

Cancer, Care and Hope – A Hospital Ethnography on Palliative Care in Dar es Salaam, Tanzania

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The emergence of hospices and palliative care in Africa during the late 20th and early 21st centuries has been tied to the fact that patients were dying from HIV/AIDS in large numbers due to the non-availability of ART at the time. Palliative care is a therapeutic approach which focusses on symptom control in patients with incurable diseases. According to the World Health Organization (WHO) definition, palliative care consists of providing “pain and symptom relief, spiritual and psychosocial support from diagnosis to the end of life and bereavement” (2002) for patients and relatives. This approach was first developed in the UK in the 1960s, and then introduced to numerous African countries over the last 15 to 20 years. The African Palliative Care Association (APCA 2016a) defines its mission in the following way:

“Acknowledging the emergence of modern palliative care from the UK, we help adapt it to African traditions, beliefs, cultures and settings – all of which vary between and within communities and countries. [...] We provide African solutions to African problems, through an approach based on the WHO [...]” (APCA 2011)

At present, while a few African countries provide comprehensive palliative care services on a national level, most countries offer locally restricted basic services only. Due to rapid demographic changes, such as extended life expectancies, the African continent is currently facing a crisis of non-communicable diseases (NCDs), such as cardiovascular diseases, respiratory diseases, diabetes and cancer. NCDs are the leading causes of death globally, killing more people every year than all other causes of death together (WHO 2011). Among these, cancer stands out with the highest mortality and fastest deterioration of patients especially in the African context, where screening examinations are scarce and the diagnosis is often only made in advanced stages.

This blog piece is based on data from my PhD research in Tanzania’s only governmental cancer hospital, the Ocean Road Cancer Institute in Dar es Salaam. In this project, I aimed to capture patients’ perceptions of cancer and the provision of care inside the hospital. I focused on the implementation, acceptance and significance of palliative care in this hospital setup. It was particularly interesting to observe the adaptation of the palliative care service to the constantly changing conditions in the hospital over a period of two and a half years.

In this paper, I give an insight into some important topics I came across during this time, and which influence the provision of palliative care significantly. I firstly present the current state of the cancer epidemic in Tanzania and provide background information about my research field. Subsequently, I show you around the hospital, and depict palliative care and its significance and practice in this setting. Thereafter, I introduce you to a patient called Anna and her experience

of being a cancer patient. Her narrative illustrates which difficulties most patients face when undergoing cancer treatment. During my research, I came across two issues concerning the hospital routine, which are strongly linked to palliative care and significantly influence its provision. Firstly, the ongoing changes in the prescription of oral morphine, and secondly the lack of communication and information disclosure about their cancer diagnosis for patients. Based on these insights and results, I argue that in-hospital care practices are inseparably interwoven with curative treatment services, and both are components in preserving patients' hopes. But additionally, these hospital routines hinder comprehensive palliative care service and change its role within the hospital. This raises the question if palliative care as such is still feasible, or whether it 'simply' has to be reconceptualised in the respective setting.

The data I am drawing on originate from 12 months of ethnographic fieldwork carried out between 2012 and 2015. The research involved participant observation, narrative and informal interviews, semi-structured interviews conducted within the hospital setting and a limited number of home visits, as well as a short palliative care questionnaire (APCA patient outcome scale) and focus-group discussions, conducted in Kiswahili and English.

Cancer and Palliative Care in Tanzania

Tanzania is a country with a growing number of cancer cases and related deaths. According to official statistics around 3% of the nation-wide mortality is attributable to cancer, but the estimated number of unreported and undetected cases is much higher (WHO 2014). Experts anticipate about 40.000 new cancer cases annually (Cancer Today 2017). The illness is often treated or even diagnosed at a very late stage, due to insufficient opportunities for screening, health professionals' lack of knowledge, and individual and economic reasons, which will be illustrated by the ethnographic data presented below. By the time the diagnosis is made, many diseases are so advanced that cure is no longer possible, and pain and symptom management become the main needs, which are then met by palliative care services.

At present, Tanzania is one of three African countries which have integrated palliative care into their national health policy (APCA 2016b) and is trying to expand the service provision to every region. One of the first centres for palliative care in the country was Ocean Road Cancer Institute (ORCI) which has been providing palliative care since 1994 (ORCI 2016). As a result, the institute was long considered an innovative pioneer, but, in the meantime, other hospitals have caught up and provide more comprehensive palliative care services. Every year about 5.000 new cancer patients are registered at ORCI (IPP 2016), most of them with an advanced cancer disease. According to health professionals at ORCI, about 80% of their patients are not on curative treatment. Hence, all these patients are in need of palliative care, but not even half of them get it, because of insufficient resources, and the lack of promotion and support for this special service. In 2012, 1.000 patients were registered at the palliative care office. This represents only 20% of all patients admitted to the hospital. The number decreased even further in the following years.

Also, the hospital authorities are struggling to keep up with the growing number of new patients (IPP 2016). In 2013 and 2014, the hospital's capacity was expanded from just under 100 beds to around 250. Nonetheless, after the promotion of cancer screenings (especially on cervical cancer) by the Ministry of Health and Social Welfare, the capacity is still lagging behind. The ORCI being a governmental hospital, services like radiotherapy, chemotherapy, cancer screening and palliative care are available usually free of charge (INCTR Network 2003). But oftentimes machines are overused and certain chemotherapies are limited, hence treatment is temporarily delayed.

The ORCI is financed by the government, but additionally depends on international donor funding. Since its opening in 1980 as a cancer hospital, it has been supported by many national and international funders with material and financial donations. Several faith-based organisations, charity associations, women's clubs, or local companies from and around Dar es Salaam support patients with extra food, toiletries or small amounts of money. Foreign hospitals from Europe or the US donate mainly dressing material or other hospital supplies, and a Norwegian hospital even dispatched their oncology nurses within an exchange program. International governmental and non-governmental partners, such as the International Network for Cancer Treatment and Research (INCTR) and the International Atomic Energy Agency (IAEA) Program of Action for Cancer Therapy (PACT), have donated much of the hospital's technical equipment for cancer diagnostics and treatment (e.g. the radiation machine). In addition, many of those donors send oncology experts or technical staff to train or support the local health professionals and keep machines running.

The Hospital: A Place of Hope?

Highly specialized hospitals such as the ORCI also play a special role in society. They are places where an unknown problem, an initial feeling of malaise, is recognized, diagnosed, named, and treated. Despite the widespread notion that hospitals are places of illness, or despair and death, they are simultaneously places stirring up patients' and families' hopes for cure and a better – and healthier – future. Alice Street and Simon Coleman describe hospitals' role in society with the following words:

“As technologies of social progress, development, and modernity, hospitals are spaces of hope that are oriented toward and anticipate a better future (Street, 2012; White et al., 2012). They are also spaces of hope in a second sense in that both patients and relatives may invest them with their hopes for a diagnosis, treatment, and cure (Vecchio Good, Good, Schaffer & Lind, 1990).” (*Street & Coleman 2012: 10*)

Hospital spaces exist because of the significance of medical advances, experience and achievements, and their relationship to the environment. Street and Coleman use the notion of Foucault's heterotopia to describe the complex character of the hospital space. Hospitals are places with inscribed meanings, still part of society, but also detached. Places where people are sheltered away because they are – due to their illness and being in need of support – ‘off the

norm'. By looking at the example of the ORCI, we find a largely well-equipped hospital which is infused by local and global health politics, international donor practices, developments in health service provision, lay knowledge, and adapted to local conditions. Therefore, I follow Sullivan's approach to hospitals as

“productive sites for exploring the politics of how global and state forms travel and their impact on the lived experience of actors interacting within hospital perimeters.” (2012: 58)

According to this idea of hospitals, a patient becomes a patient by the acts of care provided inside the hospital space. The reason for the hospitalization and the involved expectations turn a 'normal person' into a 'sick patient'. Hence, the patient needs to pass through different stages, like registration, medical examination and diagnosis, followed by inpatient admission and treatment. After the diagnosis, the next and perhaps most important step is treatment. It contains hope for recovery, or at least improvement.

One of the first patients I interviewed during my research was Said^[1], a young man in his twenties, diagnosed with Leukaemia. When I asked him (the very open question) what he thought of his cancer and hospitalization, he answered the following:

“So even when they told me that I have cancer, I was not afraid of [it] because the disease is there and we human beings are the one to get them. What I'm encouraged with is that experts are there and they have discovered it to me, so I'm getting hope.”

Benson Mulemi describes similar observations from a Kenyan cancer ward where patients link up their expectations with hospital technologies. He calls them 'technologies of hope', which stir hope and raise expectations by patients and family members (Mulemi 2013). In Tanzania, patients enter the hospital with high expectations about the abilities and knowledge of biomedical experts. These hopes are mainly shaped by ideas of global health and the successful story of HIV interventions. HIV/AIDS has been seen as the “African catastrophe” of the turn of the millennium, but the implementation and distribution of antiretroviral therapies (ARVs) with international aid was a turning point in many African countries. It had high impacts on the health system of the country and continues to influence the population's view of health problems significantly (Sullivan 2012).

The appearance of the ORCI in the city centre of the metropolis Dar es Salaam intensifies this perception. The massive whitewashed colonial building with its two towering turrets is situated right next to the Indian Ocean and next to governmental institutions, international organisations and embassies, and bank headquarters. Since 2013 the old building has been complemented by a new and equally bright building with a typical flat roof hospital architecture. Inside the large new building, the out-patient clinic, diagnostic and treatment rooms, the pharmacy, and three wards stretch across four floors. This new building offers amenities such as spacious corridors, an elevator, bright patient rooms with large windows with mosquito nets, air-conditioning and

fans, attached bathrooms, and only six to ten beds per room. The whole hospital compound is always tidy with a swept yard and parking area, framed by neat lawns and hedges. The two bright buildings, the old white colonial and the new light beige one, give the impression of a place where the long history of medical science and new high-tech biomedicine merge. This place, with its bright external appearance and the medical services provided inside, is a symbol of development in health care service, yet at the same time this is more illusion than reality. But patients' expectations are shaped by this appearance. The hospital is the place where hopes gain meaning and take effect.

However, not only the external appearance of the ORCI, but also the inside facilities, such as diagnostic rooms with body and bone scanning machines, treatment facilities with radiation therapy machines, the chemotherapy room, and the hospital's own pharmacy, are symbols of biomedical progress and part of the maintenance of patients' hopes. These technologies purport that they are the solution in eliminating cancer. Simultaneously, care practices are important, too, to keep machines running and patients' hopes alive. But where is the place of palliative care within this structure? This is the question I will turn to in the following section.

Palliative Care: Care, Hope and Technologies

The palliative care team at ORCI consists of two fulltime nurses, who have studied palliative care at Makerere University in Uganda, where the African Palliative Care Association is based, and received additional training in various places abroad. The small team is supported temporarily by a varying number of other health professionals trained in palliative care – a social worker, a pharmacist, the head nurse, one or two doctors, and a few nurses. The original idea of palliative care is defined as a holistic multidisciplinary concept focussing on the quality of life of patients and relatives corresponding to their individual expectations and needs. Care implies something humane, a direct act of altruism from one person to another, and detached from technology. There exists a predominant idea of the separation of care as warm and emotional, and technology as cold and material. As Annemarie Mol has put it:

“During the twentieth century, it was commonly argued that care was other than technology. Care had to do with warmth and love while technology, by contrast, was cold and rational. Care was nourishing, technology was instrumental. Care overflowed and was impossible to calculate, technology was effective and efficient. Care was a gift, technology made interventions. Care (and caring relations) at home, technology (and instrumental relations) in the workplace.” (Mol 2010: 14)

In a hospital setting, these two spaces intersect. It is a place some people may call temporarily their home, others their workplace. There, care and technology unite, caring and instrumental relations connect with each other and become mutually interdependent. Care practices are influenced by and consist of technology, and vice versa technology depends on care. Tools need to be handled with a certain knowledge and accuracy, and they have to be serviced and repaired from time to time (Mol 2010).

At ORCI the small palliative care core team is responsible for taking care of in-patients with palliative care needs, counselling out-patients and their relatives, organizing home-visits, and supporting and training hospital staff and community health workers. Furthermore, they monitor the supply of oral morphine in Tanzania. The hospital pharmacy oversees the administration and distribution of this opioid drug for the whole country. Other hospitals and palliative care teams must order and pick up their morphine supply at the hospital's pharmacy. As the number of palliative care service programs across the country grows, these administrative duties are becoming more and more part of their main work.

Inside the hospital care is understood in that broader sense, especially by patients themselves. It is not restricted to an inter-human act of aid provision, like washing or feeding the patient. It ranges from a variety of bodily experiences to financial support or psychological counselling to different kinds of medical services involving technological devices. When I asked research participants how they experience hospital care, they referred to a multiplicity of hospital services like doctors' consultations and medical examinations, the application of treatment, the prescription and distribution of medications, the provision of food and toiletry, and financial support. Palliative care was rarely mentioned in this context. Due to its non-curative approach and often not clearly visible presence, it obviously did not match with patients' general expectations of a hospital as a place of treatment and cure. Hence, even palliative care, which commonly aims at being emotional and person-centred, is becoming more technical in the hospital setting. The use of pharmaceuticals for pain management is, thereby, central. Patients and practitioners attach importance not only to their physical effects, but also to the practices of counselling, prescribing and dispensing.

Experiencing Cancer

As the growing significance of cancer and other NCDs is changing the global health landscape, it is also changing the lives of individuals. Cancer as a diagnosis is more than just being sick, it becomes a social fact, which is changing lives and personal relations. It is a disease that is closely bound to place and has diverse meanings around the globe (Livingston 2013). Consequently, expectations, experiences, fears and hopes related to it are shaped by local circumstances. Cancer hits the rich or strong just as the poor or weak. It can afflict everyone: the businessmen in the city, the women who earn their families' living on the fields, the grandmothers caring for their grandchildren, or such children themselves.

One of those patients is Anna. She was admitted to ORCI as in-patient four weeks before I first met her during my research in 2012/2013. She came from Tarime in Mara Region, which is far up North, close to Lake Victoria on the Tanzania-Kenia-Uganda border and a two-day bus journey away from Dar es Salaam. When Anna discovered a swollen part in one of her breasts, she was first irritated because she had heard something about breast lumps on the radio, which were referred to as a dangerous disease called "kansa ya matiti" (Kiswahili: cancer of the breast). But when she found out she was pregnant, she saw the swelling as part of her changing body. During her pregnancy one nipple altered and started bleeding occasionally and

Anna had to see a doctor at the district hospital. The doctor told her that they guessed she had “this cancer”, as she said when we talked. But the definitive testing had to be done at Muhimbili Hospital, the university hospital in Dar es Salaam. Consequently, Anna took the bus and travelled to Dar es Salaam to be checked at Muhimbili. There, they conducted an autopsy of the breast tissue which was positive and Anna was told she had “this cancer”. But doctors refused to treat her before she had given birth and finished the ensuing breast feeding, so she was sent back to Tarime. Weeks later, Anna experienced a complicated delivery, where she lost her unborn child. Afterwards Anna had to return to Muhimbili Hospital to undergo surgery and was then admitted to ORCI for adjuvant radiotherapy. During her hospitalization, Anna had to leave her three older children at home. The three younger ones moved to her mother who lived half a day’s journey away from Dar es Salaam.

Anna’s story is exceptional regarding her personal experience of her cancer illness, pregnancy and stillbirth. However, it also depicts clearly the type of situations and obligations many patients are torn away from. Thus, Anna’s story is one of many similar experiences faced by cancer patients at ORCI. Often months or even years go by from the first feeling of a vague indisposition to the final diagnosis of cancer. Family responsibilities and financial pressures often keep patients away from hospitals in the first place. But even when the decision to see a doctor is taken, many patients visit different health facilities such as traditional healers, community health centres, regional hospitals or private health services, but the final diagnosis is mostly only made after the referral to the university hospital.

Another woman told me about her difficulties reaching the hospital earlier:

“[There are] these difficulties we get in the lower class, because we have children to send to school. I was supposed to come since last year in January. It was during summer of last year [...] when I had settled everything. Then I went to Kilwa hospital and we got that letter of referral for Muhimbili and it was like this [pointing at her breast] because I delayed for almost two years.”

The significance and consequences of a presumed or definite cancer diagnosis often remain unclear to many patients until the very end. Patients from the educated middle class are more likely to be diagnosed and referred to ORCI earlier, because they know about the disease from newspapers, radio or TV. Most of them have health insurance, often live closer to a regional hospital, and thus have fewer obstacles to visit a doctor after recognizing bodily changes. Due to successful cervical cancer screening programs in 2013 and 2014, many female patients reached the hospital much earlier, some of them even with cancer stage one, which has a good chance of recovery. But cancer is a silent and insidious illness. Unlike infectious diseases cancer is not something that is affecting one’s body from the outside, but rather a disease that evolves from the inside. Due to the predominance of infectious diseases in the region over the last decades this seemed an incomprehensible idea for many. Frequently I heard that patients felt excluded from society due to the misbelief that they were contagious in a way. The cause of the cancer disease was still seen as something caused by external reasons. A common explanation was bad nutrition, like too little fruits and vegetables and too many heavy meals. Accordingly, patients’ expectations and attitudes towards the hospital are influenced by this

common understanding of the cause of the disease and chances of recovery.

But reaching ORCI does not automatically mean immediate admission and treatment. Depending on the situation at the time of their arrival, patients have to wait days or weeks before they are hospitalized and treatment can begin. Radiation machines work non-stop every day from dawn until late at night, even on weekends. Daytime appointments are reserved for out-patients; beyond normal working hours the machines are used to treat in-patients. Frequent machine break-downs interrupt this cycle and keep patients waiting. Those receiving chemotherapy are always in hope that the right substance is in-stock or they can afford to buy it at a local pharmacy. Then they are asked to wait outside the always crowded therapy room until it is their turn to get the intravenous infusion. This treatment is provided in one of the old ward rooms, outside the main building. Inside this stuffy old room, about 40 patients sit or lie densely on discarded hospital beds with dozens of drip stands between them. Incessantly running old ceiling fans hardly manage to keep out the humid, oppressive heat and the open windows only provide little fresh air to those patients waiting for their chemo drip to be finished. The nurses are constantly buzzing around, providing new patients with chemo IV bags and releasing those who have already finished. On the opposite of the compound, other patients are waiting for their radiotherapy appointment under shady trees. The daily hospital routine consists of waiting times interrupted by ward rounds, treatment appointments, and attending to the different physical needs of patients.

Furthermore, being a cancer patient does not only concern the patients themselves. It affects whole families when a mother, father or grandparent needs to be treated at ORCI. In these cases, one wage earner or caregiver is suddenly gone without replacement. And on top of that, he or she now needs additional care and financial support. Like Anna, many patients travel far distances to reach ORCI, leaving their dependents behind. Others are abandoned by family members and friends. An unmarried young man in his thirties told me: *“Since I have this disease for [a] long time now, people have been tired of me.”* These reasons make the provision of institutionalized care essential, because most patients depend on physical, psycho-social, spiritual, and also financial support while hospitalized.

However, there are not only neglected patients. There are also those accompanied by husbands, sisters, mothers or other relatives, who care for their beloved ones day and night. They cook food to complement the monotonous hospital diet, wash clothes or weak patients' bodies, talk to the hospital staff about diagnosis and treatment, and provide moral support – sometimes even for patients in the neighbouring beds. Unfortunately, only a minority of in-patients are accompanied by a caring relative, which contrasts with the common understanding of hospital care as provided by relatives in Tanzanian hospitals. Many families are incapable of supporting patients permanently and on-site. For this reason, palliative care was introduced to support patients at ORCI.

Pain Management in Palliative Care

Aside from providing social and psychological support, palliative care's first priority is to ease or relieve patients from physical pain by using suitable pain medication. Pain is one of the most uncertain and diffuse symptoms or conditions. It varies enormously from disease to disease, from patient to patient, and from day to day. It depends on surrounding conditions and the emotional state of the respective person. Thus, pain is a complex phenomenon which is still not fully understood – and will most likely never be. Individuals with the same pathology respond very differently to the experience of pain,

“depending on the meaning of the pain, the life world of the sick person, and his or her relationship to family, health-care [...], and resources available to treat pain.”
(*DeVecchio et al, 1994: 10*)

Nevertheless, cancer pain is known as one of the most painful conditions. 70% of cancer patients experience pain during their illness (Myers & Shetty 2008: 41). Cancer patients suffer from tumour related pain, and most likely, from side-effects of their therapy. The most effective, and one of the oldest substance in pain treatment is morphine. Its usefulness is often treated with caution and it is very hesitantly prescribed, because of fears regarding its addictive character and numbing effects (Meldrum 2003: 2471).

“Opioid prescribing for the effective management of cancer pain continues to be an issue and a challenge for health-care professionals. There is evidence of continued opioid phobia amongst medical colleagues though lack of understanding and lack of training [...]” (*Rawlinson 2014: 3*)

Tanzania has a young history in morphine use, but the underlying myths and fears attached to it are present, too, and the phenomenon of ‘opioid-phobia’ often causes underuse (Kamuhabwa & Ezekiel 2009). However, at the ORCI, where morphine is mostly available, prescribing habits are different from other health facilities in the country. Due to the currently high numbers of new patients and low humane, financial and treatment capacities, prescribing practices have changed immensely within the last years. Instead, they have become an act of compensation during times of low resources, chemotherapy stock-outs or radiotherapy machine breakdowns. But palliative care professionals moan about doctors’ low knowledge of morphine use. Accurate pain assessment is commonly not applied, nor are the doses adapted to the individual patient, as one of the palliative care professionals told me. Counselling about accurate prescriptions and administration has formerly been the work of the palliative care team. But nowadays the number of patients in need is unmanageable for the two of them. On the one hand, patients experience these new prescribing habits as a form of care. But on the other hand, they are oftentimes confused about the correct application and feel uninformed about the drug’s effect.

Non-disclosure and Palliative Care

Low provision of information does not only concern the prescription of morphine. During my research I realized, that many patients are insufficiently or even uninformed about their

diagnosis, prognosis and treatment. Missing clarification of the right application of pharmaceuticals goes hand in hand with non-disclosure practices. Although the palliative care practice of morphine prescription collides with the fundamental thinking of doctors to treat patients and cure diseases, it simultaneously substitutes other health investigations in times of low resources. It also helps them to avoid conversations about a life-threatening diagnosis and end-of-life decisions. With the diagnosis of end-stage cancer and no curative treatment options, ethical questions about the necessity of life-prolonging treatments, which are stressful and often expensive for patients and their families, are raised. Physicians feel expected to do something and simultaneously protect patients from huge expenditures for (needless) treatment (Harris et al 2010; DeVecchio et al., 1999).

This practice of non-disclosure of the actual cancer diagnosis is common in Tanzania – as in many other, including ‘Western’, countries, too – and seen as *care* by those concealing the truth (Harris et al 2010). Patients in pain, who are admitted to a hospital and undergoing stressful treatment, should not be additionally worried by a life-threatening diagnosis, as most relatives think, too. Susan R. Whyte (1997) observed similar ‘care-ful’ conversations in Uganda, where family members avoid the harshness of the medical diagnosis. They want to protect the vulnerable relatives from fears about their future, in order to help them maintain hope. Such vague and selective information practice additionally impinges on palliative care provision. In fact, it diametrically opposes one of its most foundational tenets. For the initial concept of palliative care calls for an informed patient, who is aware about what will happen to her or him in the future. The practice of non-disclosure not only has an enormous impact on the provision of palliative care, but consequently also on the implementation of research in this field.

I started my research with the assumption of finding well-informed palliative care patients. My initial research idea was to focus on patients’ perspective on end-of-life issues, their experience of and ways of dealing with an incurable disease, and the role palliative care services play in this context. This research approach was approved by the ethical review board of the medical university of Dar es Salaam in cooperation with the ORCI. However, within the first weeks of my research, it soon became obvious that the implementation of such a research idea was *de facto* impossible. Most patients were uninformed about their diagnosis and often only had little knowledge about cancer. This inevitably raises the question as to whether an informed patient is indispensable for the provision of palliative care with its different pillars, or not. With the transfer of the European concept of palliative care to African contexts, this question needs to be discussed. And not only for Africa: The practice of disclosure varies around the globe, from country to country. Most often, professionals and relatives seek to protect patients from worries and – in particular – loss of hope (Harris, 2010; Good, 1999).

Conclusion

At the end of this piece, the question arises what effect the depicted aspects of institutionalized care have on palliative care practices? In light of the aforementioned adaption to “African traditions, beliefs, cultures and settings” demanded by APCA (2011), is it still possible to provide palliative care as taught by the Makerere University and closely linked to the UK concept? Palliative care at ORCI finds itself in a dilemma. The care service, ostensibly deemed

unnecessary by health politics' priorities but simultaneously indispensable in clinical reality, requires much activity from the palliative care team. More active case finding and inter-professional support is necessary, but it is nearly impossible to implement such improvements due to the shortage of human and financial resources. Reducing palliative care to a morphine distribution program contradicts the approach of the holistic, multidisciplinary concept. The increase of morphine prescription results in a technologization of care and replaces social components that are central to the original idea of palliative care.

The practice of non-disclosure of cancer diagnoses seems to be a further obstacle for the provision of palliative care services. It inevitably raises the questions of the possibility to provide palliative care services for uninformed patients, because end-of-life topics are intrinsic aspects of these services' underlying work concept. Given these circumstances, I argue that a fundamental discussion of the palliative care concept as such and its propagation by the WHO is necessary to guarantee and facilitate its provision in settings like the ORCI. The central question should be whether the concept needs to be softened and broadened, which would simultaneously render it even more vague, or whether hospital routines should open up towards a multi-professional cooperation in providing services for people suffering from life-threatening diseases.

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Bio Statement

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Bibliography

Adamou, A., F. T. Odedina, J. Torode, D. J. Kerr. 2013. Cancer in Africa: supporting advocates to stop the runaway train. In: *Annals of Oncology* 24 (4), 855–856.

APCA. 2016a. Palliative Care in Africa. The Need. Available online at

<https://www.africanpalliativecare.org/awareness/palliative-care-in-africa-the-need/>. Last access: 6/25/2016.

APCA. 2016b. Palliative Care in Africa. Delivery. Available online at <https://www.africanpalliativecare.org/awareness/palliative-care-in-africa-delivery/>. Last access: 6/25/2016.

APCA. 2011. About APCA. Available online at <https://www.africanpalliativecare.org/about/about-apca/>. Last access: 6/25/2016.

Brown, Hannah. 2010. "If we sympathise with them they'll relax". Fear/respect and medical care in a Kenyan hospital. In: *Medische Antropologie* 22 (1), 125–142.

Cancer Today. 2017. United Republic of Tanzania. Available online at http://gco.iarc.fr/today/online-analysis-map?mode=cancer&mode_population=continents&population=900&sex=0&cancer=29&type=0&statistic=0&prevalence=0&color_palette=default&projection=natural-earth. Last access: 05/26/2017.

Good, Mary-Jo DelVecchio, Esther Mwaikambo, Erastus Amayo & James M'Imunya Machoki. 1999. Clinical Realities and Moral Dilemmas: Contrasting Perspectives from Academic Medicine in Kenya, Tanzania, and America. In: *Daedalus* 128 (4), 167-96.

Good, Mary-Jo DelVecchio, Paul E. Brodwin, Byron J. Good, Arthur Kleinman. 1994. Pain as human experience. An anthropological perspective. Berkeley: University of California Press.

Harris, Julian J., John Shao & Jeremy Sugarman, Jeremy. 2003. Disclosure of cancer diagnosis and prognosis in Northern Tanzania. In: *Social science & medicine* 56 (5), 905–913.

INCTR Network. 2003. Network Magazine. Available online at http://www.inctr.org/fileadmin/user_upload/inctr-admin/Network%20Magazine/Vol%203%20No%203%20-%20Winter%202002-2003LLR.pdf. Last access: 7/5/2016.

IPP Media. 2016. Cancer Cases Soar. Available online at <http://ippmedia.com/en/news/cancer-cases-soar-dar%E2%80%99s-largest-hospital-overwhelmed>. Last access: 5/1/2016.

Kamuhabwa, A. & D. Ezekiel. 2009. Rational use and effectiveness of morphine in the palliative care of cancer patients at the Ocean Road Cancer Institute in Dar es Salaam, Tanzania. In: *Tanzania journal of health research* 11 (4), 170–174.

Livingston, Julie. 2012. Improvising medicine. An African oncology ward in an emerging cancer epidemic. Durham: Duke University Press.

Livingston, Julie. 2013. Cancer in the shadow of the AIDS epidemic in southern Africa. In: *The oncologist* 18 (7), 783–786. doi:10.1634/theoncologist.2013-0215.

- Meldrum, Marcia L. 2003. A Capsule History of Pain Management. In: JAMA 290 (18), 2470-2475.
- Mol, Annemarie, Ingunn Moser & Jeanette Pols (Eds.). 2010. Care in practice. On tinkering in clinics, homes and farms. Bielefeld: transcript-Verlag.
- Mulemi, Benson A. 2013. Technologies of Hope. Managing Cancer in a Kenyan Hospital. In: Prince, Ruth Jane & Rebecca Marsland (Eds.). Making and unmaking public health in Africa. Ethnographic and historical perspectives (Cambridge Centre of African Studies series), 233–261.
- Mulemi, Benson A. 2010. Coping with cancer and adversity. Hospital ethnography in Kenya. Leiden: African Studies Centre.
- Myers, Jeff & Niren Shetty. 2008. Going beyond efficacy: strategies for cancer pain management. In: Current Oncology 15 (Suppl 1), 41-49.
- ORCI. 2016. Palliative Care. Available online at http://orci.or.tz/palliative_care.php. Last access: 05/26/2017.
- Oxford Dictionary: Palliative. <http://www.oxforddictionaries.com/definition/english/palliative>. Last access: 05/26/2017.
- Rawlinson, F. M. 2014. The current situation in education and training of health-care professionals across Africa to optimise the delivery of palliative care for cancer patients. In: *ecancer* 8. doi:[10.3332/ecancer.2014.492](https://doi.org/10.3332/ecancer.2014.492).
- Street, A., S. Coleman. 2012. Introduction: Real and Imagined Spaces. In: *Space and Culture* 15 (1), 4–17.
- Sullivan, N. 2012. Enacting Spaces of Inequality: Placing Global/State Governance Within a Tanzanian Hospital. In: *Space and Culture* 15 (1), 57–67.
- WHO. 2011. Global Status Report on Noncommunicable Diseases 2010.
- WHO. 2002. WHO Definition of Palliative Care. Available online at <http://www.who.int/cancer/palliative/definition/en/>. Last access: 05/26/2017.
- WHO. 2014. Noncommunicable Diseases (NCD) Country Profiles. United Republic of Tanzania. Available online at http://www.who.int/nmh/countries/tza_en.pdf. Last access: 05/26/2017.
- Whyte, Susan Reynolds. 1997. Questioning misfortune: the pragmatics of uncertainty in eastern Uganda. Cambridge University Press.

[1] The names of research participants in this paper are pseudonyms.