***GNOSI:* An Interdisciplinary Journal of Human Theory and Praxis**
Volume 8, Issue 2, March (Special Issue), 2025
ISSN (Online): 2714-2485

Dignity at the End of Life: Lessons from the COVID-19 Pandemic for End-of-Life Care in Africa

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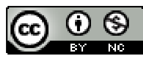
(**Received**: January-2026; **Accepted**: April -2026; Available **Online**: April -2026)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ABSTRACT

The COVID-19 pandemic exposed profound fractures in the capacity of health systems worldwide to ensure dignified death, yet nowhere were these fractures more consequential than across the African continent, where pre-existing deficits in palliative care infrastructure intersected catastrophically with viral containment imperatives. This paper examines the lessons that the pandemic yields for reimagining end-of-life care in Africa, arguing that the crisis has made visible what was long known but insufficiently addressed: the systematic neglect of dying as an essential component of health and humanitarian response. Drawing on diverse examples from South Africa, Uganda, Kenya, Zimbabwe, Zambia, and other African nations, the analysis interrogates how pandemic restrictions on family presence, communal mourning, and traditional death rituals collided with deeply held cultural understandings of personhood and communal obligation, producing forms of suffering that exceeded the physical trajectory of disease. The paper traces how community-based palliative care models, task-shifting initiatives permitting nurse-prescribing of morphine, and culturally grounded bereavement practices offer instructive counter-narratives to the technocratic, hospital-centric approaches that dominated pandemic response. The work is structured across five interconnected themes: the right to dignity as a foundational principle, the disruption of familial and communal caregiving, the cultural violence enacted through mortuary protocols, the critical shortage of opioids and trained personnel, and the neglect of bereavement as a public health concern. The analysis demonstrates that dignity at the end of life in African contexts cannot be secured through the simple transplantation of Western palliative care frameworks but requires sustained engagement with local moral economies, community structures, and postcolonial realities. The paper concludes by advancing recommendations for integrating palliative care into universal health coverage, reforming restrictive opioid prescription laws, embedding culturally competent death practices within emergency preparedness, and recognizing family caregivers as essential partners in care delivery.

Keywords: Palliative care; COVID-19; Africa; dignity; end-of-life care; health systems; cultural competence; bereavement.

INTRODUCTION

The coronavirus disease 2019 (COVID-19) pandemic did not create the crisis in end-of-life care across the African continent so much as it illuminated with devastating clarity what had long existed in the shadows of health systems organized around curative imperatives. Prior to the pandemic, the World Health Organization (2021) estimated that fewer than one in ten individuals in Africa who required palliative care received it, a statistic that represented not merely a service gap but a profound moral failure in the global architecture of health. The pandemic, in rendering visible the conditions under which millions of Africans have always died from cancer, from HIV-related complications, from organ failure, from the ordinary devastations of bodies confronting life-limiting illness without adequate symptom control or psychosocial support, offered an unsparing education in the consequences of neglect.

Yet the pandemic also generated something else: an unprecedented global conversation about what it means to die well, or at least to die without the compounding of physical agony by social abandonment. Across news media, academic journals, policy briefs, and community forums, questions that palliative care advocates had raised for decades suddenly commanded mainstream attention. What does dignity require when cure is impossible? Who has the right to be present at the bedside of the dying? How should the bodies of the dead be handled, and by whom, and according to whose protocols? What obligations do health systems owe to the bereaved? These questions, which the pandemic forced into public consciousness through the sheer scale of death and the spectacle of patients dying alone in intensive care units, resonated with particular force across Africa, where death has never been understood as a private event but as a communal passage requiring the mobilization of kinship networks, the performance of ritual, and the reaffirmation of social bonds that extend across generations (Nunez Carrasco et al., 2025) .

This paper takes the COVID-19 pandemic as a critical case from which to derive lessons for strengthening end-of-life care across African health systems. The argument proceeds from the premise that the pandemic was not merely a transient emergency but a revelatory crisis that exposed the normative inadequacy of health systems designed exclusively around survival. In making this argument, the paper draws on a diverse evidentiary base encompassing peer-reviewed literature from bioethics, palliative medicine, anthropology, and health policy; reports from humanitarian organizations and palliative care associations; and documented case studies from specific African countries that illustrate both the challenges encountered and the innovative responses mounted by communities and clinicians.

The geographic scope encompasses sub-Saharan Africa with particular attention to South Africa, Uganda, Kenya, Zimbabwe, and Zambia, though the analysis is intended to yield insights transferable across diverse African contexts while remaining attentive to the specificity of local cultural formations. The central contention of this paper is that the COVID-19 pandemic has furnished African health systems with an opportunity that must not be squandered: the opportunity to recognize that a health system incapable of ensuring dignified death is, in a fundamental sense, incomplete.

DIGNITY AT THE END OF LIFE: CONCEPTUAL FOUNDATIONS AND AFRICAN PERSPECTIVES

The concept of dignity occupies a central but contested position in contemporary discourse on end-of-life care. In the Western bioethical tradition that has dominated global palliative care advocacy, dignity is frequently operationalized as respect for individual autonomy, understood as the capacity of persons to make informed choices about their care and to have those choices honoured by health professionals and institutions. This

construction of dignity underpins the emphasis on advance care planning, on the right to refuse burdensome interventions, and on the importance of enabling patients to die in their preferred location, typically framed as home rather than hospital. It is a conception of dignity that is fundamentally individualistic, locating moral worth in the sovereign decision-making capacity of the person and positioning the role of others as facilitating rather than constituting that person's good.

This individualistic framing, while generative of important protections against medical paternalism and unwanted treatment, sits uneasily with African conceptions of personhood that emphasize relationality, interdependence, and the embeddedness of individual lives within kinship structures and ancestral continuities.

As the philosopher Ifeanyi Menkiti (1984) argued in his influential essay on personhood in African thought, in many African cosmologies personhood is not an automatic attribute of biological humanity but a status achieved through incorporation into community, through the performance of obligations to others, and through participation in the rituals and practices that sustain social life across temporal boundaries. The Nigerian philosopher's work has been extensively engaged by subsequent scholars who have sought to understand the normative dimensions of African personhood and its implications for bioethics (Flikschuh, 2016; Molefe, 2020) . From this perspective, dignity at the end of life cannot be reduced to the protection of individual choice; it must encompass the maintenance of those relational bonds that constitute the dying person as a person, even as biological vitality wanes.

The contrast between these two conceptions of dignity became starkly visible during the pandemic. In many African contexts, what patients and families sought was not primarily the right to make autonomous decisions about treatment, though this was not unimportant, but the right to be accompanied through the dying process by those whose presence affirmed the dying person's continued membership in the human community. The prohibition on family visitation in hospitals, rationalized by infection control imperatives, was experienced not merely as an inconvenience but as an assault on the very conditions that make dying bearable. To die alone, separated from the hands that should be washing the body, from the voices that should be offering prayers and farewells, from the eyes that should witness the final breath as testimony to a life that mattered, was to die in a manner that violated fundamental understandings of what it means to be human (Nunez Carrasco et al., 2025) .

If dignity in the Western tradition is understood as the quality of being worthy of respect grounded in individual autonomy, dignity in many African traditions is understood as the quality of being worthy of respect grounded in one's embeddedness within a community of persons, living and dead. As Gyekye (1995) argues in his analysis of the Akan concept of honour, dignity is not an abstract property but a relational achievement, conferred and sustained through the recognition of others. This relational conception has direct implications for end-of-life care: a dying person's dignity is not secured by respecting their autonomous choices alone but by ensuring that they remain embedded in the web of relationships that constitute them as a person. The pandemic's prohibition on family visitation was not merely a restriction on choice; it was an assault on the very conditions of dignified dying.

The African Palliative Care Association, in its advocacy during the pandemic, consistently emphasized that dignity in African contexts must be understood as encompassing not only symptom control and respect for preferences but also the facilitation of culturally prescribed rituals and the involvement of family and community in care processes (Afolabi et al., 2021). This broader conception of dignity aligns with the influential framework developed by Chochinov et al. (2002) in their work on dignity-conserving care,

which identifies illness-related concerns, dignity-conserving repertoire, and social dignity inventory as interacting domains that shape the experience of dying persons. Within this framework, social dignity, encompassing the quality of interactions with others and the maintenance of valued social roles, emerges as particularly salient in African contexts where personhood is constitutively social.

The pandemic also illuminated how dignity at the end of life is mediated by structural conditions that precede and exceed individual clinical encounters. The right to dignity, enshrined in the Universal Declaration of Human Rights and affirmed in numerous regional and national instruments, including the African Charter on Human and Peoples' Rights (African Union, 1981), cannot be meaningfully exercised in the absence of basic material conditions: access to analgesia, to skilled care, to environments conducive to privacy and comfort. The Sphere humanitarian standards, which were updated to include palliative care as an essential component of humanitarian response, articulate a clear expectation that people should have access to palliative and end-of-life care that relieves pain and suffering, maximizes comfort, dignity and quality of life, and provides support for family members (Sphere Association, 2018). Yet the translation of this standard into practice across African health systems remains profoundly incomplete.

Afolabi et al. (2021) conducted a systematic review of COVID-19 clinical management guidelines from 29 African countries and found that only eight countries included identifiable palliative care recommendations within their guidelines. Of these eight, only South Sudan provided comprehensive palliative care recommendations covering the domains of physical, psychological, social, and spiritual wellbeing, while Namibia and Uganda addressed only physical and psychological wellbeing, and the remaining five countries addressed only physical symptom management. This finding is striking: during a pandemic that produced mass death and suffering, the majority of African nations lacked even basic guidance on how to care for the dying. The absence of such guidance reflects a deeper neglect of palliative care within health systems planning that long predated the pandemic.

The disconnect between normative commitments to dignity and the material conditions of dying across much of Africa points to what the medical anthropologist Paul Farmer (2006) termed "structural violence": the embodied experience of suffering produced by social arrangements that systematically expose certain populations to harm while shielding others. The COVID-19 pandemic did not distribute its dignitary harms evenly; it concentrated them among populations already marginalized by poverty, by geographic isolation, by the maldistribution of health infrastructure. In the rural Eastern Cape of South Africa, in the informal settlements encircling Harare and Nairobi, in the villages of Uganda and Zambia, the pandemic compounded existing deficits in palliative care capacity, rendering visible what had long been invisible to policy-makers and global health institutions.

THE DISRUPTION OF CARE: ISOLATION, ABANDONMENT, AND THE ABSENT FAMILY

Among the most searing images of the COVID-19 pandemic were photographs of patients dying alone in intensive care units, separated from family members by infection control barriers, their final communications mediated by tablet screens held by healthcare workers in full personal protective equipment. These images, circulated globally, came to symbolize a particular form of pandemic suffering: the transformation of death from a communal event into an isolated physiological termination. Yet the images also revealed something about the normative assumptions embedded in healthcare delivery, assumptions that prioritize biological survival over social connection and that construe family presence as a potential threat rather than an essential component of care.

Across African health systems, the imposition of visitor restrictions produced effects that were at once similar to and different from those observed in high-income settings. The similarity lay in the universal human anguish of separation from dying loved ones. The difference lay in the cultural meaning of that separation. In contexts where care for the dying has traditionally been a family and community responsibility, where the hospital has been understood as a place for acute intervention rather than for dying, and where the physical presence of kin at the deathbed carries profound spiritual and social significance, the prohibition on visitation represented not merely a suspension of customary practice but a rupture in the moral order itself.

Nunez Carrasco et al. (2025) documented how COVID-19 restrictions in South Africa removed the handling and control of the deceased body from families, limited the duration of funerals, and reduced the number of people allowed in attendance . These restrictions, while epidemiologically rational, represented a profound disruption of the grief work that communities ordinarily undertake collectively. The study emphasized that within African traditions in Southern Africa, the dead body is not understood as inert. There exists a vital connection between the spirit and the body, and between the living and the dead, a connection that continues to exist after death. Death therefore needs to be treated with respect as manifest in several ritualized practices. These metaphysical principles are essential for understanding why the COVID-19 protocols, which treated bodies primarily as sources of contagion requiring sanitary disposal, perturbed the possibility of the dead to rest properly and generated distress among the living who feared that their unquiet dead might trouble the community.

The disruption of family caregiving during the pandemic extended beyond the hospital to encompass the home, where the majority of dying across Africa occurs. Public health measures that restricted movement, prohibited gatherings, and mandated physical distancing transformed homes from sites of communal care into sites of isolation. Family members who would ordinarily have traveled to care for dying relatives were prevented from doing so. Neighbours who would have provided practical support and companionship stayed away. The dense social networks that traditionally surround the dying in African communities were forcibly thinned, leaving primary caregivers, typically women, to manage alone with inadequate resources and support.

Research examining transnational families across Zimbabwe and South Africa documented how mobility constraints forced families to experience death and mourning in unorthodox ways (Maviza & Thebe, 2023) . Families participated in online memorial, funeral, and burial services and eulogies, embracing transnationalism by virtually participating in funerary processes at home in Zimbabwe while based in South Africa. Yet these virtual rituals, while giving members an appreciated sense of togetherness, did not suffice to replace the embodied presence that traditional mourning requires.

The Ugandan experience offers another instructive case study of how pandemic restrictions disrupted end-of-life care. Uganda has been recognized as a leader in palliative care integration within sub-Saharan Africa, having enacted legislation in 2004 that permits trained palliative care nurses and clinical officers to prescribe oral morphine, a policy innovation that dramatically expanded access to essential pain relief in a context of severe physician shortages (Jagwe & Merriman, 2007) . The Palliative Care Association of Uganda has worked consistently with stakeholders to ensure sustainable supply of oral morphine, and in 2023 presented a position paper to the Committee on Health at the Parliament of Uganda on the Narcotic Drugs and Psychotropic Substances (Control) Bill 2023, resulting in its amendment based on their recommendations (Palliative Care Association of Uganda, 2025) .

However, the pandemic threatened to reverse these gains. When COVID-19 arrived in Uganda in early 2020, public transportation was suspended, outpatient services were

curtailed, and patients who had previously relied on regular visits to facilities such as Kitagata Hospital for morphine refills and wound care found themselves cut off from the palliative care services that had been their lifeline. The response of individual healthcare workers to this crisis offers an important counter-narrative to the story of systemic failure. Across Uganda, palliative care nurses used personal vehicles and cellphones to coordinate the delivery of morphine to patients in remote villages, arranged transport for those requiring hospital assessment, and maintained communication with patients and families who would otherwise have been abandoned.

The Ugandan experience highlights the significance of regulatory frameworks that enable task-shifting. The permission for trained nurses to prescribe opioids, enacted in 2004 and preserved despite subsequent legislative challenges, represents a pragmatic recognition that in health systems with severe physician shortages, restricting opioid prescription to doctors effectively denies pain relief to the vast majority of patients who need it. The Ugandan model demonstrates that with appropriate training, supervision, and accountability mechanisms, nurse-prescribing can be implemented safely and effectively, dramatically expanding access to essential palliative medications (Jagwe & Merriman, 2007) .

The lesson that emerges from these experiences is not that infection control is unimportant or that pandemic restrictions were categorically unjustified. It is rather that the design and implementation of such restrictions must be informed by a richer understanding of what constitutes care for the dying. When visitor policies are formulated exclusively through the lens of infection risk, they inevitably produce dignitary harms that may outweigh their epidemiological benefits. A more adequate approach would recognize family caregivers as essential partners in end-of-life care, would invest in the personal protective equipment and training necessary to enable safe visitation, and would involve communities in developing contextually appropriate protocols that balance competing values rather than simply subordinating relational goods to biomedical imperatives.

THE FATE OF THE DEAD: MORTUARY PROTOCOLS, CULTURAL VIOLENCE, AND COMMUNITY RESISTANCE

If the separation of the dying from their families represented one form of pandemic-induced suffering, the treatment of the dead represented another, arguably more profound, violation of cultural and spiritual norms. Across much of Africa, death does not mark the termination of social existence but its transformation. The deceased continue as ancestors, as spiritual presences who remain engaged with the living community, offering protection, demanding remembrance, and serving as moral exemplars whose lives and values shape contemporary conduct. The transition from living person to ancestor is not automatic; it must be accomplished through the proper performance of funeral rites, through the respectful handling of the body, and through the mobilization of the community to witness and affirm the passage.

The pandemic threatened this entire edifice of meaning. Government-mandated protocols for the management of COVID-19 deaths, often developed with technical input from the World Health Organization and shaped by assumptions about infectious disease control derived from the Ebola experience, prescribed rapid burial or cremation, minimal handling of bodies, and the prohibition of traditional funeral gatherings. These protocols, while epidemiologically rational, were culturally catastrophic. They reduced the dead from persons deserving of ritual attention to biohazards requiring sanitary disposal.

Nunez Carrasco et al. (2025) provided detailed insight into these dynamics in the South African context, documenting how the restrictions removed the handling and control of the deceased body from families . Traditionally, funerals in South Africa are extraordinarily important community events, serving not only as occasions for mourning

but as spaces of encounter, political contestation, and the reaffirmation of social bonds. Through the lens of COVID-19, however, funerals were reinterpreted as potential super spreader events, sources of risk and contagion rather than sites of healing and social repair.

The study by Nunez Carrasco et al. (2025) emphasized that the dead body in African traditions is not inert . The connection between the spirit and the body, and between the living and the dead, continues to exist after death, and this connection requires ongoing ritual attention. The COVID-19 protocols, by preventing families from washing bodies, dressing them in traditional cloth, and performing the customary rites of farewell, perturbed the possibility of the dead to rest properly. This generated profound distress among the living, who feared that their unquiet dead might trouble the community, bringing misfortune, illness, or other forms of spiritual disturbance.

The South African experience of excess deaths added another layer of complexity to the disruption of ritual. The South African Medical Research Council initially estimated that official COVID-19 deaths represented only approximately one-third of the total number of excess deaths during the period 2020 to 2021 (Bradshaw et al., 2022). Subsequent research concluded that 85 to 95 percent of excess natural deaths were attributable to COVID-19 (Moultrie et al., 2021). The scale of death overwhelmed both formal healthcare systems and community coping mechanisms, producing what Nunez Carrasco et al. (2025) described as "unaccomplished grief work" that would have lasting consequences for mental health and social cohesion .

The resistance of communities to these protocols took various forms. In some cases, families complied reluctantly, their grief compounded by the knowledge that they had failed in their obligations to their dead. In other cases, they negotiated with authorities for accommodations, such as the provision of personal protective equipment to enable ritual washing of bodies or the relaxation of gathering restrictions for funeral ceremonies. And in some cases, particularly in the rural Eastern Cape of South Africa, resistance was more active and organized, including documented instances of families exhuming bodies that had been buried without proper ritual to rebury them according to custom (Bank et al., 2020).

The study by Nunez Carrasco et al. (2025) also illuminated how the South African state's response to the pandemic, while drawing on guidance from the World Health Organization and the local scientific community, failed to adequately incorporate the vast local expertise garnered through decades of responding to the HIV and tuberculosis epidemics . This contextual misalignment meant that universal COVID-19 prescriptions were applied without sufficient consideration of how they would interact with local cultural practices and community structures. The restrictions on gatherings, for instance, treated funerals primarily as potential super spreader events rather than as essential rituals for the maintenance of social and spiritual order.

Across the continent, COVID-19 deaths were subject to protocols that, while varying in their severity and implementation, consistently marginalized family and community involvement. In Nigeria, patients attempted to escape from isolation centres, not primarily to avoid treatment, but to ensure that if they died, they would die at home where proper funeral rites could be performed (Omonzejele, 2020). The fear of dying in an isolation centre was not a fear of medical neglect but a fear of ontological violation: a fear that one's body would be disposed of without the rituals necessary to secure ancestral status and that one's spirit would remain trapped, unable to join the community of the dead or to fulfill its protective obligations to the living.

The response of the state to these concerns varied across countries. Some governments, recognizing the legitimacy of cultural claims, developed protocols that sought to

accommodate traditional practices within the constraints of infection control. The provision of personal protective equipment to family members so that they could perform ritual washing of bodies represented one such accommodation. The relaxation of gathering restrictions for funeral ceremonies, with appropriate physical distancing measures, represented another. Yet these accommodations were unevenly implemented and often came too late to prevent the initial wave of cultural violations that characterized the early pandemic response.

The lesson that emerges from these experiences is that emergency public health powers, however necessary, must be exercised with careful attention to the cultural and spiritual dimensions of death. The treatment of the dead is not a matter of secondary importance that can be deferred until the emergency has passed; it is a matter of fundamental human dignity that must be addressed in real time, with the active involvement of affected communities. The development of pandemic preparedness plans should include, as a matter of routine, consultation with religious leaders, traditional authorities, and community representatives about how deaths will be managed in a manner that respects local custom while protecting public health.

THE CRISIS IN PAIN RELIEF: OPIOID AVAILABILITY AND PALLIATIVE CARE WORKFORCE

The disruption of social and ritual dimensions of dying during the pandemic occurred against a backdrop of pre-existing crisis in the material conditions of end-of-life care across Africa. Central to this crisis is the persistent and severe shortage of opioid analgesics, particularly oral morphine, which remains the gold standard for managing moderate to severe cancer pain and other forms of pain associated with life-limiting illness. The International Narcotics Control Board (2022) has consistently documented that low- and middle-income countries, particularly in Africa, consume a tiny fraction of the global supply of medical opioids, with consumption concentrated overwhelmingly in high-income countries in North America, Western Europe, and Oceania.

The consequences of this maldistribution are measured in preventable suffering. The Lancet Commission on Global Access to Palliative Care and Pain Relief (Knaul et al., 2018) estimated that more than 25.5 million people who died in 2015 experienced serious health-related suffering, with more than 80 percent of these deaths occurring in low- and middle-income countries. The Commission characterized the global disparity in access to pain relief as a "travesty of justice" and called for an essential package of palliative care, including immediate-release oral morphine, to be made universally available. Yet progress toward this goal has been slow, and the pandemic threatened to reverse such gains as had been achieved.

The reasons for the persistent shortage of opioids in African health systems are multiple and mutually reinforcing. Restrictive drug control policies, enacted in response to international drug control treaties that prioritize the prevention of diversion and abuse over the imperative of ensuring medical access, create regulatory barriers that deter healthcare institutions from stocking opioids and deter healthcare workers from prescribing them (Knaul et al., 2018). Fear of legal consequences, including prosecution for drug trafficking, leads to excessive caution among administrators and clinicians. Supply chain weaknesses, including unreliable procurement systems and inadequate storage facilities, mean that even when opioids are theoretically available, they may not reach the patients who need them.

In South Africa, palliative care remains one of the most underutilized medical services, with inadequate access to essential pain relief including oral morphine despite its inclusion in the country's Essential Drugs List (PALPRAC, 2025) . Only doctors can prescribe morphine, while nurses are limited to dispensing it. Supply chain disruptions often

leave hospitals and clinics without stock, and many patients and families must travel long distances for their medication. Additionally, inadequate palliative care training leaves many healthcare providers uncertain about proper prescribing and management of side effects.

The Ugandan experience with nurse-prescribing of oral morphine offers an important counter-example that demonstrates the feasibility of expanding access within a robust regulatory framework. Uganda's 2004 amendment to the Narcotic Drugs and Psychotropic Substances Act explicitly authorized trained palliative care nurses and clinical officers to prescribe oral morphine, a policy innovation that recognized the impossibility of relying exclusively on physicians in a country with one of the lowest physician-to-population ratios in the world (Jagwe & Merriman, 2007) . The policy has been implemented safely and effectively, with no documented cases of diversion or abuse of morphine prescribed by nurses, and has dramatically expanded access to pain relief, particularly in rural areas where physicians are scarce.

The Palliative Care Association of Uganda has continued its advocacy efforts, and in 2023 reported that there were no morphine stockouts in the country (Palliative Care Association of Uganda, 2025) . The organization's multifaceted approach has encompassed addressing regulatory barriers, strengthening medical education on pain management, fostering collaboration between stakeholders, and building evidence through supporting research. This demonstrates that advocacy by civil society can ensure sustainable supply of oral morphine for children and adults who need it when they need it.

Other African countries have pursued similar innovations. Kenya has integrated palliative care into its national health strategy and has made progress in training healthcare workers and establishing palliative care units in public hospitals (Rhee et al., 2017). South Africa has a relatively well-developed palliative care sector compared to many of its neighbours, with a national hospice and palliative care association that provides training and advocacy, though access remains heavily skewed toward urban areas and the privately insured population. Zimbabwe's Island Hospice and Healthcare, the first hospice established on the African continent, has pioneered community-based palliative care models that rely on training community volunteers and family caregivers to provide basic symptom management and psychosocial support.

Yet these examples of progress remain the exception rather than the rule. The pandemic exacerbated pre-existing deficits in several ways. Supply chains for essential medications, including opioids, were disrupted as international transport was curtailed and as manufacturing capacity was diverted to pandemic-related products. Healthcare workers who had been trained in palliative care were redeployed to COVID-19 response, leaving palliative care units understaffed or closed entirely. Outpatient services were suspended, meaning that patients who had previously received regular morphine refills and symptom assessments were cut off from care. And the fear of contracting COVID-19 in healthcare facilities deterred many patients and families from seeking care even when services were theoretically available.

The pandemic thus revealed with painful clarity what palliative care advocates have long argued: that the neglect of end-of-life care is not a matter of unfortunate oversight but a systemic failure that produces preventable suffering on a massive scale. The question now is whether the visibility of this suffering during the pandemic will translate into sustained investment in palliative care infrastructure, workforce development, and regulatory reform.

BEREAVEMENT: THE NEGLECTED DIMENSION OF PANDEMIC RESPONSE

The final dimension of end-of-life care that the pandemic illuminated concerns the experience of those who survive: the bereaved families and communities who must navigate grief under conditions of profound disruption. Bereavement care has historically been among the most neglected domains of palliative care, even in high-income countries with well-developed hospice and palliative care services. During the pandemic, as deaths occurred in unprecedented numbers and under conditions of enforced separation, the neglect of bereavement became impossible to ignore.

Nunez Carrasco et al. (2025) documented how the disruption of funeral and burial practices during the pandemic produced what they termed "unaccomplished grief work" among black African communities in South Africa . The study emphasized that within African traditions, death and mourning practices are guided by the intertwining of Christian and African cultural traditions, and that the restrictions imposed during the pandemic prevented the performance of rituals that are essential to the healthy processing of grief. The inability to wash the body of the deceased, to dress them in appropriate clothing, to hold vigil over the body, to gather the community for funeral ceremonies, and to perform the customary rites of separation and remembrance left many bereaved individuals in a state of suspended grief, unable to move forward in their mourning.

The concept of "incomplete ritual" that Nunez Carrasco et al. (2025) employed is analytically powerful . Rituals, whether religious or secular, provide structure and meaning to the experience of loss. They mark the transition of the deceased from the world of the living to the world of the dead or ancestors, and they mark the transition of the bereaved from one social status to another. When rituals are prevented or truncated, these transitions are left incomplete, with consequences for both the deceased and the living. The deceased may be understood as not having properly departed, remaining in a liminal state that is dangerous to themselves and others. The living may be understood as not having properly mourned, remaining in a state of unresolved grief that manifests as psychological distress, somatic symptoms, or social dysfunction.

The South African study also highlighted how the experience of excess deaths compounded the disruption of ritual. When communities experience multiple losses in rapid succession, the normal processes of grieving are overwhelmed. There is insufficient time and emotional capacity to mourn each death properly before the next occurs. Funerals, which under normal circumstances are occasions for the community to gather and support the bereaved, become abbreviated and depersonalized. The cumulative burden of grief produces what has been termed "bereavement overload," a state in which individuals and communities are unable to process loss effectively because the losses are occurring too frequently and under conditions that prevent normal mourning practices.

The neglect of bereavement care during the pandemic reflects a broader tendency within health systems to treat death as the endpoint of clinical responsibility. Once a patient has died, the health system's obligation is understood to be discharged, with the care of the bereaved falling outside the scope of health services. This understanding is inadequate on multiple grounds. First, bereavement is itself a health issue, associated with increased risks of depression, anxiety, substance abuse, and even mortality, particularly among vulnerable populations such as older adults and those with pre-existing mental health conditions (Stroebe et al., 2007). Second, the manner in which deaths occur and are managed has profound implications for the mental health of survivors, making bereavement care an essential component of comprehensive end-of-life care.

The African Palliative Care Association's standards for providing quality palliative care, referenced by Afolabi et al. (2021), explicitly include bereavement care as a core domain, recognizing that support for families extends beyond the death of the patient.

Yet the review of COVID-19 clinical management guidelines conducted by Afolabi et al. (2021) found that bereavement care was almost entirely absent from these documents, a finding that underscores the gap between normative standards and actual practice.

The pandemic has demonstrated that bereavement cannot be relegated to the private sphere or to the domain of religious and community organizations alone. When deaths occur under traumatic circumstances, when normal mourning rituals are disrupted, and when communities experience multiple losses in rapid succession, the need for organized bereavement support becomes urgent. Health systems, humanitarian organizations, and governments have an obligation to anticipate and respond to these needs, integrating bereavement care into emergency preparedness and response planning.

LESSONS AND RECOMMENDATIONS: TOWARD DIGNIFIED END-OF-LIFE CARE IN AFRICAN HEALTH SYSTEMS

The COVID-19 pandemic has furnished African health systems with an unsparing education in the consequences of neglecting end-of-life care. The lessons of this education are clear, even if the political will to act on them remains uncertain. This concluding section synthesizes these lessons and advances actionable recommendations for policy, practice, and future research.

The first and most fundamental lesson is that dignified end-of-life care is not a luxury to be addressed once communicable diseases are controlled and non-communicable disease burdens managed. It is an essential component of health systems strengthening that speaks to the most basic obligations of states to their citizens. The pandemic demonstrated that when health systems are organized exclusively around curative imperatives, they are incapable of responding humanely to the reality of death. A health system that cannot ensure that its citizens die without preventable pain, without social abandonment, and without violation of their cultural and spiritual commitments is, in a fundamental sense, incomplete.

The second lesson is that dignity at the end of life in African contexts cannot be secured through the simple transplantation of Western palliative care frameworks. While the clinical principles of symptom management are universal, the social and spiritual dimensions of dying are culturally specific and must be addressed through engagement with local moral economies, community structures, and religious traditions. The pandemic demonstrated that protocols developed without attention to these dimensions, whether for hospital visitation or for the management of dead bodies, produce harms that may outweigh their intended benefits. Future pandemic preparedness and health systems strengthening efforts must involve communities in the design of policies that affect how they die and how they mourn.

The third lesson concerns the critical importance of opioid availability. The pandemic exposed the consequences of restrictive drug control policies that prioritize the prevention of diversion over the imperative of ensuring medical access. The Ugandan model of nurse-prescribing demonstrates that it is possible to expand access to essential pain relief safely and effectively within a robust regulatory framework (Jagwe & Merriman, 2007) . Other African countries should be supported to adopt similar reforms, adapting them to their specific legal and health system contexts. International bodies, including the World Health Organization and the International Narcotics Control Board, should intensify their advocacy for balanced drug policies that recognize pain relief as a human right.

The fourth lesson concerns the palliative care workforce. The pandemic demonstrated that healthcare workers who are trained in palliative care are an essential resource, not only for routine service delivery but for emergency response. Yet across most of Africa, palliative care training remains limited, and palliative care services are concentrated in

urban areas and tertiary hospitals. Expanding the palliative care workforce through pre-service and in-service training, through task-shifting to nurses and community health workers, and through the integration of palliative care into primary healthcare must be a priority for health systems strengthening.

The fifth lesson concerns bereavement. The pandemic revealed that the neglect of bereavement care is not sustainable, particularly in contexts of mass death. Health systems must develop capacity to support bereaved families and communities, recognizing that unresolved grief has long-term consequences for mental health and social functioning. This capacity should be integrated into emergency preparedness and response planning, ensuring that bereavement support is available when communities experience traumatic loss.

The sixth lesson concerns the importance of community-based palliative care models. The pandemic demonstrated that hospital-centric approaches to end-of-life care are both undesirable and unfeasible in many African contexts. Most Africans prefer to die at home, surrounded by family and community, and this preference should be supported through the provision of community-based palliative care services that enable effective symptom management and psychosocial support in the home setting.

Based on these lessons, the following recommendations are advanced. First, African governments should integrate palliative care into universal health coverage packages, ensuring that essential palliative care services, including access to oral morphine, are available at all levels of the health system. Second, drug control policies should be reformed to enable safe and effective access to opioid analgesics, including through nurse-prescribing where physician shortages make physician-only prescribing unfeasible. Third, palliative care training should be integrated into pre-service curricula for all health professionals, and in-service training should be expanded to build capacity among existing health workers. Fourth, pandemic preparedness plans should include explicit protocols for the management of death and bereavement, developed in consultation with religious leaders, traditional authorities, and community representatives. Fifth, family caregivers should be recognized as essential partners in end-of-life care and provided with the training, support, and resources necessary to fulfill this role.

The COVID-19 pandemic has been a catastrophe of historic proportions, measured not only in excess deaths but in the manner of those deaths and in the suffering of those who survive. Yet catastrophes can also be occasions for moral reckoning and for transformative change. The pandemic has made visible what was long known but insufficiently addressed: that how a society cares for its dying is a fundamental measure of its collective humanity. The question now is whether this recognition will translate into sustained investment in the systems, policies, and practices necessary to ensure that all Africans can die with the dignity that is their birthright.

CONCLUSION

The COVID-19 pandemic did not invent the crisis in end-of-life care across Africa. It revealed it. It forced a reckoning with what had long been known but conveniently ignored: that millions of Africans die each year in preventable pain, in social isolation, and in conditions that violate their most deeply held cultural and spiritual commitments. The pandemic stripped away the pretense that health systems organized exclusively around curative imperatives are sufficient to meet the needs of populations confronting life-limiting illness. It demonstrated, with terrible clarity, that a health system incapable of ensuring dignified death is not merely incomplete but fundamentally unjust.

This paper has traced the multiple dimensions along which the pandemic disrupted dignified dying in African contexts. It has examined how Western conceptions of individ-

ual autonomy, embedded in global palliative care advocacy, collided with African understandings of personhood as constitutively relational, producing forms of suffering that exceeded the physical trajectory of disease. It has documented how the prohibition on family visitation transformed death from a communal passage into an isolated physiological termination, severing the bonds that affirm the dying person's continued membership in the human community. It has analyzed how mortuary protocols that treated bodies as biohazards requiring sanitary disposal violated deeply held beliefs about the ongoing connection between the living and the dead, generating spiritual distress that will reverberate for generations. It has traced the persistent crisis in opioid availability that condemns millions to preventable pain, even as the Ugandan model of nurse-prescribing demonstrates that this crisis is neither inevitable nor intractable. And it has illuminated the neglect of bereavement as a public health concern, documenting how the disruption of funeral and mourning rituals has produced "unaccomplished grief work" with lasting consequences for mental health and social cohesion.

From this analysis, six lessons emerge with particular force. First, dignified end-of-life care is not a luxury but an essential component of health systems strengthening, integral to the most basic obligations of states to their citizens. Second, dignity in African contexts cannot be secured through the transplantation of Western frameworks but requires sustained engagement with local moral economies, community structures, and religious traditions. Third, the Ugandan model of nurse-prescribing demonstrates that expanding access to essential pain relief is feasible and safe within a robust regulatory framework, and other African countries should be supported to adopt similar reforms. Fourth, the palliative care workforce must be expanded through pre-service and in-service training, task-shifting, and integration into primary healthcare. Fifth, bereavement care must be recognized as an essential component of comprehensive end-of-life care and integrated into emergency preparedness and response planning. Sixth, community-based palliative care models that enable home death and involve family caregivers as essential partners represent the most appropriate and sustainable approach for many African contexts.

The recommendations advanced in this paper are not novel. They echo calls that palliative care advocates have made for decades, calls that have too often gone unheeded by policy-makers and global health institutions. What has changed is the visibility of the suffering that results from neglect. The pandemic has made it impossible to pretend that the status quo is acceptable. It has created a window of opportunity for transformative change, a moment in which the moral imperative to ensure dignified death might finally translate into sustained political will and resource allocation.

Whether this opportunity is seized will depend on the actions of multiple actors. African governments must integrate palliative care into universal health coverage packages and reform restrictive drug control policies. International bodies, including the World Health Organization and the International Narcotics Control Board, must intensify advocacy for balanced drug policies that recognize pain relief as a human right. Health professional training institutions must integrate palliative care into pre-service curricula. Humanitarian organizations must include palliative care and bereavement support in emergency response planning. And communities must be involved as partners in the design of policies that affect how their members die and how they mourn.

The pandemic has taught us, if we are willing to learn, that how a society cares for its dying is a fundamental measure of its collective humanity. It has shown us that dignity at the end of life is not a matter of individual choice alone but of communal obligation, not a luxury for the few but a birthright for all. The question that remains is whether we will honour this lesson. Will we build health systems that can care for the dying as well

as cure the living? Will we ensure that no African dies in preventable pain, in social abandonment, in violation of their cultural and spiritual commitments? The answer to these questions will determine not only the quality of death for millions of Africans but the moral character of the societies we are building. The pandemic has given us the knowledge we need. What remains is the courage to act.

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