

End-of-life experiences and expectations of Africans in Australia: Cultural implications for palliative and hospice care

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Abstract

The ageing and frail migrants who are at the end of life are an increasing share of migrants living in Australia. However, within such populations, information about end-of-life experiences is limited, particularly among Africans. This article provides some insights into the sociocultural end-of-life experiences of Africans in Australia and their interaction with the health services in general and end-of-life care in particular. It provides points for discussion to consider ethical framework that include Afro-communitarian ethical principles to enhance the capacity of current health services to provide culturally appropriate and ethical care. This article contributes to our knowledge regarding the provision of culturally appropriate and ethical care to African patients and their families by enabling the learning of health service providers to improve the competence of palliative care systems and professionals in Australia. Additionally, it initiates the discussion to highlight the importance of paying sufficient attention to diverse range of factors including the migration history when providing palliative and hospice care for patients from African migrant populations.

Keywords

Afro-communitarian ethics, African migrants, cultural competence, end-of-life care

Introduction

Australia is one of the most culturally diverse populations in the world, and the population continues to grow in diversity of language, religion, history and country of origin.¹ According to the 2011 Census, over a quarter (26%) of Australia's population were born overseas, and a further one-fifth (20%) had at least one overseas-born parent. The Census also reports that Australians identify themselves with over 300 separate ancestries, and almost half (49%) of longer standing migrants and 67% of recent arrivals spoke a language

other than English at home.² This increased diversity brings about diversity in the cultural beliefs, attitudes, values and patterns of behaviour in the Australian population that could be different from the mainstream Western-based beliefs, attitudes and values.

This diversity is expected to bring differences in the way(s) people view and experience end of life in Australia. It is well acknowledged that experiences of end of life in any community bring issues at the heart of people's identities to the fore.³ People's faith, customs, traditions and core values all play part in our confrontation with mortality. At the same time, the dying and their loved ones must deal with both physical and psychological pain. In this context, the provision of culturally appropriate and ethical end-of-life care is essential.³ Traditional practices of caring for the dying used in the African countries may not be the norm in Australia.⁴ African cultures are based on collectivist values, and older people and the sick are cared for by their extended family. Every member of the extended family has a role to play and is a source of support. This could, however, change when African cultural values are challenged by the culture in the new environment. It is also clear that most African migrants do not have extended families in Australia⁵ to support them as they become frail and terminally ill.

For these reasons, it is important that we understand the history, culture and ethical issues related to the end-of-life care of African people, as doing so will support the provision of culturally appropriate and ethical end-of-life care to these new and emerging communities.

Population movements between Africa and Australia have a long history, originally starting in the 1800s. However, those who immigrated to Australia prior to 1991 were mainly African-born persons with European descent.⁶ The immigration of the majority of African-born persons of black ethnic African origin only started after the increase in the intake of humanitarian entrants after the 1990s. This might have been influenced by three factors among others: the abolition of the White Australia policy in 1973, the end of apartheid in South Africa in 1994 and the eruption of major political crises in East and Central Africa and later in West Africa in the 1990s.^{7,8}

Current estimates inform that there are over 250,000 Africans in Australia,⁶ and the majority are humanitarian entrants who have witnessed brutal wars and endured substantial challenges in their countries of origin and countries of asylum.⁸ The majority have been forced to flee their countries of origin en masse to neighbouring countries and live in refugee camps sometimes for decades. Due to these experiences, many Africans have arrived in Australia with poor level of education, health, English language proficiency and employment skills, which put them at a disadvantage from the beginning. These refugee experiences and associated mental disorders and stigma are also reported to have created barriers for the African community members to access appropriate end-of-life care.⁹

With this background, this article aims to provide some cultural insights into how some African communities perceive the provision of health care in general and end-of-life care in particular and advocate for the consideration of appropriate ethical framework that take African cultural and ethical values into account. Informed by a phenomenological study of end-of-life experiences of some Africans that we have observed in Australia and our own lived experiences, this article provides some points for discussion to enhance the capacity of current health services to provide culturally appropriate and ethical services. In other words, this article provides insights and additional information to policymakers, health practitioners and academics to enhance both their understanding and cultural competence to contribute to and/or improve end-of-life care for Africans in Australia. This article also contributes to the provision of culturally appropriate and ethical care for African patients and their families by enabling two-way learning to improve the competence of palliative care professionals.¹⁰

It is, however, important to place one caveat – the intention of this article is not to put all Africans into one box nor is it to promote cultural essentialism; hence, it should not be construed as such or used to stereotype Africans in Australia per se.¹¹ 'In a culturally diverse society it is as important to remember our shared humanity as well as our differences' (p. 312).¹⁰

Africans and access to health-care services in Australia

As identified above, the majority of Africans in Australia are humanitarian entrants who, as a result of their background (life as refugees) and cultural beliefs, experience barriers when accessing culturally appropriate health services within Australia.^{9,12-14} Although these barriers can be complex and culture specific, health service (including palliative and hospice care services) barriers among Africans in Australia can fit into what Murray and Skull¹² call the 'hurdles to health', including economics and employment, cultural differences, language difficulties, an undertrained workforce, legal barriers and the impact of current Australian policies.

A prolonged stay in refugee camps has left the majority of Africans with significant disadvantages including low literacy and low skill base. This in turn has become a hurdle to accessing meaningful employment opportunities. At times, even when they have the skills, the 'lack of recognition of overseas qualifications, lack of references in Australia, and lack of support to transition into work experience programs' (p. 92)¹⁵ create high level of unemployment and/or underemployment among Africans. These factors can lead to many being trapped within the vicious cycle of poverty, poor health outcomes and lower access of health-care services. Linguistic and cultural differences also impact on access to health-care services. For example, the majority of Africans originated from oral and collectivist traditions that tend to rely on religious and community elders, who in some cases could be the first point of call including when accessing some health-care services. As such, it has been noted that within the African communities, 'religious leaders and community elders are traditionally regarded as persons of wisdom, experience, and high standing to whom one can bring personal or family problems for guided resolution' (p. 129).⁹

Because Africans are new and emerging communities in Australia,⁵ studies describing experiences of these populations and how they access palliative and/or hospice care in Australia are difficult to find. However, studies of similar populations from the United Kingdom and United States show that awareness of and access to palliative and hospice care services are lower among people of African descent and other minority ethnic groups compared to the general population.^{16,17} Additionally, palliative and hospice care services are either virtually unknown or have only been established recently in African countries. For example, the African Palliative Care Association (APCA)¹⁸ was formally established only recently (in 2004) in Tanzania by 28 palliative care trainers from across Africa. It is therefore plausible to postulate that the majority of Africans in Australia would have lower awareness and lower access to palliative and hospice care services when compared to the general Australian population. This reduced and unequal access to end-of-life care among Africans in Australia raises some ethical questions and violates the desire for justice in the health services.¹⁹

We therefore argue that understanding the history, culture, religious and spiritual experiences and attitudes towards death, dying, pain and suffering exhibited by the majority of Africans in Australia is of high importance. Additionally, understanding the ethical/philosophical perspectives of Africans and ethical issues associated with their experiences is critical to ensure equitable access to end-of-life care in these communities. To substantiate these points, we will present a case study from an Ethiopian community as a milieu to the discussion, which will be followed by a presentation of some insights into the understanding of these meanings, experiences and perceptions informed by our own lived experiences and work with Africans. We will also highlight some of the ethical perspectives and issues related with end-of-life experiences of African people that need to be considered and propose the inclusion of Afro-communitarian values to enhance the provision of culturally appropriate and ethical services to Africans and other migrants.

Case study

Mr Dagne (pseudo name) was a male from Ethiopia in his 40s who was admitted to a palliative care ward after his struggle with cancer. Mr Dagne arrived in Australia as a humanitarian entrant and was diagnosed

with cancer a year after his arrival. He had been taking treatment for several years before his admission to the palliative care ward. One of the authors had known him for over 4 years; he had visited him in his house as Dagne went through the ordeal of cancer. This case study documents the authors' observation and interaction with Mr Dagne before and after his admission.

At the first visit to the palliative care wards (1 week after admission), Dagne seemed physically weakened, although his spirit was as vibrant as ever. The Ethiopian tradition demands that 'a man shows courage and resilience no matter what the situation'. This is also strengthened by the religious belief that 'death is only a way to a better life – life with your God'. These customs and beliefs seem to have permeated Dagne's contemplation as he dealt with dying on a daily basis. During this visit, he was calm and collected, and his smile conveyed the sense that 'everything was well'. Of course, it was not – death was near, at least that was how one feels visiting the palliative care ward. People were here for end-of-life care, for their last days in life. But perhaps to the Ethiopian, or African psyche for that matter, 'the last days are also the important days' – as it is in these last days that one makes and is expected to make peace with everyone.

Dagne had an unflinching will to live and a radiant and positive attitude to what is considered a negative experience. His family was always beside him, and it was not easy for them to let him be cared for by others at the palliative care ward. However, when the doctor advised that Dagne be transferred to the palliative care, they had to agree mainly out of respect of authority rather than preference. Traditionally, such an arrangement would be less acceptable (at least in rural Ethiopia). His wife, children and even his relatives would be considered as people who let their loved one down. Thus, they would have preferred to take care of him at home by themselves. These last days are days where friends and relatives gather around the dying person talking to each other and with the dying person. Even those who may have had differences with the dying person are expected to visit. These are also days when various spiritual and religious leaders (priests, pastors, sheikhs, traditional healers, etc.) spend time with the person. Again traditionally, this is also considered as the right time to reconcile with people and God and make things right.

Where Dagne came from, it is common to find family members who may not have had regular contact with the dying person while she/he was well to turn up when they hear the news that a member of their family is dying. Ironically, dying seems to evoke a strong desire on such person to visit and do something for the family member or relative who is dying. In some cases, people leave whatever they were doing and carry whatever money they may have saved (even borrowed) and travel to where the dying person is and do whatever they can to save him/her. When Dagne was hospitalised, many people travelled to see him from across Australia – to pay their last respect to make things right before 'God takes him away'. He had more visitors during his time in palliative care than he would normally have, and his room at the palliative care ward was one of the busiest. These visitors and their acts were intended to give Dagne a 'good death' or a good send-off. However, this clashed with the norms in the ward and created extra work and concern to the nurses and other staff who were not accustomed to this culture. Nurses were trying their best to let people know that there were other patients and that Dagne's visitors needed to be quiet and respectful.

A few days later, Dagne passed away, and the Ethiopian community and other Africans gathered in big numbers in the palliative care ward. Many were crying loudly and wailing, while others were standing in the narrow corridors with sadness and a sense of great loss. Some were talking to the nurses who seem to have been taken by surprise by the unfolding drama and sheer number of Africans who turned up at the palliative care ward. There was an observed frustration on the part of nurses and doctors as no one expected the Africans to cry and wail in the ward. Although the nurses tried their best to empathise with the community, it was clear that the health-care system was not prepared for such an event and perhaps it looked difficult for nurses to handle the situation appropriately.

Finally, a priest had to come to prepare the body for funeral, after which Dagne was buried in a cemetery. This did not, however, stop people from crying. People were crying and wailing even louder as they went to the cemetery (a council cemetery). The funeral ceremony continued to his house. The house was turned into

a communal mourning place where people cried, shared meals and spent sleepless nights for at least 7 days. Of course, this would have had significant health and economic impacts on the family.

This case study provides an insight into the end-of-life experiences of one African (Ethiopian) and his family and community's interaction with health-care services, particularly end-of-life care. In this sense, it is only a story of one subculture and does not reflect the enormous diversity of experiences of individuals of the African continent and even Ethiopia, which has over 80 ethnic groups. However, as a case study, we believe that it is also a story of a community and its traditions coming to terms with new ways of dealing with death and dying and is instrumental in enabling a wider discussion of both cultural and ethical issues related to end-of-life care of African people in Australia. The case study also provides an indication as to how the dead are mourned in some African cultures here in Australia. This has implications on health service delivery.

African culture, end-of-life experiences and care

Although culture is often a contested idea, Sonia Nieto²⁰ defines culture as something that:

... consists of the values, traditions, social and political relationships, and worldview created, shared, and transformed by a group of people bound together by a common history, geographic location, language, social class, and/or religion. (p. 139)

Culture includes not only what we touch, see or smell – the 'tangibles' such as the colourful African dresses and the peculiar dance moves – 'but also less tangible manifestations such as communication styles, attitudes, values, and family relationships'. These less tangible cultural expressions are as important as the tangible ones, and they enable us to understand how a group of people communicate or what attitudes they may have to a certain phenomenon like end of life or dying. For the anthropologist Sir Edward Taylor,²¹ 'Culture' is simply that complex whole that includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society.

The Africans in Australia have acquired knowledge, beliefs, morals, customs, communication styles, attitudes and values that influence their actions in the Australian society. It is important to pay attention to these cultural beliefs as they influence ethical perspectives of these populations and practices of end-of-life care.²² However, it will be an impossible task to reflect the enormous diversity of the African culture in this article. Hence, we propose to base our discussion around some identified common African cultural values (these are also Ethiopian cultural values) such as the 'sense of community life', 'good human relations', 'sacredness of life', and 'sacredness of religion'^{23,24} and their influence on both the ethical perspectives of Africans and their attitudes towards end-of-life care.²⁵ To enrich our discussion, we will draw some examples and lessons from the Ethiopian case study presented earlier.

A strong sense of community and human relations

Life in the African culture (including the Ethiopian culture) is often communitarian, and the idea of community is central to the African ethos.^{23,26–28} This communal way of life brings not only family members or relatives but also people who identify themselves as part of 'a community' to participate in communal activities such as taking care of the elderly or the sick and frail. It is a general norm and expectation that members of the African community spend time together to celebrate, mourn and perform other day-to-day duties and rituals. In general, human relationship is valued over material possessions, and sense of pride is often driven not by what you have but who you have – 'your people'. Many African authors suggest that this strong sense of community and human relation has its roots in African moral theory of Ubuntu or 'Afro-communitarianism' – the idea that 'a person is a person through other people'.^{26,27,29–31} An Afro-communitarian moral perspective

is essentially relational in the sense that the individual is considered in light of his family and community. This is different from Western bioethical models that focus on individuality. In the Afro-communitarian ethic, the individual has the moral obligation to be concerned for the good of others and to think of oneself as bound up with others.²⁷ This has practical implications to how questions of patient autonomy particularly those related with confidentiality are dealt with. While Western bioethical models give priority to patient autonomy and hence privacy is strictly upheld, Metz and Gaei notes that 'the privacy of an individual will not be as weighty in an Afro-communitarian ethic'. This is mainly because the individual has duty to family members and the community and that family members and the community have a stake in the individual's health.

The influence of Afro-communitarian ethic is evident in the way Africans in Australia care for the sick and the dying in their communities. In the event that a member of a family is unwell or terminally ill, close and extended family members consider it their responsibility to take care of the person. Anecdotal evidence also suggests that other community members offer psychological security to the individual by visiting and making sure that all is taken care of. For example, in the Ethiopian case, we see that both his family members and other members of the Ethiopian community were in close contact with Dagne and provided him with the support he needed. This has implications to how end-of-life care to Africans in Australia is planned and carried out.

The Afro-communitarian ethic and the strong sense of community also influence the care preference of Africans. There is evidence that the majority of Africans prefer to be taken care of at home by family members instead of institutions. For example, a needs assessment study undertaken in Uganda shows that the majority of patients (mainly HIV/AIDS) prefer to be cared for at home and that 87% of the caregivers were family members who tended to be very supportive.³² In the study, 65% of patients considered their pain and other symptoms as a problem, but their main concern was the fear of death and abandonment. In a way they did not want family members to leave them alone in the hands of professionals. The study concluded that home was the best place to care for the terminally ill in such a culture. Studies of ageing in new and emerging migrant populations in Australia have also reported similar findings and indicated that the old and the frail in these communities prefer to be cared for at home rather than in aged care facilities.^{33,34} Similarly, a study of African Americans facing end-of-life decisions reported that African Americans prefer to have family and friends by their side towards the end of their life.³⁵ Again, this sense of helping or caring for a family member has direct implications to how end-of-life care is provided.

Likewise, there are suggestions that life in the African community is based on the philosophy of live and let live.²⁴ People may help one another without demanding immediate or an exact equivalent remuneration. For example, we have observed Africans volunteering to help their community members to adjust to life in Australia including assisting their peers learn to drive and access Centrelink services; yet they may not register themselves as formal volunteers. Additionally, community members visit each other just to check whether there are any problems or issues that need to be addressed, and they cherish conversations with other members of the community. This sense of good human relation based on Afro-communitarian ethic is the most valuable attitude to be encouraged, particularly in relation to providing effective palliative and hospice care in what is an individualistic society. These values and associated practices in the African Community are similar to what is consistently known as community social capital and have been identified as a strong predictor of good health outcomes in populations where they are practised.^{36,37} However, whether current health-care systems are designed to tap into such community assets and integrate them into the public health-care system is questionable. This article advocates that alternative transcultural ethical frameworks that incorporate Afro-communitarian ethical principles be adopted and that health professionals learn more about these perspectives for their own benefit and that of their patients.

An ethical framework that incorporates perspectives such as the Afro-communitarian ethic will better enable nurses and doctors to understand and provide culturally appropriate and ethical services to

communities from collective cultures. This argument is also supported by Johnstone and Kanitsaki,³⁸ who after studying the ethics of advance care planning in diverse groups in Australia noted that in collective cultures, contrary to Western bioethics, group consensus and decision-making are more valued than individual decision-making and ‘family sovereignty and family determination supersedes individual-sovereignty and self-determination’. This is an important point to note as the distinction clarifies some of the clashes between perspectives based on communitarian ethic and the primacy of autonomy in normative Western bioethics, which guides nurses and other practitioners in the West.

Sense of sacredness of life and religion

The idea of 'sanctity' of life is one of the central notions that permeate the African conscience. Often it is considered an abomination for a person to help others end their life or take their own lives under any circumstances.²⁴ In the Ethiopian culture, if a family member takes their own life, it leaves a stain of shame for the remaining family members, which may be difficult to deal with at their funeral. Such sense of sacredness of life also influences ethical perspectives of Africans in relation to ending the life of loved ones. It is considered that the decision to end or not to end the life of a loved one is not a decision to be made by human beings; consequently, Africans may decide to keep a loved one on life support as long as it takes as it is considered a moral obligation to do so.³⁸ For instance, although we were unable to find related Australian studies, Taxis³⁹ points out that African American culture emphasises living and prolonging life, whereas the traditional Western approach favours helping people plan for and cope with eventual death. This study also reported that African Americans are more likely to keep a person on a life support longer. We anticipate the attitude of Africans in Australia to be similar. This is an important insight to nurses, doctors and other practitioners to consider particularly when managing decisions of African family members and their consent in relation to life support to terminally ill patients and even when communicating the death of loved ones. It also presents an ethical issue related to the autonomy of the patient.

One of the ethical questions around end-of-life care in the use of life-sustaining interventions is the question of who makes the decision whether it is necessary or appropriate to use an intervention. In Western ethics, there is an emphasis on patient autonomy, and it is often argued that the patient is the one to decide whether it is necessary or appropriate for him or her to use such intervention. However, as pointed out by Searight and Gafford,⁴⁰ some cultures such as the African culture may not place high value on the principle of autonomy, and an emphasis on autonomy alone could potentially 'isolate rather than empower' a patient. To avoid such dilemma particularly in the case of Africans in Australia, we suggest that other alternative decision-making models that incorporate Afro-communitarian ethical principles that respect the patient's preference to involve their families or community to handle such matters be considered.⁴¹

Religion, spirituality and end-of-life care

The sense of respect and the idea of sacred also fill the African as she/he approaches religious matters and elements.²⁴ In Ethiopian and other African cultures, religion and spirituality are integral components of life and health practice. As such, religion and spirituality play significant role in the way Africans view end-of-life care.³⁵ In fact, as Verhoef and Michel²⁸ argued, for the African, life and religion are interconnected and everything exist 'within a unified whole' and that morality evolves from the process of living 'grounded in the context of communal life'.

The importance of spiritual care in end-of-life care is well documented in the literature, and some indicate that doctors who have involvement in the care of a patient with a terminal illness could be involved in spiritual care.⁴² The literature seems to limit spiritual care to medical practitioners. Contrary to this, our observations of the African communities in Australia indicate that spiritual care can also be provided by family members and the community. For example, in the Ethiopian case study, we see that Dagne had received spiritual care from family members, religious leaders and other community members. Thus, it is important that services and systems allow patients and their families to decide what form of spiritual support they need.

The relationship between spirituality and religion and end-of-life care can be expressed in two ways. First, spirituality and religion are used to cope with pain, illness and death.^{17,35} In many African cultures, spiritual and end-of-life experiences are often associated with meeting 'your creator' or 'going to God' as we alluded to in the case study, and in some cases, pain is considered as a test from your creator. Consequently, by understanding pain and death in this manner, patients may draw strength to cope with pain and dying. Second, spirituality and religion influence the decision of patients in the last days. As indicated in the case study, 'the last days are important days' for the dying. Thus, how and with whom these last days are spent and who

provides spiritual care are all important decisions that need to be considered in providing end-of-life care to these populations.^{35,42}

In Ethiopian and other African cultures, the dying person has the moral obligation to be concerned for the spiritual good of others, and one of the ways that this obligation is discharged is by correcting the wrongs of the past through forgiveness. Thus, the dying person is expected to seek forgiveness from those who might have been hurt by her/his actions. For these reasons, we argue that Afro-communitarian perspectives of spiritual care that take into consideration the spiritual and religious beliefs of patients need to be included in the end-of-life care plan accompanied by a clear definition of what constitutes spiritual care and who provides spiritual care.⁴² We also argue that nurses and doctors have ethical responsibility to ensure that religious and spiritual needs of their patients including discharging their moral obligation towards the good of others (through reconciliation) are well catered for without any prejudice or judgement.

Refugee experience and end-of-life care

As indicated in the 'Introduction' section, the majority of Africans in Australia are former refugees who have been subjected to horrendous atrocities, and in some cases, they may have witnessed many of their relatives killed.⁸ Besides these atrocities and ordeals, the African communities are also new communities who are strangers in a different land. As such, challenges that include understanding the English language and legality around end-of-life and other health service provision are expected to affect their experience of and access to end-of-life care.²⁵ The refugee experiences compounded with the difference in culture influence the way Africans in Australia expect and experience end-of-life care on one hand and may act as barriers for these communities to access health-care services in general and end-of-life care in particular on the other. These socio-economic and cultural disadvantages are significant social determinants of health affecting their overall health outcomes and ultimately posing significant challenges to their settlement. They also create compounded effect on the use of health services by these populations.⁴³

The nuances in the different cultural backgrounds, languages and experiences of Africans are often not well understood by service providers, and this has created difficulty among service providers to create new programmes or adjust current programmes and services to cater for the needs of Africans.⁴⁴ The African communities have raised these issues in a wide range of forums and conferences including the African resettlement in Australian Conference in 2007.⁴⁵ Their awareness of the challenges have also led to the formation of many African community organisations across Australia including the African Communities Council of South Australia (ACCSA), the African Communities Council of Tasmania (ACCT) and the African Think Tank (ATT). Yet the issues remain largely unresolved.

This raises some ethical issues related with distributive justice, and we argue that it is the ethical responsibility of doctors and nurses to support African patients in these circumstances. While issues surrounding access and participation are complex, doctors and nurses can support their patients using ethical principles

of justice by advocating for the right of their patients to access quality end-of-life care. The complexity of the health-care system compounded by the lower literacy level and English language competency should not necessarily deter Africans from accessing quality end-of-life care. Whether people are from a refugee background or not and irrespective of their background, people deserve a dignified death and using ethical principles could enable just that.

Conclusion

The literature is well established to affirm that 'culture plays a critical role in how patients, families, and health-care providers view end-of-life' and how such understanding could enhance the cultural competence and culturally sensitive ethical practices of practitioners.^{25,46,47} This article has endeavoured to shed light upon some of the cultural and experiential differences and nuances displayed by Africans in Australia and how these may affect their views and experiences of, as well as access to, end-of-life care in Australia. These differences have implication for how palliative care and hospice services are provided to Africans in Australia and elsewhere and deserve further attention if meaningful and equitable care is to be provided to these communities. It is also important and necessary for systems to learn about the religious beliefs of the

patient and how these religious beliefs come into play in the process of dying and death. Generally, as noted by Volker,⁴⁸ it is important to consider some of these cultural, spiritual and experiential differences that inform patients' and their families' choices of end-of-life and other care in planning, any patient care plan in general and end-of-life care in particular.

It is also hoped that the different cultural nuances discussed above will enhance the ability of nurses and doctors to understand their own biases and their ability to provide culturally sensitive care to people of varying background including Africans. The insights and cultural information provided in this article are expected to contribute to the preparation and delivery of better training for nurses, doctors, social workers and personal support workers to enhance their cultural competence.^{46,47,49} We also hope that our call for the adoption of appropriate ethical frameworks that include Afro-communitarian principles will create interest among researchers and practitioners to look for alternative ethical models that integrate individual autonomy and the common good.

However, as pointed out earlier, it is not the intention of this article to stereotype Africans. It is important to understand that beyond the common cultural expressions that we tried to convey in this article, African community groups and individuals will have differences that are shaped by the complex interplay of collective norms driven from their 'culture' and the environment they live in. It is equally important to note that while we strongly advocate for the adoption of an appropriate ethical framework that incorporates Afro-communitarian principles in the provision of end-of-life care, our goal is not to create a dichotomy between Western bioethical principles and an Afro-communitarian ethics. We acknowledge that there are some universal ethical principles that are common to both African and Western cultures; however, by showing the cultural nuances and differences, it is our intention to encourage the development of an ethical framework that can be applied across different cultures.

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