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# Assessment of Knowledge, Practice and Challenges of End-of-Life Care Among Healthcare Workers: A Study at a Nigerian Teaching Hospital Assessment of End-of-Life Care in Nigeria

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***Abstract*: Background: End-of-life care is a crucial component of comprehensive patient support during their final stages of life. In order to maintain the highest level of quality of life for the patient, hospice care places a strong emphasis on facilitating a peaceful, dignified transition from life to death. While hospice care and palliative care are closely related, there are some differences between the two concepts. The main distinction is that while palliative care may entail curative treatments, hospice care does not. This study aimed to evaluate the knowledge, practice, and challenges related to end-of-life care among healthcare workers at the University of Abuja Teaching Hospital in Nigeria. Methodology: This descriptive cross-sectional study utilized a self-administered questionnaire distributed to doctors and nurses across various departments. The sample size (N=161) consisted of Doctors and Nurses. The data collected was analyzed using SPSS version 21. The questionnaire encompassed sociodemographic information, knowledge, practice, and limitations associated with end-of-life care. Result: The findings underscored a noteworthy trend in knowledge and practice among healthcare workers. Results indicated that 85.3% of participants exhibited GOOD knowledge of end-of-life care. However, the study exposed a less favorable aspect of practice, with 60.7% of respondents indicating a poor end-of-life care practice. Conclusion: The study outcomes reveal challenges that hinder optimal end-of-life care delivery. Limited resources, insufficient training opportunities, and the absence of a comprehensive national policy were identified as significant barriers. This study highlights the pressing need for additional research and evaluation to expedite the development of end-of-life care in Nigeria.**

***Keywords*: End-of-life, Knowledge, Practice, Challenges, Health workers.**

## 1. Introduction

End-of-life care, or hospice care, is a critical component of healthcare that focuses on providing comprehensive support and comfort to individuals during their final months or years [1]. It encompasses various aspects, including addressing mental, emotional, physical, and spiritual needs and assisting with practical tasks [2]. Hospice care is characterized by its emphasis on ensuring a smooth, dignified transition from life to death while striving to maintain the best possible quality of life for the individual. While hospice care is closely associated with palliative care, the two concepts differ primarily in that hospice care does not involve curative treatments, whereas palliative care might.

The provision of end-of-life care involves a multidisciplinary team of healthcare professionals, such as specialized doctors, nurses, physiotherapists, spiritual leaders, therapists, social workers, and volunteers. This team collaboratively addresses the complex needs of patients during this delicate phase of life. The care can be administered in various settings, including the patient's home, nursing homes, hospitals, or dedicated hospice centers.

The historical evolution of end-of-life care dates back to the 14$^{th}$ century. However, it gained significant recognition and development in the mid-20$^{th}$ century, thanks to the pioneering efforts of figures like Cicely Saunders in the United Kingdom [3]. Over time, end-of-life care has spread across borders, with organizations like Hospice Africa playing a vital role in its development in Africa. While developed countries have made strides in implementing hospice care, developing nations, including Nigeria, have faced challenges establishing comprehensive end-of-life care services due to limited resources, inadequate training, and cultural beliefs [4], [5].

Despite the global push for improved end-of-life care, there remains a significant gap between the demand for palliative care and its actual provision. Many individuals who could benefit from such care do not have access to it. This issue is particularly pronounced in developing countries, where the burden of non-communicable diseases and limited healthcare resources pose substantial challenges [5].

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Nigeria, with its high mortality rate and dwindling healthcare workforce, faces a pressing need to prioritize hospice care. While organizations like the Hospice and Palliative Care Association of Nigeria (HPCAN) and the Center for Palliative Care Nigeria (CPCN) have made efforts to promote hospice care, more research, advocacy, and training are required to ensure effective implementation [6], [7].

## 2. Methods

### *A. Study Location*

The study location was the University of Abuja Teaching Hospital, Gwagwalada, which is located in the Federal Capital Territory. It is the only government-owned tertiary healthcare center in the Gwagwalada area council. A five hundred (500) bed facility that can extend to 800 bed spaces. The hospital is home to various specialties, accommodating over 550 consultants, doctors, and over 460 nurses. This institution receives patients from residents in Abuja and the neighboring states, including Kogi, Kaduna, Niger, and Nasarawa, amongst others.

### *B. Study Population*

The study included 161 healthcare workers at the UATH in the Gwagwalada area council who had encountered and cared for patients whose illnesses ended their lives, particularly Doctors and Nurses.

### *C. Inclusion Criteria*

This study included doctors and nurses currently working at UATH who had practiced there for at least a year and were available during the study.

### *D. Exclusion Criteria*

This study excluded healthcare workers who were unavailable, ill, or on leave and healthcare workers other than doctors or nurses.

### *E. Study Design*

This study was a descriptive cross-sectional study that included the use of semi-structured, self-administered questionnaires.

### *F. Sampling Technique*

A stratified sampling technique was used to select departments in the hospital that offered inpatient care. From the list of departments, simple randomized sampling was done, and four departments were selected by balloting without replacement: the Department of Surgery, Internal Medicine, Paediatrics, and Obstetrics and Gynaecology. A list of all the available doctors and nurses was collected, and sample subjects were selected using simple randomized sampling.

### *G. Data Analysis*

The data collected was coded into a computer and analyzed using the Statistical Package for Social Sciences (SPSS) version 21 (IBM, Armonk, NY, United States of America). The data was analyzed for descriptive statistics of all variables, such as measures of central tendency to identify odd values, missing values, or outliers. The frequency of socio-demographics, graded knowledge, practice, and limitations was reported using cross-statistics and inferential statistics.

### *H. Ethical Consideration*

All participants were kept confidential, and no personal information was required. Ethical approval will also be obtained from the Research Ethics committee at UATH.

## 3. Results

The survey yielded a ninety-three (93%) percent response rate reflecting data on the sociodemographic characteristics of the respondents, the knowledge, practice, and the limitations to the practice of end-of-life care among healthcare workers at the University of Abuja Teaching Hospital.

### *A. Sociodemographic Characteristics*

Table 1
Socio-Demographic findings of the participants

| S.No. | Variables | Frequency | Percentage |
|---|---|---|---|
| 1 | **Age (in years):** | | |
| | 20-29 | 48 | 32.0 |
| | 30-39 | 68 | 45.3 |
| | 40-49 | 22 | 14.7 |
| | 50-59 | 12 | 8.0 |
| | Total | 150 | 100.0 |
| | **Gender:** | | |
| 2 | Female | 92 | 61.3 |
| | Male | 58 | 38.7 |
| | Total | 150 | 100.0 |
| 3 | **Religion:** | | |
| | Christianity | 133 | 88.7 |
| | Islam | 17 | 11.3 |
| | Total | 150 | 100.0 |
| 4 | **Tribe:** | | |
| | Hausa | 17 | 11.3 |
| | Igbo | 43 | 28.7 |
| | Yoruba | 21 | 14.0 |
| | Others | 69 | 46.0 |
| | Total | 150 | 100.0 |
| 5 | **Marital Status:** | | |
| | Single | 57 | 38.0 |
| | Married | 88 | 58.7 |
| | Others | 5 | 3.3 |
| | Total | 150 | 100.0 |
| 6 | **Occupation:** | | |
| | Doctor | 81 | 54 |
| | Nurse | 69 | 46 |
| | Total | 150 | 100.0 |
| 7 | **Area of Practice:** | | |
| | internal medicine | 41 | 27.3 |
| | Paediatrics | 39 | 26.0 |
| | Obstetrics/Gynaecology | 36 | 24.0 |
| | Surgery | 34 | 22.7 |
| | Total | 150 | 100.0 |
| 8 | **Designation at work:** | | |
| | Consultant | | 3.3 |
| | Registrar | 5 | 42 |
| | Medical Officer | 63 | 8.7 |
| | Senior Nursing | 13 | 13.3 |
| | Officer | 20 | 32.7 |
| | Nursing Officer | 49 | 100.0 |
| | Total | 150 | |
| 9 | **Years of service at UATH:** | | |
| | 1-10 | 99 | 66.0 |
| | 11-20 | 33 | 22.0 |
| | 21-30 | 18 | 12.0 |
| | Total | 150 | 100 |

Table 2
Assessment of the knowledge of end-of-life care Knowledge of end-of-life care

| S.No. | Variable | Frequency | Percentage (%) |
|---|---|---|---|
| 1 | **Do you know about end-of-life care** | | |
| | Yes | 141 | 94.0 |
| | No | 5 | 3.3 |
| | i don't know | 4 | 2.7 |
| | Total | 150 | 100.0 |
| 2 | **End of life care is the care offered to people with long term or life threatening illness** | | |
| | Yes | 120 | 80.0 |
| | No | 16 | 10.7 |
| | i don't know | 14 | 9.3 |
| | Total | 150 | 100.0 |
| 3 | **End of life care is the care offered to people with terminal illness with less than a year to live** | | |
| | Yes | 109 | 72.7 |
| | No | 22 | 14.7 |
| | i don't know | 19 | 12.7 |
| | Total | 150 | 100.0 |
| 4 | **End of life care can also be referred to as Hospice care** | | |
| | Yes | 111 | 74 |
| | No | 17 | 11.3 |
| | I don’t know | 22 | 14.7 |
| | Total | 150 | 100 |
| 5 | **End of life offers support to a person’s mental and emotional needs, physical comfort, spiritual needs and practical tasks** | | |
| | Yes | 127 | 84.7 |
| | No | 4 | 2.7 |
| | i don't know | 19 | 12.7 |
| | Total | 150 | 100.0 |
| 6 | **In end of life care, the patient involved is being treated only for symptoms they may experience and not the terminal disease itself** | | |
| | Yes | 94 | 62.7 |
| | No | 30 | 20.0 |
| | i don't know | 26 | 17.3 |
| | Total | 150 | 100.0 |
| 7 | **End of life care is offered based on the patients terms** | | |
| | Yes | 97 | 64.7 |
| | No | 27 | 18.0 |
| | i don't know | 26 | 17.3 |
| | Total | 150 | 100.0 |
| 8 | **End of life care can be offered at home or in a facility, be it a nursing home, a hospital or an structured hospice centre** | | |
| | Yes | 132 | 88.0 |
| | No | 0 | 0 |
| | i don't know | 18 | 12.0 |
| | Total | 150 | 100.0 |
| 9 | **End of life care is a multidisciplinary type of care** | | |
| | Yes | 136 | 90.7 |
| | No | 5 | 3.3 |
| | i don't know | 9 | 6.0 |
| | Total | 150 | 100.0 |
| **10** | **Knowledge on effects of end of life care** | | |
| | The practice of end of life care improves the general experience and practice of the healthcare worker positively | 119 | 79.3 |
| | End of life care offers a level of satisfaction and comfort to the family and caretakers of the patient | 134 | 89.3 |
| | End of life care helps the individual live best quality of life till they transit | 134 | 89.3 |
| | End of life care prepares the individual for life after death | 79 | 52.7 |
| **11** | **Overall Knowledge of End of life care** | | |
| | Poor knowledge | 22 | 14.7 |
| | Good knowledge | 128 | 85.3 |
| | Total | 150 | 100.0 |

The table 1 shows the sociodemographic characteristics of the respondents. Most respondents (45.3%) were aged 30-39 years, with most respondents (61.3%) being female. Most respondents identified as Christian 88.7%, persons from minority ethnic groups (46%), And married (58.7%). Eighty-one (54%) of the respondents were doctors, while 69(46%) were nurses with 41(27.3%) of the respondents from the department of Internal medicine, 39(26%) from the department of Paediatrics, 36(24%) from the department of Obstetrics/ Gynaecology and 34(22.7%) from Surgery department.

Among the doctors, most 63(42%) were Registrars, 5(3.3%) were Consultants, and 13(8.7%) were medical officers. Of the Nurses, 20(13.3%) were senior nursing officers and the others 49(32.7%) were nursing officers.

Most of the respondents had worked in the hospital for less than 10 years with only 18(12%) with a history of working more than 20 years in the facility.

Table 2 reflects the assessment of the knowledge of end-of-life care from the respondents; 94% of the respondents knew what end-of-life care was, the majority (80%) were aware that end-of-life care was the care offered to people with long-term or life-threatening illnesses and 72.7% knew that the care was offered to people with terminal illnesses with approximately less than a year to live. The majority of the respondents, 74%, also knew that end-of-life care is called Hospice care. Concerning end-of-life care, 84.7% knew that the care offers

Table 3
General practice of end of life care

| S.No. | Variable | Frequency | Percentage (%) |
|---|---|---|---|
| **1** | **There is an end of life care team or specialty in this facility** | | |
| | Yes no | 27 | 18.0 |
| | I don't know | 90 | 60.0 |
| | Total | 33 | 22.0 |
| | | 150 | 100.0 |
| **2** | **There is a guideline in this facility for end of life/hospice care** | | |
| | Yes no | 17 | 11.3 |
| | I don't know | 75 | 50.0 |
| | Total | 58 | 38.7 |
| | | 150 | 100.0 |
| **3** | **Satisfied with the care administered to the terminal patients in this facility** | | |
| | Yes no | 30 | 20.0 |
| | I don't know | 80 | 53.3 |
| | Total | 40 | 26.7 |
| | | 150 | 100.0 |
| **4** | **As a healthcare worker, I have offered end-of-life care to an individual on your own** | | |
| | Yes | 90 | 60.0 |
| | No | 22 | 14.7 |
| | i don't know | 38 | 25.3 |
| | Total | 150 | 100.0 |
| **5** | **The opinions and wishes of family members/caretakers considered in the management of the patient** | | |
| | Yes | 117 | 78.0 |
| | No | 7 | 4.7 |
| | i don't know | 26 | 17.3 |
| | Total | 150 | 100.0 |
| **6** | **I involved other professionals to take care of patients psychosocial and spiritual concerns** | | |
| | Yes | 100 | 66.7 |
| | No | 33 | 22.0 |
| | i don't know | 17 | 11.3 |
| | Total | 150 | 100.0 |
| **7** | **Patient was aware of his/her right to refuse treatment at any stage of the care** | | |
| | Yes | 97 | 64.7 |
| | No | 24 | 16.0 |
| | i don't know | 29 | 19.3 |
| | Total | 150 | 100.0 |
| **8** | **I implored non-medical therapies which may improve patient health in the management and treatment of patients** | | |
| | Yes | 63 | 42.0 |
| | No | 63 | 42.0 |
| | i don't know | 24 | 16.0 |
| | Total | 150 | 100.0 |
| **9** | **End of life care was administered until patients demise** | | |
| | Yes | 97 | 64.7 |
| | No | 38 | 25.3 |
| | i don't know | 15 | 10.0 |
| | Total | 150 | 100.0 |
| **10** | **In my practice, patients are adequately informed of the type of care they are receiving** | | |
| | Yes | 99 | 66.0 |
| | No | 30 | 20.0 |
| | i don't know | 21 | 14.0 |
| | Total | 150 | 100.0 |
| **11** | **In my practice, pain management is the mainstay treatment of end of life care** | | |
| | Yes | 109 | 72.7 |
| | No | 18 | 12.0 |
| | i don't know | 23 | 15.3 |
| | Total | 150 | 100.0 |

support to a person's mental and emotional needs, physical comfort, spiritual needs, and practical tasks. A good percentage (62.7% and 64.7%) of the respondents know that in end-of-life care, patients are treated only for symptoms they may experience, not the terminal disease itself. That care is offered based on the patient's terms respectively. Most respondents (88%) knew that end-of-life care could be offered at home or in a nursing home, hospital, or structured hospice center. 90.7% of the respondents knew that end-of-life care is a multidisciplinary type of care.

The majority of respondents agree that end-of-life care offers a level of satisfaction and comfort to the family and caretaker of the patient 134 (89.3%), and that end-of-life care helps the individual live the best quality of life until transition 134 (89.3%). Some also agree that end-of-life care prepares the individual for life after death 79(52.7%)

Concerning overall knowledge of end-of-life care among healthcare workers at the University of Abuja teaching hospital, only 85.3% have GOOD knowledge.

### *B. Practice of End-of-Life Care*

Table 3 reflects the general practice of end-of-life care at UATH. 60% of respondents recognize that there is no end-of-life care team within the facility, and 50% (75) of the respondents agree that there are no guidelines for the practice

Table 4
common symptoms of persons receiving end of life care

| S.No. | Variables | Frequency | Percentage (%) |
|---|---|---|---|
| **1.** | **Common Symptoms of Persons Receiving End of Life Care** | | |
| | Pain only | 57 | 38.0 |
| | Pain and other symptoms | 93 | 62.0 |
| | Total | 150 | 100.0 |
| **2.** | **Common Diseases receiving End-of- Life care** | | |
| | Cancer | 107 | 71.3 |
| | Sickle cell | 3 | 2 |
| | Liver disease | 19 | 12.7 |
| | Kidney disease | 37 | 24.7 |
| | Diabetes | 3 | 2 |
| | HIV | 13 | 8.7 |
| **3** | **Others** | | |
| | Invalid | 136 | 90.7 |
| | Destroyed Lung Syndrome | 2 | 1.3 |
| | Heart Failure | 2 | 1.3 |
| | Stroke | 8 | 5.3 |
| | Stroke, | 2 | 1.3 |
| | Total | 150 | 100.0 |
| **4.** | **Limitations of practice of end of life care** | | |
| | Patients reject end of life care even after being adequately informed | 61 | 40.7 |
| | Patients present late to healthcare facilities | 113 | 75.3 |
| | Non-inclusion of end of life care as part of training at undergraduate level | 89 | 59.3 |
| | Lack of specialized trainings for healthcare workers | 89 | 59.3 |
| | Insufficient number of healthcare professionals | 96 | 64.0 |
| | Absence of a standby end of life care team | 114 | 76.0 |
| | Socio-cultural and religious believes in the country | 103 | 68.7 |
| | Non-cooperation of faith based organization | 82 | 54.7 |
| | Lack of special funds for setting up end of life care in institutions | 104 | 69.3 |

of end-of-life care in this facility. The Majority of 80(53.3%) of the respondents indicated their lack of satisfaction with end-of-life practice in this facility.

The table also assesses the practice among healthcare workers on an individual basis. 60% of the healthcare workers had administered end-of-life care independently, and 78% considered the opinions and wishes of the patient's family members or caretakers in patient management. 66.7% of respondents stated that they involved other healthcare professionals in caring for patients' psychosocial and spiritual needs, and 64.7% ensured patients were aware of their rights to refuse treatment and care at any stage. About 42% implored non-medical therapies in patient management. In practice, 66% and 72.7% adequately informed the patient on the type of care they were receiving and managed pain as the mainstay of treatment, respectively.

The overall practice of end-of-life care at UATH was generally poor, with the majority, 60.7% (91), exhibiting poor practices.

Table 4 reveals that pain alone as the manifesting symptom for end-of-life care consisted of about 38% (57) of cases. Common disease conditions managed in end of life care were Cancer 107(71.3%), Kidney disease 37(24.7%), liver disease 19(12.7%), HIV/AIDS 13(8.7%), sickle cell disease 3(2%) and diabetes 3(2%) Some of the most commonly experienced limitations to the practice of end of life care at UATH are the absence of a designated end of life care team 114(76%), late presentation of patients 113(75.3%), lack of funding to support end of life care in the institution 104(69.3%), and sociocultural and religious believes 103(68.7%). Other limitations include the insufficient number of healthcare professionals trained in end-of-life care 96(64%), Non-inclusion of end-of-life care as part of training at undergraduate level and Lack of specialized trainings for healthcare workers both have 89(59.3%), non-cooperation of faith-based organizations 82(54.7%) and patients rejecting end of life care even after being adequately informed 61(40.7%).

### *C. Results on the Associations*

Table 5 shows the relationship between the sociodemographic characteristics of the respondents and their overall knowledge on end-of-life care. The results showed that there is a relationship between respondent's sociodemographic characteristics and the knowledge of end-of-life care. Apart from religion, ($X^2$=0.129, p=0.719) which has no statistical relationship with the overall knowledge, all the other variables age ($X^2$=34.507, p=o.oo1), gender ($X^2$ = 9.509, p=0.002), ethnicity ($X^2$ = 25.162, p=<0.001), marital status ($X^2$ =35.159, p=<0.001), occupation ($X^2$ = 10.150, p=<o.oo1), area of practice($X^2$ =21.695, p=0.001), designation at work($X^2$ =24. 695, p= 0.012) and years of service ($X^2$ =7.349, p=0.025) all indicated a statistically significant relationship between these parameters and knowledge.

Table 6 above represents the relationship between the sociodemographic characteristics of the respondents and the overall practice of end-of-life care by the respondents. The results show that there is no statistical relationship between the sociodemographic characteristics and overall practice.

## 4. Discussion

This study had a 93% response rate, which was similar to a study conducted in a teaching hospital in Enugu State, Nigeria, that focused on evaluating the knowledge and practice of end-of-life care among nurses with a response rate of 94.6%.[8] This study also had a preponderance of female respondents (61.3%) compared to other studies where the male-to-female ratio is

Table 5
Association between Sociodemographic Characteristics and Knowledge

| S.No. | Variables | Knowledge | | Chi-Square | P-Value |
|---|---|---|---|---|---|
| | | Poor knowledge Frequency (%) | Good knowledge Frequency (%) | | |
| **1** | **Age (in years):** | | | | |
| | 20-29 | 12(8) | 36(24) | | |
| | 30-39 | 0(0) | 68(45.3) | 34.507 | <.001* |
| | 40-49 | 10(6.7) | 12(8) | | |
| | 50-59 | 0(0) | 12(8) | | |
| | Total | 22(14.7) | 128(85.3) | | |
| **2** | **Gender:** | | | | |
| | Female | 20(13.3) | 72(48) | 9.509 | .002* |
| | Male | 2(1.3) | 56(37.3) | | |
| | Total | 22(14.7) | 128(85.3) | | |
| **3** | **Religion:** | | | | |
| | Christianity | 20(13.3) | 113(75.3) | .129 | .719 |
| | Islam | 2(1.3) | 15(10) | | |
| **4** | **Tribe:** | | | | |
| | Hausa | 0(0) | 17(11.3) | | |
| | Igbo | 16(10.7) | 27(18) | 25.162 | <.001* |
| | Yoruba | 2(1.3) | 19(12.7) | | |
| | Others | 4(2.7) | 65(43.3) | | |
| **5** | **Marital status:** | | | | |
| | Single | 2(1.3) | 55(36.7) | 35.159[a] | <.001* |
| | Married | 15(10) | 73(48.7) | | |
| | Others | 5(3.3) | 0(0) | | |
| **6** | **Occupation:** | | | | |
| | Doctor | 5(3.3) | 76(50.7) | 10.150[a] | .001* |
| | Nurse | 17(11.3) | 52(34.7) | | |
| **7** | **Area of practice:** | | | | |
| | Internal medicine | 14(9.3) | 27(18) | | |
| | Paediatrics | 2(1.3) | 37(24.7) | 21.695[a] | <.001* |
| | Obstetrics/gynaecology | 0(0) | 36(24) | | |
| | Surgery | 6(4) | 28(18.7) | | |
| **8** | **Designation at work:** | | | | |
| | Consultant | 0(0) | 5(3.3) | | |
| | Registrar | 5(3.3) | 58(38.7) | 12.945[a] | .012* |
| | Medical Officer | 3(2.0) | 17(11.3) | | |
| | Senior Nursing Officer | 0(0) | 13(8.7) | | |
| | Nursing Officer | 14(9.3) | 35(23.3) | | |
| **9** | **Years of service at UATH:** | | | | |
| | 1-10 | | | | |
| | 11-20 | 9(6) | 90(60) | 7.349[a] | .025* |
| | 21-30 | 8(5.3) | 25(16.7) | | |
| | | 5(3.3) | 13(8.7) | | |

*: statistically significant X2: Chi square

equal or males are the majority. For example, in a study among medical interns, there were almost five males for every one female [9].

This study had more participation from doctors than nurses, with 81% of doctors and 69% of nurses taking part.[10] interestingly, most end-of-life palliative care studies tend to focus on nurses. The respondents were sampled from four different in-patient departments, which is different from other studies where only doctors in the ICU were involved in end-of-life care research [10]. This study revealed that the healthcare workers at UATH possess a strong understanding of endof-life care, with 85.3% demonstrating overall knowledge. This is in contrast to studies conducted in the northwest Nigeria, where respondents had poor knowledge regarding end-of-life care.

To provide effective end-of-life care, it is crucial for both the caregiver and the facility to understand the principles and regulations governing this practice. Unfortunately, more is required to improve overall quality of end-of-life care in UATH is poor, with only 39.3% of respondents reporting satisfactory care. Most respondents also confirmed the absence of a dedicated hospice care specialty, team, or guidelines for end-of-life care. Although there are few studies on end-of-life care in Nigeria, there are also governing guidelines established by the federal ministry of health, which created a Palliative Care Policy for Hospice and Palliative Care to serve as a manual for all end-of-life care operations in the country.

While 90% of respondents have offered some form of end-of-life care on an individual basis, this falls short of the recommended multidisciplinary approach. Only about 67% of respondents involved other professionals in administering end-of-life care. However, 78% of respondents indicated that they considered the opinions and wishes of the patient's family in managing patients. Additionally, 66% of respondents reported adequately informing patients about the type of care they are receiving, which is essential as the WHO guidelines recommend full patient involvement in end-of-life care [11].

In this study, various disease conditions were identified in addition to cancer. These included end stage kidney disease, long-term liver disease, diabetes, HIV, sickle cell disease, stroke, and others. It's worth noting that according to the World Health Organization, all terminal illnesses are eligible for care. This underscores the importance of providing support and care

Table 6
Association between sociodemographic data and practice

| S.No. | Variable | Practice | | Chi-Square | P- Value |
|---|---|---|---|---|---|
| | | Poor practice Frequency (%) | Good practice Frequency (%) | | |
| **1** | **Age (in years):** | | | | |
| | 20-29 | 37(24.7) | 11(7.3) | | |
| | 30-39 | 39(26) | 29(19.3) | 12.477[a] | .006 |
| | 40-49 | 12(8) | 10(6.7) | | |
| | 50-59 | 3(2) | 9(6) | | |
| **2** | **Gender:** | | | | |
| | Female | 53(35.3) | 39(26) | .932[a] | .334 |
| | Male | 38(25.3) | 20(13.3) | | |
| **3** | **Religion:** | | | | |
| | Christianity | 79(52.7) | 54(36) | .791[a] | .374 |
| | Islam | 12(8) | 5(3.3) | | |
| **4** | **Tribe:** | | | | |
| | Hausa | 12(8) | 5(3.3) | | |
| | Igbo yoruba others | 34(22.7) | 9(6) | 11.681[a] | .009 |
| | | 12(8) | 9(6) | | |
| | | 33(22) | 36(24) | | |
| **5** | **Marital status:** | | | | |
| | Single | 44(29.3) | 13(8.7) | 15.940[a] | .000 |
| | Married others | 42(5) | 46(30.7) | | |
| | | 5(3.3) | 0(0) | | |
| **6** | **Occupation:** | | | | |
| | Doctor | 60(21) | 21(14) | 13.265[a] | .000 |
| | Nurse | 31(20.7) | 38(25.3) | | |
| **7** | Area of practice: | | | | |
| | Internal medicine | 26(17.3) | 15(10) | | |
| | Paediatrics | 29(19.3) | 10(6.7) | 5.761[a] | .124 |
| | Obstetrics/gynaecology | 18(12) | 18(12) | | |
| | Surgery | 18(12) | 16(10.7) | | |
| **8** | **Designation at work:** | | | | |
| | Consultant | 0(0) | 5(3.3) | | |
| | Registrar | 47(31.3) | 16(10.7) | 28.431[a] | .000 |
| | Medical Officer | 9(6) | 11(7.3) | | |
| | Senior Nursing Officer | 13(8.7) | 0(0) | | |
| | Nursing Officer | 22(14.7) | 27(18) | | |
| **9** | **Years of service at UATH:** | | | | |
| | 1-10 | 65(43.3) | 34(22.7) 14(9.3) 11. | 4.743[a] | .093 |
| | 11-20 | 19(12.7) | | | |
| | 21-30 | 7(4.7) | | | |

to patients with various diseases [11].

Furthermore, the analysis revealed a correlation between sociodemographic characteristics and end-of-life care practices. The longer the duration of practice, the better the practice. This outcome is not surprising, given that end-of-life care requires utmost maturity, empathy, and adequate training to handle patients' concerns and those of their families or caretakers.

### *A. Limitation to the Practice of End-of-Life Care*

The shortage of trained healthcare professionals remains one of the most important limitations to the proper practice of end-of-life care. This is understandable as the end-of-life care requires a team effort. Some of the reasons for not providing end-of-life care, are patients arriving at the facility too late (75.3%), which can lead to poorer outcomes, but end-of-life care should begin at the first encounter, particularly with chronic diseases, so late arrival should not deter care. Noncooperation of faith-based organizations (69%) is next because there is a spiritual aspect to end-of-life care, and a lack of cooperation may present a problem to coordinated care. The lack of a standby end-of-life care team, which is emphasized in WHO guidelines and federal ministry of health guidelines for the importance of teamwork is another major limitation [11], [12]. A study found that 64% of healthcare workers lack specialized training, highlighting a problem that affects Low-to-Middle-Income countries (LMIC) and institutions should address by providing appropriate training. Additionally, 59.3% identified the non-inclusion of end-of-life care at the undergraduate level as an issue. It's essential to start providing coverage from the grassroots level to ensure adequate care. Sociocultural and religious beliefs in the country were cited by 54.7% as a limitation, and 40% noted patients rejecting end-of-life care despite being informed. These challenges require solutions at the government, health institutional, and individual levels.

## 5. Conclusion

The United Nations Sustainable Development Goal three (3), focuses on achieving good health and well-being for everyone [13]. This includes individuals with terminal illnesses. Unfortunately, the prevalence of debilitating terminal illnesses is increasing, highlighting the need for hospice care. However, it is important to note that there is currently no established end-of-life care team, specialty, or guidelines in UATH. To address this issue, the limitations that have been identified should be addressed at the government, healthcare institutions, and healthcare provider levels.

## 6. Recommendation

The Nigerian Ministry of Health has done an excellent job developing the policy for palliative care. However, more intentional implementation through awareness creation for the populations and capacity strengthening workshops for healthcare providers are needed to make this policy more widely accepted. It should be incorporated into the manuals for health service provision in every federal health institution. In addition to the fully funded programs for diseases like HIV and TB, increased intentional collaborations, partnership creation and increased funding for end-of-life care should be encouraged.

Health institutions, should train existing workforce, increase the healthcare workforce and invite specialists in palliative care to provide training for hospital staff. A special team should be formed for end-of-life care.

Healthcare providers should take the time to learn about end-of-life care, practice how to offer it, and be prepared for when the situations arise. As the old saying goes, "If you fail to plan, you have planned to fail." Offering end-of-life care should not be a difficult task if proper planning and preparation are done beforehand.

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