

Palliative Care Needs of People Living in a Newly Established Informal Settlement

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Abstract

Evidence-based guidance for the delivery of palliative care in Africa is rare. Identifying the palliative care needs of this community could contribute evidence to guide the services provided, and could add to the body of knowledge of palliative care in Africa. Using a retrospective chart review research method, the researchers aimed to describe the palliative care needs of people using a nurse-led palliative care service situated in a newly established, underserved, informal settlement in Tshwane, Gauteng, South Africa. A quantitative inductive content analysis method was used to analyse the data. The sample realised at 48 (n = 48). The ages of patients ranged from 21 to 78 with the median age 47. Nearly half (45.9%) of the patients were functionally illiterate. The records reflected 85 different medical diagnoses and some patients suffered more than one illness. The most common diagnosis was HIV/AIDS (54.2%). Furthermore, records revealed 379 health problems, ranging from 1 to 17 per patient, with an average of 8.1. Most problems were physical symptoms (50.3%; n = 195), while 38.8 per cent (n = 147) were psychosocial problems and 9.8 per cent (n = 37) were spiritual problems. The need for pain relief (89.6%; n = 43) was the greatest, followed by the need for emotional support. Patients suffering from various medical diagnoses used the services of the palliative care clinic. Patients' care needs revolved around relief from total pain. Therefore, nurses should become aware of the suffering of palliative patients living in resource-poor communities, and through meticulous assessment, identify their main care needs.

Keywords: palliative care; palliative care needs; most prevalent problem; resource-poor community



Introduction

Palliative care focuses on people living with life threatening illnesses and their families. Palliative care improves the quality of life by preventing and relieving suffering related to pain, other distressing physical symptoms, and psychosocial and spiritual problems by means of thorough assessment and treatment (World Health Organization 2016). Africa faces unique challenges in terms of palliative care provision as it is estimated that 5 to 10 million people living on the continent will need palliative care each year (Powell et al. 2013, 163). However, in 2011, 28 out of the 54 countries in Africa had no palliative care services. Although palliative care was available in other countries, it was underprovided. South Africa is the country with the highest number of palliative care services on the African continent, with only 210 facilities to serve a population of slightly more than 50 million people, relating to 1 service for 239 000 of the population (Lynch, Connor, and Clark 2013, 1102).

Although the worldwide development of palliative care is deep-seated in oncology (Clark 2007, 430), the benefit of this care approach was recognised to manage people with other progressive chronic diseases such as organ failure, frailty (Murray et al. 2005, 1007), HIV and AIDS, tuberculosis (Powell et al. 2013, 162–163), motor neuron disease and chronic obstructive pulmonary disease (Kuebler, Davis, and Dea Moore 2005, 25). Van Niekerk and Raubenheimer (2014, 138), in a study investigating the palliative care needs of hospitalised patients, found that 54.8 per cent of patients admitted to general medical wards in public hospitals in the Cape Town Metropole in South Africa met the requirements for palliative care; 16.6 per cent of the patients had an active life-limiting disease, of which 50.8 per cent had cancer, 32.5 per cent organ failure and 9.6 per cent HIV and tuberculosis.

Palliative care can be provided in any care setting including hospitals, hospices, frail care centres, clinics and patients' homes. Palliative care can only be provided by healthcare professionals, such as doctors and nurses, who have been educated and trained to apply the relevant principles of palliative care to the stage of the patient's illness (Gwyther 2011, 291). Palliative care has a special responsibility to respond to the suffering of the poor who are subjected to great morbidity and mortality risks. Poverty is a major risk factor for suffering, premature death and many life-threatening infectious diseases (Krakauer 2008, 510). Harding (2008, 515) explains that in resource-poor settings the implications of poverty for palliative care access are greater.

The essence of a palliative care service is that it should recognise the suffering and the specific care needs of patients and be sensitive to the preferences of the patients (Douglas et al. 2005, 435). Unfortunately, care needs are often not met (Osse et al. 2005, 722). Osse et al. (2005, 722) emphasise the importance of correctly identifying the problems of patients to enable the palliative care provider to tailor care according to the patients' needs. Delivering palliative care, recognising suffering and meeting the needs of patients were the goal of establishing a nurse-led palliative care service in a

newly inhabited informal settlement in Tshwane, Gauteng, South Africa, constituting the purpose for the current study.

In 2008, the Adelaide Tambo School of Nursing Science received a grant from the Atlantic Philanthropies through University-based Nursing Education South Africa (UNEDSA), to establish nurse-led community-based health services to people living in a newly established informal settlement in Tshwane. The City of Tshwane's Department of Health identified and earmarked this new informal settlement for these services, as no healthcare services were available to this community. As part of the service package offered under this initiative, a palliative care service, managed by an oncology and palliative care nurse specialist and one trained community health worker started during June 2010.

The community living in this area, subjected to a continuous influx of people erecting informal dwellings, consisted of approximately 703 households hosting a population of 2 533, of whom 1 320 were older than 20 years of age in 2008. The majority of the population (96.3%) lived in informal dwellings and 56 per cent were unemployed. Some households (11%) had no monthly income, while another 23.4 per cent lived on less than 1 USD a day. Most households (97.8%) had access to running water by means of communal taps or a tap in the house's yard and had a pit latrine or flush toilet also in the yard (Maree and Ferns 2008, 6–9). Palliative care services were provided twice weekly by means of a nurse-led mobile clinic rendering outpatient services to those suffering from debilitating diseases. Patients unable to come to the nurse-led palliative care mobile clinic were visited at home. The research problem for this study related to the newly established palliative care service, specifically the palliative care needs of the patients utilising this service. Evidence-based guidance for the delivery of appropriate and effective palliative care in Africa is rare, necessitating the use of research findings from developed countries, which might not necessarily be transferrable to specific situations owing to differences of culture, languages, disease profiles and available palliative care services (Powell et al. 2013, 163–164). Therefore, by identifying the palliative care needs of this community we could contribute evidence to guide the services provided, and add to the body of knowledge of palliative care in South Africa.

Research Question and Study Objective

As we used a retrospective chart review research method, we formulated a research question of description that needed to be answered: “What are the palliative care needs of people utilising the services of a nurse-led palliative care mobile clinic situated in a newly established, underserved, informal settlement in Tshwane?” The objective of the study was to describe the palliative care needs of people using a nurse-led palliative care mobile service situated in a newly established, underserved, informal settlement in Tshwane.

Materials and Methods

Design, Unit of Analyses and Sampling

We used a retrospective chart review method for the study. Record reviews provide evidence-based information (Sarkar and Seshadri 2014, JG02) that can be used to improve services and patient outcomes. The authors further explain that record reviews are considered useful in gathering data about medical and surgical illnesses and investigating procedures and their outcomes. Record reviews also assist in determining the correctness of the diagnoses, problem identification, treatment and care planning and assessing adherence to standard treatment guidelines. Vassar and Holzmann (2013, 12) explain that this design uses existing patient-centred data to answer the study's research questions. Polit and Beck (2013, 190) consider patient records to be rich data sources allowing the collection of data in a cost-effective manner.

The records were photocopied patient records meeting the following inclusion criteria: all records were completed during the first consultation of patients 18 years and older, the initial consultations occurred between 1 June 2010 and 31 March 2011, and signed consent was obtained for the use of the records. The records comprised a demographic information form, admission and physical assessment, and psychosocial, hope, spiritual, symptom and pain assessment records (See Table 1). Ethical approval for the study was obtained from the Tshwane University of Technology (Reference 2010/05/005).

In consultation with a statistician, the planned sample size was 50. However, it took 10 months to register 48 people older than 18 years in the clinic, whose patient records were to be used for analyses. After analysing the records of these 48 people, the statistician advised the researchers that meaningful results were obtainable from a sample of at least 30 records. Therefore the sample was concluded and statistics were calculated for 48 ($n = 48$) records.

Table 1: Assessments included in patient records

<i>Name of document</i>	<i>Characteristics of the document</i>
Demographic data and consent to treatment and research	Obtains basic demographic data of the patient and provides consent to treatment as well as consent to use or not to use records for research purposes
Admission and physical assessment	Obtains medical and surgical history of the patient, reasons for attending the clinic, as well as identifying expectations or goals of treatment. Entails a complete physical assessment, and also indicates wounds or lesions on the picture
Psychosocial assessment	Comprises assessed support systems, roles, communication, ability of the significant other to serve as a support system, psychological status of the patient as well as the significant other, based on guidelines provided in Kinghorn and Gamlin (2001, 125)
Ingleside spiritual assessment	Explores the spiritual being of the patients including their wishes regarding death and dying (Scoenbeck et al. n.d.)
Herth Hope Index	Consists of a Likert scale designed to determine the level of hope or hopelessness in the patient (Kinghorn and Gamlin 2001, 124)
Symptom assessment	Identifies and assesses symptoms based on the location of the problem, severity rating, aggravating and alleviating factors, the effect on activities of daily living, and the effect on mood and morale (Kinghorn and Gamlin 2001, 123)
60-second pain assessment	Uses a numerical rating scale as well as words to describe the pain, location, aggravating and alleviating factors, current medication and the effect on mood and morale and activities of daily living (Kinghorn and Gamlin 2001, 18)

Data Gathering, Instrument and Analyses

A quantitative inductive content analysis method was used to analyse the records by linking and counting specified characteristics to compare categories and to make conclusions (Bowling 2009, 454). The first author developed a data extraction sheet for the purpose of recording relevant information from patients' records. The data extraction was based on reported patient problems and the findings of the various assessments indicating a problem or need to be dealt with through the provision of palliative care. Authenticity was ensured as photocopies of all the records were kept while sampling bias was excluded as the available population was studied.

Patients' problems identified on the master document were entered in an Excel worksheet. A statistician assisted data entry and analysis were carried out using the Statistical Package for the Social Sciences (SPSS), version 16.

Validity

Validity is a quality criterion indicative of the degree to which interpretations made in a study is precise and well founded (Polit and Beck 2013, 236). Internal validity was promoted by submitting the study proposal for peer review, preventing selection bias by including all available records in the study, and photocopying the original documents to ensure authenticity and credibility. The first author practised as a nurse at the palliative care clinic and could verify that the information from the records were analysed in a truthful manner and that only problems or needs identified by the patients or identified through assessment were recorded as palliative care needs. Furthermore, a statistician was used to assist with the sample size and statistical analysis. External validity was enhanced by using a document research design, which could not influence the participants.

Results

The ages of the patients ranged from 21 to 78. The average age was 46.9 (\pm 15.1) and the median age 47. Most patients were black females (66.7%, n = 32) and unmarried (66.7%; n = 32). Nearly half of the patients (45.9%; n = 22) were functionally illiterate as they never went to school or had some primary school education. Only 6.3 per cent (n = 3) of the patients were employed. The records reflected 85 different medical diagnoses and some patients suffered from more than one illness. The most common diagnosis was HIV and AIDS (54.2%; n = 26), followed by tuberculosis (33.3%; n = 16). See Table 2.

Table 2: Gender and reported medical diagnosis in terms of age (n = 48)

	Age						Total	
	20–29	30–39	40–49	50–59	60–69	>70	n	%
<i>Gender</i>								
Male	2	1	3	2	3	1	12	25.0
Female	4	9	7	9	4	3	36	75.0
<i>Reported medical diagnosis</i>								
HIV and AIDS	5	8	8	4	1	0	26	54.2
Tuberculosis	3	3	5	5	0	0	16	33.3
Hypertension	0	1	0	4	3	3	11	23.0
Rheumatoid arthritis	0	0	1	2	4	2	9	18.8
Stroke	0	1	1	1	1	0	4	8.3
Other (cancer, diabetes, asthma, osteoarthritis, heart disease, chronic kidney failure, chronic pancreatitis, uncontrolled epilepsy, and unknown)	1	1	1	5	6	5	19	39.6

The records revealed 379 health problems, ranging from 1 to 17 per patient, with an average of 8.1. Most problems involved physical symptoms (50.3%; n = 195) with an average of 4.1, while 38.8 per cent (n = 147) were psychosocial problems and 9.8 per cent (n = 37) were spiritual problems. Pain relief was the greatest need for 89.6 per cent (n = 43) of the patients. Other symptom control needs included controlling weakness, fatigue and coughing (Table 3).

Pain was reported by more patients aged 40 years and older (72.9%; n = 31) compared to younger patients (27.9%; n = 12). Pain was multifocal, reported in 1 to 6 sites with an average of 3.2 and a median of 1. Most patients reported pain in the lower limbs, especially in the knees and feet, describing the pain in the feet as stinging and burning. Abdominal pain, backache and headache were also commonly reported.

Through interpretation of pain severity using the World Health Organization pain step ladder, some patients (48.8%; n = 21) experienced moderate pain, while 39.5 per cent (n = 17) patients reported severe pain and 11.6 per cent (n = 5) reported mild pain. Most

men reported pain (91.7 %; n = 11) and 81.8 per cent (n = 10) of them reported severe pain. Women reported mostly moderate pain (59.4%, n = 19) (Table 3). Many patients (69.8%; n = 30) did not use any pain medication, 10 (23.3%) used paracetamol and/or ibuprofen, 1 (2.3%) used amitriptyline, 1 (2.3%) diclofenac and 1 (2.3%) morphine oral solution.

Table 3: Pain and other symptoms reported in terms of gender (n = 48)

<i>Symptoms</i>	<i>Female</i> <i>n = 36</i>		<i>Male</i> <i>n = 12</i>		<i>Total</i> <i>n = 48</i>	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Pain	32	88.8	11	91.7	43	89.6
Weakness	20	55.6	7	58.3	27	56.3
Fatigue	16	44.4	6	50.0	22	45.8
Cough	13	36.1	2	16.7	15	31.3
Weight loss	11	30.6	1	8.3	12	25.0
Diarrhoea	7	19.4	2	16.7	9	18.8
Constipation	5	13.9	3	25.9	8	16.7
Sleep disturbance	5	13.9	2	16.7	7	14.6
Eye problems	5	13.9	2	16.7	7	14.6
Anorexia	5	13.9	0	0	5	10.4
Nausea and vomiting	4	11.1	0	0	4	8.3
Dyspnoea	1	2.8	3	25.0	4	8.3
Night sweats	4	11.1	0	0	4	8.3
Skin rash	4	11.1	0	0	4	8.3
Other	19	52.8	5	41.7	24	50.0

There was not a big difference in the percentage of women and men reporting weakness, 55.6 per cent versus 58.3 per cent respectively, but a greater percentage of men reported fatigue (50% vs 44.4%), while women reported coughing (36.1% vs 16.7%) and weight loss (30.6% vs 8.3%) to a greater extent than men (see Table 3).

Many patients needed emotional support (85.4%; n = 41), financial support (50%; n = 24) and support for managing depression (45.8%; n = 22). More unmarried patients (single, divorced or widowed) lacked emotional support (97.5%; n = 41) compared to married patients (71.4%; n = 5). More women needed emotional support (86.1%; n = 31) compared to men (83.3%; n = 10). Women were also more inclined to report depression (55.6%; n = 20) than men (16.7%; n = 2). However, more men (58.3%; n = 7) needed financial support than women (47.2%; n = 17) as shown in Table 4.

Table 4: Psychosocial support needs according to gender (n = 48)

<i>Type of support</i>	<i>Women n = 36</i>		<i>Men n = 12</i>		<i>Total n = 48</i>	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Emotional support	31	86.1	10	83.3	41	85.4
Financial support	17	47.2	7	58.3	24	50.0
Relief of depression	20	55.6	2	16.7	22	45.8
Support to be able to fulfil roles	12	33.3	5	41.7	17	35.4
Support with transport	3	8.3	5	41.7	8	16.7
Support to maintain independence	5	13.9	3	25.0	8	16.7
Management of anger and frustration	6	16.7	1	8.3	7	14.5
Support to obtain an identity document	5	13.9	1	8.3	6	12.5
Support with food	3	8.3	2	16.7	5	10.4
Other	8	22.2	1	8.3	9	18.8

A total of 37 (n = 37) of the patients expressed spiritual care needs. Patients primarily of age 40 and older expressed spiritual needs. The need for direction was the most common spiritual care need and experienced by more women than men (19.4% vs 16.7%), while a greater percentage of men had the need to attend church (25% vs 11.1%) and not to feel alone (16.7% vs 8.3%) as displayed in Table 5.

Table 5: Spiritual care needs according to gender (n = 48)

<i>Type of care needed</i>	<i>Women n = 36</i>		<i>Men n = 12</i>		<i>Total n = 48</i>	
	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
Need for a sense of direction	7	19.4	2	16.7	9	18.8
Need to attend church	4	11.1	3	25.0	7	14.6
Not to feel alone	3	8.3	2	16.7	5	10.4
Need for religious resources	4	11.1	0	0	4	8.3
Need to combat a pessimistic outlook on life	4	11.1	0	0	4	8.3
Other	4	11.1	4	33.3	8	16.7

Discussion

Patients reporting various medical diagnoses used the services of the nurse-led mobile palliative care clinic. Whether all the patients suffered from end-of-life diseases are debatable. However, the palliative care service became available; it was accessible without requiring transport, free and accepted by the community, and therefore patients came seeking help. Not caring for the sick who suffer from pain and lack emotional support would be inexcusable as poor people living in developing countries are already disadvantaged as they are subjected to an unequal burden of disease and have less access to healthcare compared to people living in the developed world (Peters et al. 2008, 162). Providing care to people without what seems to be an end-of-life disease is also not unique as Fernandes et al. (2010, 413) illustrate when describing the palliative care service they initiated to care for underserved communities in Hawaii also provided care to patients with “advanced chronic diseases” rather than only to people with end-of-life diseases.

Patients in the current study reported fewer symptoms than those in other studies. Peltzer and Phaswana-Mafuya (2008, 1) reported that patients in the Eastern Cape province of South Africa had an average of 26.1 symptoms. A study by Harding et al. (2012, 4) in South Africa and Uganda also reported a higher symptom burden with an average of 18.1 symptoms experienced by HIV and AIDS participants. However, these studies included only people living with HIV and AIDS, which could have been responsible for the difference in symptom burden. Additionally, Homsy et al. (2006, 444), when investigating patient reported symptoms among cancer patients, found that pain is 70.3 times more likely to be reported compared to any other symptom and that severe symptoms were more likely to be reported than mild symptoms.

The finding that pain relief was the greatest care need was supported by other study findings. Norval (2004, 250) found that South African advanced HIV and AIDS patients mentioned pain to be the most prevalent symptom with an incidence of 98 per cent. Tapsfield and Bates (2011, 12), in their Malawian study, found a similar trend as 74 per cent of their patients experienced pain. In the current study more males complained of severe pain compared to females, which appears to be in contrast with other researchers' findings. Mailis-Gagnon et al. (2007, 93) and Kim et al. (2011, 1142) found that women usually complained more frequently about pain than men. Gray and Berger (2007, S13) agreed that women, compared to men, experience more pain and report more severe, widespread pain and pain of longer duration. The same authors also warned that pain in women might be under-diagnosed and under-treated as culture and other factors such as psychological, social and biological factors influence the pain experience.

Most patients who experienced pain in the current study did not use any pain medication. Moreover, the pain of those who took pain medication was not controlled. This is not unique, as Uwimana and Struthers (2007, 581) in a study conducted in Rwanda found that 72 per cent of the participants in their study had unmet pain needs. Although 50 per cent of the participants received treatment for pain, only 8 per cent indicated that the treatment was effective. Maree et al. (2013, 94) found a similar trend and identified a lack of knowledge, ineffective assessment, not adhering to the prescribed guidelines and not using a holistic approach as major barriers influencing pain control. Not meeting the pain needs of palliative care patients is still a global health problem (Gray and Berger 2007, S13; Kress et al. 2015, 1743; Ripamonti et al. 2011, vi69) and highlights our failure to respond to patients' need for effective pain management.

The need for controlling symptoms such as weakness, fatigue, cough and weight loss is not unique to our study. Harding et al. (2012, 5) found tiredness and a lack of energy to be the second and third most common symptoms after pain, while weight loss was reported by 60.3 per cent of their study population, slightly more than in the current study. In contrast, Kikule (2003, 193), in a Ugandan study, found vomiting and diarrhoea to be the most prevalent symptoms after pain, reported by 58 per cent of patients, while Homsí et al. (2006, 449), in an American study, found fatigue to be the most prevalent symptom (72.5%), followed by a dry mouth (67%) and pain (64%) with weight loss fifth on the list reported by 53.5 per cent of the respondents. However, Homsí et al. (2006, 449) found fatigue to be the second most distressing symptom after pain, with weight loss not on their list. It is quite possible that weight loss in our study population would be distressing owing to the socio-cultural belief that being underweight signals suffering from HIV and AIDS (Matoti-Mvalo and Puoane 2011, 24), but this warrants further research.

The need for emotional support was the most prevalent psychosocial need and the second most common problem after pain in our study population. Farrant et al. (2012, 499), in a study conducted in three HIV clinics in South Africa, found

psychological problems were among the 10 most prevalent symptoms with sadness being the most prevalent, while Uwimana and Struthers (2007, 582) found that 65 per cent of their respondents had psychological or emotional support needs. Jorgensen and Marwit (2001, 173) concluded that the emotional support needs of patients living with HIV and AIDS included encouragement, expression of love and concern, and positive feedback. Whether these elements would meet the emotional support needs of the population we were caring for has to be explored before conclusions could be made, as culture influences the needs of people and the manner in which these needs should be met (Owens and Randhawa 2004, 414; Uwimana and Struthers 2007, 575). Additionally, lacking significant others and not receiving emotional support from social structures, could be the result of stigma and rejection (Campbell et al. 2005, 808; Delius and Glaser 2005, 29) and social isolation (Fitzsimons et al. 2007, 317; Selman et al. 2013, 1) when suffering from a debilitating chronic illness.

Considering the scarcity of employment opportunities and an unemployment rate of close to 5 million (Statistics South Africa 2017), people living with end-of-life or debilitating chronic diseases would not be the preferred employees, explaining why financial needs were the second most common psychosocial problem in our study sample. However, financial problems have also been reported in other African countries (Kikule 2003, 193; Makoae et al. 2005, 30; Selman et al. 2013, 1; Uwimana and Struthers, 2007, 580). Despite South Africa's negative poverty index, with 45.5 per cent of the population living in poverty and 20.2 per cent in extreme poverty (Statistics South Africa 2017), only 10.4 per cent of the participants in our study reported the need for food support. In contrast, Harding et al. (2012, 5) found that 71.4 per cent of their respondents reported suffering from hunger, while in the Rwandan study of Uwimana and Struthers (2007, 580) 44 per cent of the patients required nutritional support. Some patients in our study were beneficiaries of social grants, providing a small monthly income to 16.1 million South Africans (National Treasury South Africa 2013), which explain the difference.

Despite suffering pain and other symptoms, lacking emotional support and experiencing financial difficulties, the records of the current study's patients reported a small percentage of spiritual care needs and most practised religious activities. Similarly Jameson (2008, 1), in a South African study, found that in spite of isolation and rejection, spiritual issues were not major issues in their palliative care population, as 80 per cent had support from the church and 90 per cent had close family relationships. The role of religion and spirituality should not be underestimated, as Maman et al. (2009, 969) found that spirituality and religious leaders were important sources of support for patients' long-term strategies to cope with HIV and any other disease resulting in the need for palliative care.

Limitations of the Study

The findings presented were the results of a retrospective study, which provide a lower level of evidence compared to prospective studies. The study was also subjected to

misclassification bias and confounding, as other problems experienced by the patients were not explored. However, our study provided evidence of the palliative care needs of the people living in the specific informal settlement.

We used reported diagnosis and it is possible that more of the patients could have suffered from HIV and AIDS and did not disclose it owing to a fear of stigmatisation and discrimination, a reality for many people and their families living with HIV and AIDS in South Africa (Gilbert and Walker 2010, 139; Skinner and Mfecane 2004, 157).

Conclusion

The study provided evidence that patients suffering from various medical diagnoses used the services of the nurse-led palliative care mobile clinic; some might not have suffered from an end-of-life disease but rather a debilitating chronic disease. Several palliative care needs were identified. Pain relief was the most prevalent care need as most of the patients lived with uncontrolled pain due to not using pain medication or not getting relief from the medication used. The need for emotional support existed and a small percentage of patients reported spiritual care needs. Furthermore, patients' care needs revolved around relief from total pain (Clark 1999, 727). However, identification of the palliative care needs of this population living in a resource-poor community highlighted the necessity of holistic assessments. Suffering of palliative patients living in resource-poor communities should therefore be seen in its totality and not only focus on a diagnosis or a certain stage of disease. Thus taking into consideration the person, the health condition and the environment, which all influence the way a person experiences suffering.

Therefore, through meticulous assessment, nurses should identify the main care needs of patients. In addition to ensuring access to appropriate pain medication, other management strategies such as support groups could be considered and even home industries and small-scale vegetable gardens can be initiated to improve the palliative care experience and lives of these patients.

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