Rural and Remote Health
MEDLINE listed
Impact factor .820
The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy
ISSN 1445-6354

ORIGINAL RESEARCH

A qualitative study: potential benefits and challenges of traditional healers in providing aspects of palliative care in rural South Africa

LM Campbell, NN Amin

Edgewood College, School of Education, University of KwaZulu-Natal, Durban, South Africa

Submitted: *16 October 2012;* ***Revised:*** *4 September 2013;* ***Accepted:*** *26 September 2013;* ***Published:*** *11 May 2014*

Campbell LM, Amin NN

A qualitative study: potential benefits and challenges of traditional healers in providing aspects of palliative care in rural South Africa
Rural and Remote Health **14: 2378. (Online) 2014**

Available: http://www.rrh.org.au

ABSTRACT

Introduction: This article draws on selected palliative care providers' views and experiences to reflect on the potential benefits and possible challenges of involving traditional healers in palliative care in rural areas of South Africa. There is increasing consensus that palliative care should be offered by a range of professional and non-professional healthcare givers. Including non-professionals such as traditional healers in a palliative care team may strengthen care provisioning as they have intimate knowledge of patients' local culture and spiritual beliefs.

Methods: Employing the qualitative method of photo-elicitation, one-on-one discussions about the photographs taken by participants were conducted. The participants – 4 palliative care nurses and 17 home-based care workers – were purposively selected to provide in-depth information about their experiences as palliative caregivers in rural homes.

Results: Healthcare workers' experiences revealed that the patients they cared for valued traditional rituals connected to illness, dying, death and bereavement. Participants suggested that traditional healers should be included in palliative care training programs as they could offer appropriate psychological, cultural and spiritual care. A challenge identified by participants was the potential of traditional healers to foster a false sense of longevity in patients facing death.

Discussion: The importance of recognising the value of traditional practices in palliative care should not be underrated in rural South Africa. Traditional healers could enhance palliative care services as they have deep, insider knowledge of patients' spiritual needs and awareness of cultural practices relating to illness, death, dying and bereavement. Incorporating traditional healers into healthcare services where there are differences in the worldviews of healthcare providers and patients, and a sensitivity to mediate cultural differences between caregivers and patients, could have the benefit of providing appropriate care in rural spaces.

Rural-and-Remote-Health
The International Electronic Journal of Rural and Remote Health Research, Education Practice and Policy

Conclusions: Considering the influences of cultural and spiritual beliefs on the wellbeing of patients living in rural areas, the inclusion of traditional healers in a palliative care team is a sensible move. It is, nevertheless, important to note that unanticipated challenges may arise with respect to power differentials within the palliative care team and to beliefs that contradict medical prognosis.

Key words: palliative care, qualitative research, South Africa, traditional healer.

Introduction

This article is based on findings from a larger study[1], which reviewed the experiences of nurses and home-based care workers who provide palliative care in patients' homes in a rural area of South Africa. A small number of participants suggested that traditional healers may be vital to the psychological health of those facing death. Though not a widespread finding, the idea mooted offered an opportunity to consider the suggestion in view of the large number of persons facing death in rural KwaZulu-Natal in South Africa and the imperative to provide appropriate support.

The disparity of basic services in South Africa is evident in the difference between distribution of basic services to highly developed urban spaces and to underdeveloped rural areas. Homes in many rural areas have limited access to clean water, electrification and waste disposal services. Rural residents have reduced access to medical services compounded by poor service infrastructure and reluctance of trained medical personnel to serve in these areas. The population is often poor and mainly comprises older women as the men and younger females are migrant labourers who work in urban areas where employment is available. There is a high incidence of persons with life-limiting illnesses in these areas as migrants with HIV and AIDS return to be cared for by family members or by home-based palliative caregivers. The palliative care offered in rural spaces is often provided by volunteer caregivers with basic training as there is a shortage of professionally trained healthcare workers. The burden of care is borne by 'home-based care workers', volunteer caregivers or individuals selected from a local community, trained in basic aspects of palliative care, and supervised by professional healthcare providers. The reliance on volunteers to provide home-based care is a vital scaffold of the distribution of health service delivery in an area where human capital resources are scarce and serious illness is high as very few individuals in rural areas can afford private medical care.

The use of untrained volunteers could be viewed as standing in opposition to suggestions in established literature emerging in the developed world that individuals diagnosed with a life-limiting or life-shortening illness be cared for by medical personnel, which include specialist palliative care physicians and non-specialists such as family medicine practitioners and nurses[2]. The contextual complexities of under-resource and inequitable healthcare provisioning means that in Africa, by contrast, the ideal of professionals taking care of the dying is improbable. It follows then that palliative care requires the healthcare provider to offer holistic care that should account for patients' unique contexts. This article considers one such context in KwaZulu-Natal, which reflects the aforementioned characteristics of a rural area.

Taking cognisance of the principles of palliative care and aiming to care for patients in familiar contexts, there is potential to include traditional healers within a palliative care team for some areas of KwaZulu-Natal. Indeed, the African patient may be familiar and comfortable with receiving care from traditional healers. In Africa, traditional healers are valued for preserving and appreciating a sense of a distinctive 'African' identity[3]. The benefit of the traditional healing system lies in its sharing of the worldviews and belief systems of its users[4]. Traditional healers can offer privacy in patients' homes without the time limitations per consultation that characterise western approaches to medical consultations

and, more importantly, they provide culturally appropriate psychological counsel[3]. Furthermore, traditional healers have been reported as having a caring attitude and concern about the wellbeing of the patient[5].

As long ago as 1978, the World Health Organization noted the need to include traditional healers as a part of healthcare services[6]. In Africa, it is estimated that up to 80% of the population consult traditional healers in the first instance, and in some cases traditional healers are vital for gaining community approval and improving health service uptake[7]. Traditional healers continue to be the primary, and are sometimes the only, accessible healthcare option for the vast majority of people living in sub-Saharan Africa[6]. In South Africa, since the end of apartheid in 1994, and a concomitant acceptance of the legitimacy and benefit of Indigenous medicine, increasing numbers of people are becoming traditional healers[3]. It is likely, therefore, that traditional healers' influence over and presence in healthcare provisioning will rise. It is thus not surprising that the Hospice Palliative Care Association of South Africa (HPCA) has encouraged dialogue between healthcare professionals and traditional healers[8]. Of greater importance is the HPCA's position that there should be empowerment of traditional healers to provide basic palliative care services[8].

The involvement of traditional healers is not unique to South Africa; studies from Zambia and Tanzania report that traditional healers can be effective in providing aspects of palliative care, such as counselling and support[9,10]. The importance of the traditional healer, especially in caring for dying patients and to prepare families to accept the inevitability of death, is described thus in the literature[11]:

> *Traditional healers are informed by the ancestors when a patient is dying. They summon and counsel the family of the patient, advising them to take the patient home and to seek no further treatment because God and the ancestral spirits are taking the person who has finished what he came to do in this world … They ask God and the ancestors to take away the patients' pain and allow him or her to go peacefully.*

The involvement of traditional healers in palliative care, however, is not unproblematic. Studies report that visiting a traditional healer may cause patients to delay seeking medical attention from formal healthcare providers[12]. The consequences of the delay could result in a patient only visiting a doctor or nurse when the illness has progressed beyond potential cure or when the patient is already in the terminal stages without having had an opportunity for palliation. The work of traditional healers also involves a significant 'supernatural' component, which includes spiritual procession through which the ancestors pass on inspired knowledge on how to assess and treat patients[3]. As such, traditional healers and healthcare workers may have different religious ideologies and opposing views of the cause and treatment of disease, resulting in conflict. Some doctors and nurses may be hesitant to collaborate with traditional healers in patient care as traditional healers' work is often associated with 'witchcraft'[4].

Methods

Setting

The study took place in a rural area of KwaZulu-Natal, the most population-dense province of South Africa. It is also the space where Zulu culture is most dominant and prevalent in the country. The study site was selected for several reasons, including that nurses and home-based care workers there were trained in palliative care and supervised by a local hospice. This situation is uncommon in South Africa: few healthcare workers and home-based care workers are trained in palliative care and few hospices are available to supervise and support palliative care in rural areas.

Sample

The participants in the study included nurses and home-based care workers who practise palliative care in patients' homes. Those selected for inclusion were purposively considered to be information-rich; this method of selecting participants is common in qualitative research[13]. Potential participants were

available at a hospice and three affiliated home-based care (HBC) organisations. Four Zulu-speaking nurses (from a total of five) and 17 home-based care workers (from 45) agreed to participate. Three nurses were female and one male and their age range was 40–60 years. The nurses had worked in palliative care for an average of 3 years and had all qualified in a short, distance-course on palliative care nursing for professional nurses. The home-based care workers comprised 15 females and 2 males. They attended to patients' basic hygiene, provided counselling, were supervised by nurses and received a stipend for their work. They had no formal healthcare or palliative care education and their work experience varied from 1 year to 15 years.

Data collection

Data were collected using a method of photo-elicitation in which participants were requested to take photographs that they felt depicted issues related to experiences of their daily work. This data collection method has been used in South Africa to generate qualitative data when the topic under investigation is sensitive for participant discussion[14]. Photographs were not used as a direct method to elicit data, but as a reference point to be used for subsequent discussion in one-to-one interviews between participants and the researcher. Participants were requested to avoid taking photographs of people; if they wished to they were asked to take the photograph in such a way that the person could not be identified. Visual data (especially photographs produced by participants) is often subjected to more rigorous scrutiny by ethics boards than most other data sources[14]. In this study, to ensure that both participants and their photographic subjects were not placed at any risk, the researcher presented all photographs to the institutional research ethics committee, which made the final decision about photographs suitable for the public domain.

The researcher discussed each photograph with the participant and interviews were carried out in English; the services of a translator were made available when participants responded in isiZulu, the dominant language of communication in the areas of the study. Duration for discussions of the photographs were about 1 hour and were tape-recorded and later transcribed. The researcher and participants looked together at each photograph and the researcher asked participants to explain why they had taken that photograph. The role of the researcher was to prompt, encourage expansion of discussions and to seek clarification.

Data analysis

When using qualitative methods, there is no quick and easy way to map out the interpretive processes involved with analysing data; literature offers useful suggestions and guidelines on analytical approaches[13]. In this study, analysis involved an inductive rather than deductive approach (looking at themes that 'naturally' arose from data rather than fitting data into predetermined categories). Analysis involved five steps: familiarization and emersion, inducing themes, coding, elaboration, and interpretation and checking[13].

Generalisability, replicability and validity

Qualitative research does not aim to produce generalisable or replicable data – it is expected that participants' perceptions will be subjective and unique[13]. A common, consensual truth is not sought; instead there is sensitivity to and recognition of multiple truths that occur simultaneously depending on individual participant perspectives. The subjective construction of the world explains the contradictions and disparities of views and perceptions relayed by participants. Qualifying checks of data collection and interpretation included the validity concepts of transparency (participants were informed about the study), authenticity (persons with insider knowledge were selected) and trustworthiness (the claims in this study are made in terms of contextual relevance)[13].

Ethics approval

Ethical clearance was obtained from the research ethics committee at the University of KwaZulu-Natal (HSS 0079/10D). The aims of the study were communicated to hospice and HBC managers who in turn informed nurses and

home-based care workers of the intentions of the study. Coercion was minimised as those volunteering participation made direct contact with the researcher. Participation was not mediated through official channels. Consent forms and study information forms were available in both English and isiZulu (the first language of participants). Prior to giving written consent, participants were fully informed of their right to anonymity and confidentiality. They were informed that they could withdraw from the research process at any time, and participants received feedback on completion of the study.

Results

Importance of traditional practices in a rural community

Most participants' descriptions of their experiences alluded to the continued importance of traditional practices in the context of rural home-based palliative care:

> *I think that on the African side of the family as such, no not the family – the clan – they used to acknowledge, oh there is a death in that family and that there is a certain way that is expected for them to behave. For instance, especially if I have lost my man, my husband, I'm not allowed to go to the social gathering for the family. The women should be quiet; there should be no fighting and no raising of the voice.*

> *The customs are mainly for women who must be seen to be mourning. A man is just expected to wear a black belt for one month or three months … They used to have this belief that a man should get married before the gall bladder bursts, so the quicker the better.*

> *One month after the person has died we have to slaughter a goat to cleanse the family. The people then are allowed to attend the social gathering but you as a woman you have to mourn the whole year.*

The data reveals that traditional practices are rooted in community, not in individuals: entire clans are involved in issues related to illness and death. Within such extended family structures, roles are deeply gendered, with clearly defined 'rules' for men and women. It becomes necessary, therefore, for nurses and home-based care workers to be aware of local practices and traditions in connection with illness, dying and death. For example an outsider may mistakenly interpret the traditional practice of silence and social isolation as depression in women mourners. Additionally, practices such as slaughtering a goat could be seen as cruel and primitive. The challenge associated with the tradition of slaughtering animals is also illustrated in data:

> *I still remember that there is a patient who died at the hospice and these African people they wanted to go and slaughter the chicken there. They wanted to call the ancestors and the hospice staff said that they were not allowed to do this.*

In this instance, scientific tradition (the hospice) and African tradition are in conflict. The former determines and prescribes care practice without due consideration of the worldviews of the latter. Challenges for both hospice and tradition arise. The hospice is a place of care for people of different cultures and the slaughtering of an animal may be offensive to non-Zulu patients. Zulu patients, on the other hand, may feel marginalised and helpless and mourn not only the loss of a family member, but also the missed opportunity to cope with grief as prescribed by tradition.

The participants' experiences reveal just the tip of the iceberg of cultural practices that need to be understood by those who provide care. Unlike a hospice, in which individuals from many races and cultures are treated, home-based care workers are not faced with multiple worldviews. It is essential, therefore, that they are guided and prepared to work with local traditions. It is unlikely that even insiders to Zulu culture, for instance, are fully cognisant of all cultural practices, and the need to include traditional healers in palliative care was alluded to by participants in the study.

Potential benefits of including traditional healers in palliative care

In several instances participants described the advantages of a palliative care approach that allowed traditional healers to provide traditional medicines:

> *Families used to take care of their own. For example, we traditional Zulus have had our own traditional herbs that could help the patient. You know like if the patient had a sore the traditional healer was able to put some herbs to heal it, if the patient had diarrhoea they had medicinal substances that they could prepare and give to the patients.*

The benefit arising from patients being providing traditional medicines is that it would reduce reliance on the services of nurses and home-based care workers; the services could be deployed to areas where healthcare services are lacking. Crucially, patients in rural areas believe and have experienced the healing properties of traditional medicines, which could relieve their pain symptoms. Relieving pain, whether the relief is actual or imagined, is vital as home-based care workers cannot by law dispense medicines to patients. Traditional medicines, by contrast, can be dispensed by traditional healers.

Participants' views on the importance of traditional healers were expressed in palliative care training courses as well. Participants felt that traditional healers were especially knowledgeable of patients' psychological problems:

> *Our palliative care course didn't involve people who are practising traditional medicines. You never invited a Sangoma [practitioner of herbal medicine, divination and counselling in traditional Nguni (Zulu, Xhosa, Ndebele and Swazi) societies of southern Africa] there and you never invited an Inyanga [herbalist who makes medicines from plants and animals] there to tell us what they think we need to do in order to ease the life of the person that is suffering.*

I believe that it would have been useful to include traditional healers in palliative care training as they will come with their own understanding of the whole problem because some of the patients' problems are not really physical. The problem is psychological so if you address the issue of the mind sometimes the person gets relief.

The belief in the power of traditional healers to deal with palliative care patients is evident. The participants in the study perceived their training as incomplete because it did not provide training to deal with the 'whole problem', which, in this case, meant including psychological care from a cultural perspective. From this perspective, one can deduce that traditional healers are also seen as preservers of culture.

Potential challenges to collaboration with traditional healers in palliative care

Whilst there was general consensus that traditional healers were essential in a palliative care program, some participants identified points of tension that may arise:

> *It's very difficult to explain to our own Africa people that their disease, such as HIV/AIDS, cannot be cured because Africans always believe there is a miracle going to happen. They go to the Inyanga. They still believe that there is an Inyanga who can do a miracle and get them cured.*

> *Sometimes, traditional healers want everyone to come to them and they share over the radios that they can cure AIDS.*

The resistance to believe in the incurability of an illness coupled with traditional healers' beliefs in their ability to 'cure', for example, HIV and AIDS provides traditional healers with opportunities to exploit palliative care patients for personal gain. Credibility is given to claims of 'cure' through advertisements over the radio, which, in rural spaces, is the most common mode of public communication. Particularly in rural parts of KwaZulu-Natal, many people believe that traditional healers can cure diseases such as HIV and AIDS.

Producing quantifiable evidence about the benefits of traditional healing in palliative care is challenging because the success of traditional care-giving may rely heavily on patients' subjective beliefs and on a placebo effect, as recounted by a participant:

> *It is not scientifically proven and it is not tested in laboratories but traditional healers do work as most of the time it is about faith. If you believe in something that is going to help you then it does help you even if it wasn't designed to cure the illness that you are having. The mere fact that you believe that it is going to work will help you.*

The data in this instance highlights that some participants, who are trained as well as volunteer palliative care workers in rural areas and who have been exposed to scientific interpretations of illness and care, are aware of the contradictions and uncertainties of supposed cures and the role of the psyche. The potential for conflict between members of a palliative care team that includes allopathic and traditional caregivers cannot be ignored.

Discussion

Findings from this study point strongly to the continuing importance of traditional practices around illness, dying, death and bereavement in a rural Zulu community. Traditional healers have knowledge of local traditional practices, referred to as Indigenous knowledge[15]. South African-based studies have established that Indigenous knowledge is beneficial as it is valued by patients, especially in rural areas[15]. Indigenous knowledge is important because some Zulu patients believe that ancestors must be involved in the dying process and bereavement. Given that traditional healers have Indigenous knowledge, further research could consider whether traditional healers could integrate aspects of Indigenous knowledge within the knowledge and practice of a palliative care team.

Literature notes that in a developed-world context healthcare professionals are increasingly caring for patients from a culture different to their own[16]. It also provides evidence that people from cultures other than Anglicised cultures experience poorer health outcomes. These poorer health outcomes are due to issues such as differences in patients' ability to access healthcare services, language challenges, and institutional racism where organisations fail to provide culturally and linguistically appropriate services[16]. It may be possible that lessons learnt in a South African context of collaboration between healthcare professionals and traditional healers and caring across cultures can be extrapolated to a developed-world context. The developed world is increasingly becoming more multiracial, multilingual and multicultural. One can anticipate that the conflict associated with dominant and marginal worldviews is likely to emerge in the developed world too.

Participants were of an opinion that their palliative care training neglected the area of traditional healing. Possible reasons for this exclusion may be that it is difficult to identify a traditional healer who would be willing to impart information on Indigenous knowledge. Traditional healers may also be overlooked in palliative care training as it may be complicated to decide if a traditional healer is accredited. Although the government of South Africa has taken steps to standardise traditional healer training and accreditation processes, attempts at standardisation have been perplexing as there are many forms of traditional healer training and practice (literature describes at least three categories)[3]. Some form of accreditation is important as data illustrates that traditional healers could foster a belief that they cure illnesses such as AIDS. Means to foster collaboration and synergy between healthcare providers and traditional healers could be gathered from other studies. For example, literature indicates that there can be synergy and collaboration between healthcare providers and traditional healers in training and in practice of HIV and AIDS care and prevention[17].

In this study, the benefit of the traditional healers' involvement was the provision of psychological care for patients that emanated from the traditional healers' knowledge of the 'whole person'. Palliative care providers could potentially learn from traditional Zulu culture, which cherishes a concept of 'a whole self' and *Ubuntu*, a holistic and collective approach to caring[18]. Including traditional healers within a palliative care service could be useful as they can provide the traditional medicines valued in this society. However, traditional medicines are not without problems

and literature indicates that they may cause adverse effects and toxicity[19].

Palliative care training in South Africa highlights some potential benefits of including traditional healers. However the benefits should be moderated with awareness of potential challenges such as traditional healers' exploitation of patient beliefs for personal gain. Challenges may arise when assessing the impact of traditional healers' care as it is an evidence-based practice and discipline. Literature suggests that quantitative research should be prioritised in aligning African palliative care with an evidence-based approach[20]. Given that patient responses to traditional healing are subjective, producing a quantitative evidence-base may not be achievable.

Limitations of the study

The findings serve to illustrate and not represent the experiences and opinions of nurses and home-based care workers in the study context. The study was not deliberately designed to identify the experiences of palliative caregivers about traditional healers; the views of nurses and home-based care workers of traditional healers emerged indirectly from interviews. Extensive data was not sought and, therefore, not available for analysis. A future design that specifically aims to directly assess the opinions of participants is necessary. Findings could be supported by triangulation using data from nurses and home-based care workers in differing sites and by using various data collection methods. The views of those who chose not to participate in this study and views of patients, families and traditional healers would be useful as well.

Conclusions

This study has provided brief glimpses of the views of participants. It is evident that local spiritual and cultural customs of dying, death and bereavement, and Indigenous knowledge, are important when providing healthcare services in rural areas. Undoubtedly, traditional healers could collaborate with palliative care providers to meet the spiritual and cultural needs of patients. A traditional healer could also be of benefit in a palliative care team as they can dispense traditional medicine and have an in-depth knowledge of patients' psychological needs, which could supplement and complement the work of nurses and home-based care volunteers. Traditional healers could also be included in palliative care training and practice, although the potential for conflict and complications would need to be acknowledged. The implications for harmonising the roles of traditional healers and health professionals would be vital for the success of such collaborations. Collecting data about the impact of traditional healers in palliative care may be particularly challenging as the effect of their care is subjective and their practice may be difficult to standardise. Finally, the authors concede that there is need for further research into the potential role of traditional healers in palliative care.

References

1. Campbell L. Experiences of nurses practising home-based palliative care in a rural South African setting. *International Journal of Palliative Nursing* 2011; **17(12):** 593-597.

2. Gardiner C, Gott M, Ingleton C. Factors supporting good partnership working between generalist and specialist palliative care services: a systematic review. *British Journal of General Practice* 2012; **62(598):** e353-362.

3. Thornton R. The transmission of knowledge in South African traditional healing. *Africa* 2009; **79(1):** 17-34.

4. Staugard F. *Traditional healers*. Gaborone, Botswana: Ipelegeng Publishers, 1985.

5. Staugard F. Role of traditional health workers in prevention and control of AIDS in Africa. *Tropical Doctor* 1991; **21:** 22-24.

6. World Health Organization (WHO). *Primary health care*. Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 1978. (Online). Available: http://whqlibdoc.who. int/publications/9241800011.pdf (Accessed 12 May 2013).

7. Homsy J, King R, Balaba D, Kabatesi D. Traditional health practitioners are key to scaling up comprehensive care for HIV/AIDS in sub-Saharan Africa. *AIDS* 2004; **18:** 1723-1725.

8. Sephton S, Sithole Z. *Palliative care: access to care*. (Online) 2008. Available: http://www.hospicepalliativecaresa.co.za/Legal_Resources.html (Accessed 22 May 2013).

9. Green E. *AIDS and STDs in Africa: bridging the gap between traditional healing and modern medicine*. Boulder, CO: Westview Press, 1994.

10. Kikule E. A good death in Uganda: survey of needs for palliative care for terminally ill people in urban areas. *British Medical Journal* 2003; **327(7408):** 192-194.

11. Hewson M. Traditional healers in Southern Africa. *Annals of Internal Medicine* 1998; **128(12):** 1029-1034.

12. Harding R, Stewart K, Marconi K, O'Neill J, Higginson IJ. Current HIV/AIDS end-of-life care in sub-Saharan Africa: a survey of models, services, challenges and priorities. *BMJ Support Palliative Care* 2011; **1:** 118-122.

13. Cohen L, Manion L, Morrison K. *Research methods in education*. London and New York: Routledge, 2011.

14. Mitchell C. Getting the picture and changing the picture: visual methodologies. *South African Journal of Education* 2008; **28(3):** 365-383.

15. Moos A, Struwig J, Roberts B. Local is lekker: Indigenous knowledge should be encouraged. *HSRC Review* 2010; **8(4):** 10-11.

16. Naravanasamy A, White E. A review of trans-cultural nursing. *Nurse Education Today* 2005; **25(2):** 102-111.

17. Colvin M, Gumede L, Grimwade K, Wilkinson D. Integrating traditional healers into a tuberculosis control programme in Hlabisa, South Africa. MRC Policy Brief No 5, December, 2004. (Online). Available: http://www.mrc.ac.za (Accessed 12 May 2013).

18. Boon M. *The African way*. Cape Town: Zebra Press, 2007.

19. Hedberg I, Staugard F. *Traditional medicinal plants*. Gaborone, Botswana: Ipeleng Publishers, 1989.

20. Powell R, Downing J, Harding R, Radbruch L, Mwangi-Powell F. Advancing palliative care research in Sub-Saharan Africa: from the Venice Declaration to Nairobi and beyond. *Palliative Medicine* 2008; **22(8):** 885-887.

