How to Integrate Palliative Care Within Primary Healthcare- Perspectives of People Living With Serious Illnesses, Their Family Caregivers and Primary Healthcare Professionals in Nigeria

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Abstract

Background

Palliative care should be integrated into primary healthcare systems within low- and middle-income countries to achieve Universal Health Coverage goals. We aimed to identify preferences and expectations for primary healthcare support among people living with serious illness and their families in Nigeria, and to determine feasible steps palliative care integration within the health system.

Methods

Qualitative interview study with 48 participants including people living with serious illnesses (n=21) and their family caregivers (n=15) recruited from specialist clinics at a Teaching hospital in Nigeria; and healthcare providers (n=12) recruited from three primary healthcare facilities in Nigeria. Data were analysed using thematic analysis.

Results

Three major themes were identified. 1) Balancing patients and families' expectations and preferences for easily accessible service and opportunities for social interaction and adequate communication with available human resource. 2) Engaging patients requires existing trust and bonds from their current use of primary healthcare and support to develop patients' agency. 3) Development of healthcare providers is needed to ensure an appropriate clinical response, manage interprofessional trust and ensure clear role delineation.

Conclusions

Palliative care integration within primary healthcare in Nigeria can be achieved through building information and communication skills of healthcare providers, engaging and empowering patients to exercise their agency in care decisions, and adequately delineating healthcare providers' roles to ensure staff work within their competencies and training.

Key Statements

What is already known about the topic?

- Palliative care improves outcomes for patients and family members and can save costs
- Palliative care must be integrated across all levels of the healthcare system to achieve the universal health coverage goal

- Palliative care service delivery in Nigeria and many African countries is currently focused at the tertiary healthcare level

What this paper adds?

- Patients with serious illnesses and their families would value a flexible service, provided by qualified providers who prioritise quality information, education and communication and foster social interaction and shared experiences.
- Integration of palliative care in primary healthcare is constrained by healthcare providers' response to serious illnesses, interprofessional distrust and the lack of agency among patients and family
- Integration of palliative care within primary healthcare should build on existing trust and bonds between patients and primary healthcare providers

Implications for practice, theory or policy?

- Investment in information and communication skills training for health providers must be prioritised to improve health literacy and empower patients as active participants in their care.
- Policymakers and continuous professional development must emphasise the critical role and function of healthcare providers at the primary healthcare level in the ongoing management and palliative care for patients with serious illnesses at this level.
- Healthcare providers at the primary healthcare level must be trained and supported to deliver safe palliative care.

Background

By 2060, the number of deaths with serious health-related suffering in the last year of life in low and lower-middle-income countries will be 5.14 million and 16.84 million respectively(1). This is an increase of 155% and 87% respectively compared to the year 2016. In Africa, the WHO mortality data project a 403% increase in cancer mortalities; a 213% rise in kidney disease-related mortality; an increase in chronic obstructive pulmonary diseases mortality of 255% and a 316% increase in cardiovascular disease-related deaths (including stroke) between 2016 and 2060(2). Patients living with these serious illnesses and their families report pain, suffering, poor quality of life and physical, psychological, social and spiritual needs that are amenable to palliative care(3, 4).

In low- and middle-income countries, palliative care can improve outcomes for patients and their family members and saves costs(5). However, palliative-care services remain largely fragmented within, or operate outside of national health systems(6). For example, Nigeria has 23,640 healthcare facilities within the public health system, of which, 85.8% are primary, 14% secondary and 0.2% are tertiary. However, there are only 17 reported palliative care facilities catering for a population of ~190 million(7) located mostly at the tertiary healthcare level in urban cities. This centralisation of palliative care neglects

the base of the health system pyramid i.e. primary healthcare reducing access to relief from pain and suffering(8).

Palliative care is integral to the achievement of the Universal Health Coverage goal, yet limited access puts the achievement of this goal at risk(8). Primary healthcare remains the base on which strong and sustainable health systems are built(9, 10), and should provide health promotion, prevention, treatment, rehabilitation and palliative care services(9). Specialist hospital-based palliative care alone cannot be relied upon to meet the burden of palliative care needs. Primary healthcare has enormous potential to sustainably increase access to quality palliative care(11) and the WHO affirms palliative care as an essential function of primary healthcare(12).

Engaging with patients with serious illnesses, their families and primary healthcare providers can provide insights into the opportunities to integrate palliative care in a person-centred manner. Hence, this study aimed to identify the preferences and expectations for support among people living with serious illness and their families, and implications for palliative care integration at the primary healthcare level in Nigeria.

Methods

Study design

This cross-sectional qualitative interview study is part of a larger sequential mixed-methods project to develop and integrate palliative care within the primary healthcare level in Nigeria. We report in line with the consolidated criteria for reporting qualitative research (COREQ)(13), to enhance the trustworthiness and transparency of findings.

Study Participants and Setting

We sampled from three populations: patients and family caregivers attending specialist outpatient clinics at a teaching hospital, and healthcare providers at three primary healthcare centres in Ibadan, Nigeria.

Eligible patients were adults (aged at least 18 years) with a diagnosis of serious illnesses ranking among the top causes of mortality in Nigeria(14) and recognized as causing a high level of palliative care need(15), including in Africa(3). These were tuberculosis (patients with Multidrug-resistant (MDR), Extensively Drug-Resistant (XDR) and Post-Tuberculosis Lung disease(16)); ischaemic heart disease (patients who developed heart failure as a complication and currently in stage 3 and 4 of New York Heart Association (NYHA) Functional Classification of Heart failure OR American Heart Association Heart Failure stages C and D); malignant neoplasm (any malignancy which is life-threatening but unlikely to benefit from curative-intent therapy or not responsive to curative treatment and for which only conservative management is planned(17), usually stage 3 and 4 cancer); Stroke (acute, serious, and life-threatening stroke, including those patients for whom some reversibility is a realistic goal(18)).

Inclusion and exclusion criteria for patients included:

- a score of 3-5 on at least two domains of the APCA POS(19),
- a functional limitation in any of the six basic activities of daily living(20) that significantly affects daily function and quality of life and
- the capacity to give informed consent.

Family caregivers identified by the patient were aged 18 and over and have been involved in day-to-day unpaid caregiving for the patient for at least 6 months. Healthcare providers with at least six months of experience delivering care for patients in primary healthcare were eligible.

Recruitment and Sampling

Patients were informed about the study by their healthcare providers while attending the clinic. Interested patients then contacted the researcher to express their interest in participating. Purposive sampling criteria were patient diagnosis, duration of serious illness, palliative care referral status (for patients and family caregivers), and for staff, professional training and years of experience(21, 22). Recruitment continued until data saturation was reached, i.e. the point at which identification of new themes during the iterative analysis added no new insight to achieve the study objectives(23).

Data Collection

Semi-structured in-depth interviews were conducted by OA between January 2020 and March 2020. OA is a male researcher and registered nurse. He is Yoruba (the same cultural background as most of the population in Ibadan), conversant with the dominant local language (Yoruba) and understands important cultural cues and dynamics within conversations and dialogues. Our study-specific topic guide covered patients and families' experience of using primary healthcare while living with serious illness, healthcare providers experience supporting these patients and families, participants' understanding of palliative care needs, their priorities, expectations for primary healthcare level-based support for palliative care needs of patients with serious illnesses. The guide was piloted with 3 patients, 2 family caregivers and 1 primary healthcare provider then refined. Clarifications and probes were used during the interview to ensure adequate details were captured. Interviews lasted 20 to 75 minutes and were audio-recorded.

Patient participants and family participants were interviewed separately unless a preference to be interviewed together was expressed. OA maintained an ongoing journal to enhance the reflexivity, transparency and auditability of the research.

Data Analysis

Interviews were transcribed and translated verbatim, pseudonymised, and uploaded to NVivo software version 12(24). Translated transcripts were back-translated and verified against the audio files by OA for accuracy, consistency, fidelity and to optimise interpretation. Where translated quotes formed key segments of analysis, a second translator (OS) reviewed content to ensure that the meaning of participant responses was maintained.

Analysis was undertaken by OA and KN using thematic analysis(25). Data analysis started after the first three interviews and proceeded iteratively. OA read the interview transcripts repeatedly to familiarise with the data and develop a preliminary understanding of themes within individual cases and across the data set. OA inductively identified themes from the data which were reviewed by KN, and OS independently, new themes were created, existing ones were revised as necessary and a mutually agreed coding frame was developed and applied to all remaining transcripts. Transcripts were coded line by line; patterns and themes of particular salience for participants and across the data set were identified and analysed at the semantic or explicit level(22, 25). While the data was coded for convergence of participants' perspectives, deviant or non-confirming themes were also coded. The analysis was reviewed by MM and RH plus project expert advisory group (GW, CE and VS) and clinical experts in Nigeria (OS, AA and AO) at regular intervals. Global themes were developed based on a summary of coded themes to form an overall coherent story.

Results

Sample characteristics

Of the 29 patients, 17 carers and 12 healthcare professionals who expressed interest in the study, 8 patients and 2 carers later declined and 1 patient was too fatigued. 47 participants (20 patients, 15 family members and 12 primary healthcare providers) were recruited and interviewed. Table 1 highlights the demographic characteristics of the participants. Patients were living with cancer (n=6); heart failure (n=5) post tuberculosis lung disease or MDR TB (n=5) or were post-stroke (n=4). Healthcare providers were nurses (n=7), doctors (n=3), or community healthcare extension workers (n=2) (Table 1).

Table 1
Demographic characteristics of participants

	Patients (n=21)	Family caregivers (n=15)	Healthcare professionals (n=12)
Gender	n	n	n
Male	6	7	3
Female	15	8	9
Total	21	15	12
Age in years (Mean± SD)	54.48 ± 12.99	40.73 ± 16.74	
Profession			n
Medical Doctors			3
Nurses			7
Community health officers or extension workers (CHOs/CHEWs)			2
Total			12
Diagnosis	n	n	
Cancers	7	5	
Heart failure	5	5	
Tuberculosis	5	1	
Stroke	4	4	
Total	21	15	
Years of experience within PHC [Median (Range)]			22 (15-26)
Educational level	n		
No education	4		
Primary	3		
Secondary	6		
Tertiary	8		
Total	21		
Relationship to patient		n	

	Patients (n=21)	Family caregivers (n=15)	Healthcare professionals (n=12)
Son		4	
Daughter		4	
Spouse		6	
Others (Daughter-in-law)		1	
Total		15	
Marital status	n		
Single	3		
Married	9		
Widowed	8		
Divorced	1		
Total	21		
Palliative care referral	n		
Yes	1		
No	20		
Total	21		

Main findings

Three main themes were developed: engaging patients and families, managing patients' expectations, and addressing staffing related issues. Figure 1 illustrates the summary of themes.

Engaging patients and families

Patients, family caregivers and healthcare providers identified opportunities and potential constraints for palliative care delivery existing within current primary healthcare structures.

The desperation of patients and families for healthcare

After living with and enduring unresolved symptoms and other concerns related to serious illnesses patients and family caregivers were desperate for any available support to improve their quality of life, including palliative care. They described challenges in trying to access care for their concerns between their specialist appointments at tertiary healthcare facilities. They also described fears of taking inappropriate actions that might further complicate their health which often results in them presenting at the emergency unit or out-patient.

'Yes. No matter how little the support is, no matter how little the care will be, she will be very glad and grateful for anybody that will help her.' - Carer of patient with stage 3 Cervical cancer

Patients and families' current use and existing trusting bond within primary healthcare

For less financially-privileged participants, public primary healthcare facilities were usually their first point of call before attending the tertiary hospital where the diagnosis of a serious illness was made. More financially-privileged individuals described their use of private primary healthcare facilities as both their first point of call for minor illnesses and last resort when systemic problems sometimes make it difficult to access care at a tertiary healthcare centre.

Participants described their existing trust and bond with primary healthcare providers established from ongoing use of these accessible facilities situated nearby. They believed that engaging in communication relating to diagnosis and prognosis, what to expect from illness course, what supports are available and how to prepare within the context of serious illnesses would be less challenging.

'But you know family doctors now, they have been the ones we go to for malaria, typhoid, cough and cold, so he has created a bond with the family and I feel like based on that, the family will listen to him more than just anybody that just comes.' – Carer of patient with stage 4 anorectal cancer

Patients and families' lack of agency

When asked their priorities and what support they would like from a palliative care intervention delivered within primary healthcare, patients and their family caregivers often responded that healthcare providers should decide what kind of support to provide. Most patients described not being knowledgeable enough and would defer to what the healthcare providers judge as necessary to meet their needs. Even for those patients who wished to exercise their agency, the communication challenges they faced in interacting with their current healthcare providers meant their involvement and opinions in decisions made by healthcare providers were minimal.

'I believe that's your work. You are the one that will know what is good for us, especially with the kind of treatment she needs.' - Carer of patient with stage 3 heart failure

Managing patients and families' preferences and expectations

Ease of access and use

Patients and caregivers described the need for any intervention to be easily accessible in terms of proximity to home, with a conducive and welcoming environment, short waiting times and prompt response. This was often discussed in the context of their current experience with seeking care at tertiary healthcare centres.

'Somebody like me would prefer to go to where I would be attended to immediately rather than queue in a bigger place like this. If the quality of what I would be getting in primary health care is okay, and quality

drugs, you know, just like that...' - Patient with stage 3 heart failure

Quality of care and Staffing

Patients and family caregivers emphasised the need to improve the quality of care and the skills of primary healthcare providers. Patients highlighted the need for the palliative care provided at primary healthcare facilities to be aligned with their specialist care received at the tertiary level, fearing differing opinions or treatment. Family caregivers felt that the culture and less-pressured environment of primary healthcare mean patient monitoring may be better provided.

'If we do that at the primary healthcare level, are we going to be consistent with the care being provided by the consultants? Are we going to be consistent with it?' - Patient with stage 4 breast cancer

Finding shared experiences, social interaction and respite

All groups of participants highlighted the role of primary healthcare space in facilitating opportunities for social interactions and shared experiences. As patients and caregivers interact with one another, this helped them to cope with social stigma of serious illnesses which are usually shrouded in mystery. Patients and carers also described the anticipated psychosocial benefits from having better access to palliative care including reduced social isolation and an opportunity to leave the house and share their concerns. Carers emphasised the current lack of home care support and their expectation of respite to help them deal with burn-out and to relieve them of their obligation while they recuperate mentally.

'it is good. You know she is getting older. If she has a place she can be going closer to home and not just sitting at home on her concerns. It will be good. If she comes she will be able to explain her perspectives and you can discuss with her as well. That opportunity to even get out of the house will help her a lot. It is a good thing.' - Carer of patient with stage 3 heart failure

Information, education and communication

Patients and family caregivers highlighted the importance of receiving education about the illness-causes, course and consequences, including clear and focused communication around treatment and support plans. They highlighted the difficulty they faced in communicating with specialist providers, and the need for a less pressured environment with providers who can communicate using understandable language, listen to their concerns and educate them. Participants expected healthcare providers' attitude and approach to communication to be open, patient, and supportive. They emphasised this can foster a sense of shared understanding of their needs and goals of care, manage their expectations concerning the course of the illness and plan appropriately for eventualities.

'It will be very helpful because even the way you are talking and explaining things, it is different from the doctors here and if we can hear the explanations, it will help us to be more conscious of what we need to do to support mama and to understand her condition.' - Carer of patient recovering from stroke

Addressing staffing-related issues

Inconsistent perception of the competence and function of PHC

Some patients and carers feared that the primary healthcare level was staffed by lay healthcare workers and that care was rudimentary and of lesser quality compared to secondary and tertiary care. However, others, in agreement with healthcare providers, reported that primary healthcare facilities are already staffed by qualified healthcare providers (i.e. nurses and doctors) supported by trained community healthcare workers. However, healthcare providers acknowledged that the facilities do not always have the appropriate staffing ratio, with shortages of nurses and doctors in many facilities. They felt that the resulting pressure sometimes affects care quality. They further highlighted the need to be trained to provide palliative care for patients.

'That will be good. At least it will be closer to home. However, I do not know whether the doctors and nurses there will be able to handle my condition because even the general hospital that I went referred me here. That said, if they will be able to attend to me at least that will reduce the burden a lot.' - Patient with stage 3 cervical cancer

Inter-professional distrust about working within competencies

The participants' responses also revealed a constant tension between healthcare provider cadres due to the lack of a clear definition of roles, responsibilities, and limits of competence. This distrust is majorly directed at the community health officers and community health extension workers (CHOs/CHEWs). Nurses were concerned that this category of healthcare providers see themselves as equally competent as nurses despite having different training. This creates an atmosphere of rivalry with the patients at the receiving end. Doctors and nurses reiterated their worries about the competence of the CHOs/CHEWs to deliver care out of hours, to deliver care for patients with serious illnesses, to follow care plans designed by the nurses and to work within the limits of their competence. They provided instances where they have been forced to cover up problems created by the CHOs/CHEWs.

There was also a pattern of vertical interprofessional distrust within the healthcare system. Primary healthcare level providers suggested that tertiary and secondary level providers do not trust them to competently deliver care for patients with serious illnesses and hence fail to refer patients back to them after stabilising any exacerbations. This meant they usually did not hear back from patients referred to the higher level of care, losing most patients to follow up in the community.

'It's not to say we can't treat them, but hmmm... and it's when we that are registered are around and some of these people that are capable. If another person mishandle them that will cause another problem for them, and they are not...we cannot say we are proud of most of the care work that they do here and be able to monitor them. That is where the problem is.' - Nurse at primary healthcare

Primary Healthcare providers' response to serious illnesses

Primary healthcare providers explained that their first response to patients with serious illnesses is to refer them to other levels of care for treatment. They highlighted that they currently only have resources to support some patients with HIV or TB. Orientation of primary healthcare towards the treatment of minor acute and not chronic illnesses has informed the perception of the limits of their care at this level. Therefore, some healthcare providers did not feel they have a role to play in the ongoing management of patients with serious illnesses, with care rarely focused on long term management, reluctance to dying process, administrative and legal implications from patients dying at the primary healthcare level and a shortage of qualified healthcare providers such as nurses and doctors.

'And as you also know, in primary health care, we try as much as possible to avoid any form of death. We are not here to just be recording death -death. If a patient needs an higher care, let the patient go as much as possible.' – Doctor at primary healthcare

We already do this somehow

Some healthcare providers acknowledged that they have no prior knowledge of what palliative care entailed. They variously described it as focused on pain management, rehabilitation, relief of symptoms or end-of-life care. However, they felt that they already perform some palliative care activities e.g. managing physical symptoms such as uncomplicated pain, nausea and diarrhoea, delivering health education to patients, and providing counselling support to families.

'At least if we have malaria patient, the relatives too, they are disturbed, they have anxiety, and so on. And we take care of it. So if these patients too are around us, we know how to take care of it, if we can allay the fear of those other patients, we can allay their own fear too.' – Nurse at primary healthcare

Discussion

Our findings highlight the expectations and preferences of patients and family caregivers for shared experiences in the delivery of palliative care within primary healthcare in terms of prioritising information, communication, education and social spaces. Adequate palliative care integration at the primary healthcare level must capitalise on patients' current use of primary healthcare facilities and existing bonds; address healthcare providers understanding of their roles in the ongoing management of persons with serious illnesses and families at this level, and support clear delineation of competency-based roles and responsibilities to foster interprofessional trust for collaboration.

The concept of palliative care was new to many of the participants interviewed for this study. Most patients and family caregivers contextualised their expectations within their current experience of accessing care at specialist clinics. These clinics are based on rigid appointment schedules which do not align with the unpredictable and fluctuating nature of many problems associated with serious illnesses, leaving patients and families without adequate support. The clinic environments are also highly-pressured and make quality communication difficult to attain, leaving patients and families disoriented with their conditions. The healthcare providers also showed varied understanding around what

constitutes palliative care, palliative care needs and their role in providing palliative care at the primary healthcare level.

Patients emphasised the need for easily accessible and flexible support delivered in a more flexible and less-pressured. They emphasised the need for clarity about the breadth of concerns that can be discussed with healthcare providers and the need for quality information, education and communication to help them understand the causes, course and consequences of their illnesses and treatments. These findings underscore earlier studies that show that patients with serious illnesses and their families want adequate information, communicated with clarity, accuracy, and sensitivity (3).

The healthcare provision structure contributed to these challenges faced by patients with serious illnesses in accessing support for palliative care needs. Previous authors have reported dysfunctionalities in the structure of the Nigerian healthcare delivery system concerning the provision of palliative care(26). Our study builds on this with opportunities for the integration of palliative care within the current primary healthcare. Patients and families highlighted that their previous use of the primary healthcare facilities helped build therapeutic bonds and trust with the healthcare providers at this level. This aligns with earlier findings that social relationships are crucial to the decision-making of patients about the use of palliative care and oncology services in Nigeria(26).

Participants raised several constraints that may hamper the integration of palliative care within the current primary healthcare structure. Patients relinquishing their agency and deferring to the healthcare providers for the decisions about their care may constrain the provision of person-centred palliative care driven by patients' preferences and concerns. The low health literacy of the patients and the years of healthcare providers paternalistic attitudes to care within this setting(27) may have reinforced this lack of agency. This implies that patients are seldom involved in participating in the decisions about the plan for their management, and instead follow decisions led by healthcare providers about their management. Often patients expected the healthcare providers to know what support they need, however, healthcare providers were constrained by limited understanding of palliative care, limited resources, high workload and paternalistic attitudes. To deliver palliative care within this setting, healthcare providers will need to help to build patients' agency and involvement by giving information to and, engaging patients to participate in the decisions about their care.

The primary healthcare system in many low and middle-income countries has been largely focused on minor acute illnesses usually related to infections and maternal and child health services(28). This has resulted in a transactional approach to service delivery and the diversion of support for patients with serious illnesses away from this level. The response of many primary healthcare providers to patients and families presenting with serious illnesses is onward referral with minimal engagement. Ineffective referral feedback from the higher level of care can mean the patients may never be seen again at the primary healthcare level, even when back home in the community with ongoing symptoms and concerns from serious illnesses(29). For palliative care to function appropriately within the primary healthcare in Nigeria, there is a need to re-orientate healthcare providers about the roles of primary healthcare in

managing people with serious illnesses and change the perception that primary healthcare is for the provision of rudimentary care. It is also imperative to revamp referral feedback from the higher levels of care to primary healthcare to ensure that ongoing support is available to patients in between secondary and tertiary clinic appointments.

Quality palliative care delivery thrives on a strong multidisciplinary. The chronic suboptimal staffing of nurses and doctors at the primary healthcare level means community healthcare workers and community health extension workers (whose training was geared towards health promotion and first aid for acute conditions) have now become the backbone of staffing for the primary healthcare centres(30). Our findings revealed some interprofessional distrust among the healthcare providers with nurses and doctors expressing doubts about the community health workers' knowledge, competence to provide care for patients with serious illnesses and discipline to work within the limits of their competence.

Previous interventions within primary healthcare in Nigeria successfully trained community healthcare workers to deliver stepped-care interventions within the task-shifting framework(31–33). To deliver palliative care within primary healthcare in low and middle-income countries, wide-scale engagement to clarify the roles and responsibilities of the community health officers and community health extension workers and their fit within the organisational structure at the primary healthcare level is important to improve task shifting and reduce the burden on acute care facilities and tertiary hospitals.

Methodological reflection

To our knowledge, this is the first study to consider how to integrate palliative care for a broad range of serious illnesses within primary healthcare on the African continent. We employed a robust design and maximum variation sampling to ensure the perspectives of patients, family caregivers and healthcare providers were heard.

Some limitations may affect the interpretation of our findings. The local language in which interviews were conducted does not have a direct interpretation for palliative care, and the term was new to many of the participants, including healthcare providers. This may have limited the ability of the participants to express themselves. Nevertheless, our topic guides were influenced by a systematic review of palliative care needs in Africa(3) to explore different areas of palliative care need with the participants. In addition, the lead author (OA) is a native speaker who understands and speaks the local language and conducted all the interviews. The results were also presented to local experts to enhance the interpretation of the findings within context.

This paper focused on service delivery and human resource for health as two of the six WHO building blocks of the health system. This is not to undermine other building blocks which might support the integration of palliative care within primary healthcare, but these are usually already defined within the context of the health system. Further work on, for example, leadership and governance, and healthcare financing remain important.

Conclusions

Our findings demonstrate how to integrate palliative care within primary healthcare to address the multidimensional needs of patients with serious illnesses and their families. Such integration must emphasise clear role descriptions for primary healthcare providers to ensure an appropriate response to patients with serious illnesses and encourage interprofessional trust for collaboration and task-shifting. Primary healthcare providers must be trained and supported to foster quality communication, education and information for patients and families to express their symptoms and concerns, and to support patients' agency and involvement in their care. Policies and continuous professional development must emphasise the critical role and function of primary healthcare providers in palliative care for patients with serious illnesses.

Declarations

Ethics Approval and Consent to Participate

Ethical approvals were sought and obtained from Kings College London Ethical Review Board (HR-18/19-13585) and the University of Ibadan/ University College Hospital Ibadan Research Ethics Committee (UI/EC/19/0422). The research process and data collection procedures adhered to sound ethical principles. Fully informed consent was sought from all participants in the study.

Consent for publication

Not Applicable

Availability of data and Materials

The summary table of themes and supporting data has been included as a supplementary file. Anonymised copies of interview transcripts conducted for the current study are available from the corresponding author upon reasonable request and subject to ethical review.

Competing Interests

The authors declare that they have no competing interests.

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Authors' Contributions

OA: design of the work; acquisition, analysis, and interpretation of data; drafting and substantial review of manuscript

KN: design of the work; acquisition, analysis, and interpretation of data; drafting and substantial review of manuscript

OS: acquisition and interpretation of data; review of manuscript

AA: acquisition and interpretation of data; review of manuscript

AO: acquisition and interpretation of data; review of manuscript

RH: design of the work; acquisition, analysis, and interpretation of data; drafting and substantial review of manuscript

MM: design of the work; acquisition, analysis, and interpretation of data; drafting and substantial review of manuscript

All authors approved the final version of the paper to be published.

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Figures

Figure 1

Considerations for integrating palliative care within PHC

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