority of the population, might lead to more deaths (World Economic Forum, 2020). This also highlights the additional responsibilities for healthcare professionals in dealing with the symptoms related to psychological issues, stigma, and bereavement (Mahase, 2020). Also, there has been a recent call for a policy guide to improve care for cancer patients in this context, and recent research has recommended the use of a more conservative way of managing COVID-19 cases, such as palliative care, since most patients with severe symptoms do not benefit from ventilation (Fusi-Schmidhauser et al, 2020). However, most African countries lack the capacity of providing for palliative care.

A recent review suggest the need for palliative care services to respond promptly (Etkind et al, 2020), and the need for African governments to prioritise and ensure that palliative care services are available to COVID-19 patients (Afolabi et al 2020). In addition, there are also increasing reports of mental health challenges as a result of COVID-19 and social distancing (European Commission, 2010; Hall et al, 2019), such as anxiety and post-traumatic stress disorder (Dorjee, 2020; Xiang et al, 2020; World Health Organization (WHO), 2020a; 2020b). Although the understanding of the full impact of COVID-19 on mental health, including depression and anxiety, is not conclusive (Salifu et al., 2020), COVID-19 could be stigmatising as other diseases due to its dreadful nature. Evidence suggests that stigma is associated with mental health (Goffman, 1963), resulting in a reluctance to seek help or self-disclose experiences of mental health challenges (WHO, 2020a; 2020b). As such, mental health experiences that otherwise would have been treated with little or no medical intervention may become clinical, where the individual, or in this case, individuals, may require medical treatment, including medication and/or hospital admission. Indeed, research evidence suggests that social isolation and stigma are a precondition for increased experiences of mental health challenges and a trigger for mental health symptoms (European Commission, 2010; Hall et al, 2019). As stated by the United Nations' (UN) Secretary-General Policy briefing (Guterres, 2020)

'The mental health and wellbeing of whole societies have been severely impacted by this crisis and are a priority to be addressed urgently.' (Page 2)

Therefore, as we wait for a vaccine, and with the increasing number of COVID-19 cases in Africa, strategic thinking into the readiness for dealing with the mental health of patients and loved ones of those needing palliative care and intensive care services is also urgently required (Kissler et al, 2020).

Other substantial issues of particular concern in Africa are high levels of epidemics such as HIV/AIDS and tuberculosis (TB) (Kagaayi and Serwadda, 2016), making a greater number of the population susceptible to COVID-19 (Nordling, 2020). People with these conditions (i.e. HIV/AIDS and TB) are considered immunosuppressed, likely to have reduced lung functional capacity and other underlying medical conditions, putting them at them at higher risk of having worse experiences of COVID-19, and a high number of deaths (Shuchman, 2020;

UNAIDS, 2020). This makes palliative care a critical aspect of COVID-19 response in resource-poor low- and middle-income countries, particularly in the continent of Africa.

In addition, data from Public Health England (2020) suggests a disproportionate impact of COVID-19 on people from Black, Asian and minority ethnic (BAME) groups. The Public Health England (2020) report further indicates that the Intensive Care National Audit and Research Centre (ICNARC) had a significant fraction of critically ill COVID-19 patients admitted in intensive care units (ICU) from the most deprived (25.0%), usually from BAME communities. The ICNARC (2020) reports that, based on ethnicity, out of the 1840 patients receiving critical care for at least 28 days for COVID-19, Asian constituted 18.8%, Black (11.3%), Mixed (2.4%), White (58.3%) and others (9.3%). This statistic means that close to one-third of the critically ill COVID-19 patients were from BAME (Asian and Black), and this represents a higher percentage when compared to the national data of the BAME population in the UK. The ICNARC (2020) further reports that BAME COVID-19 patients are more likely to die while receiving critical care than Whites and Mixed ethnic group. Although the above reports were based on data from the UK population, it could place African and other resource-poor countries from Asian backgrounds more at risk of being affected by COVID-19, thus raising concerns about increasing palliative care services in resource-poor low- and middle-income countries.

The anticipated increase in the number of patients needing palliative care in Africa, therefore, calls for a strategy for palliative care services, in expectation of increasing COVID-19 cases in general and among vulnerable groups who will require specialist palliative care management (Gilbert et al, 2020). The provision of adequate palliative care facilities will not happen in a vacuum, but with the will of those entrusted to make decisions for and on behalf of the people - policymakers, health experts, and government. Although most countries in Africa have inadequate healthcare systems that affect their capacity to conduct evidence-based surveillance and laboratory investigations, however, with a strong desire by policymakers and healthcare providers to provide adequate and equitable healthcare, this will be achievable. We believe that this can be achieved through the provision of rapid credit facility from the International Monetary Fund, IMF, to help resource-poor low- and middle-income countries mitigate the economic and health impact of COVID-19 (IMF, 2020).

Furthermore, although literature supports the emergence of active palliative care services in a few African countries (Rhee et al, 2017; 2018), the majority of African countries do not have palliative care resources, creating a challenging situation for managing the complications associated with the pandemic among patients with palliative care needs. Indeed, Africa has a greater population of BAME community and, having increased cases of immunosuppressive conditions such as HIV/AIDs and TB, is at much higher risk (Nordling, 2020; UNAIDS, 2020). However, the limited healthcare provision, inadequate psychosocial support, such as mental health and spiritual support, pose significant challenges. As such, there is a worrying possibility that family and friends of people needing palliative care may not be able to support them during their last days of care (Busolo & Woodgate, 2016).

Few African countries have palliative care integrated into their health systems, fewer have specialist services, and these are not coordinated (Court & Olivier, 2020). Thus, there will be the need for a unified care pathway that combines sporadic, hospital-based palliative care with home and community-based services during COVID-19 outbreaks. For example, in Ghana and Nigeria, the designated facilities to support people with long-term conditions who are likely to die with or from COVID-19 do not have a palliative care facility. This is partly due to limited facilities for palliative management and a lack of health professionals with the expertise to deal with such cases.

To conclude, palliative care provision is generally poor and uncoordinated in Africa, and there is a fear that with increasing COVID-19 cases, most palliative patients may be deprived of adequate care. This is due to the lack of resources, timely or adequate treatment, especially with existing high incidence of other underlying medical conditions such as HIV/AIDs and TB, which are associated with immunocompromised health status. Therefore, low- and middle-income countries within Africa could stand better prepared by making a rapid reconfiguration of the service capacity to deal with palliative cases, supporting and empowering family caregivers to provide emotional and psychological support. It will also include organising intensive in-service palliative care training for health workers to stand in, when the number of patients needing palliative care increases, and simultaneously providing mental health care to those who need it.

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