

Perceived barriers to paediatric palliative care in a Palestinian children's hospital

George Ghareeb and Daniel Kelly

Abstract

Background: This study aimed to identify barriers to paediatric palliative care provision at one Palestinian paediatric hospital, elucidate reasons for the barriers, provide recommendations for enhancing care and identify topics for future research in other low- to middle-income countries. **Methods:** A mixed-method cross-sectional study, employing both quantitative and qualitative methods was conducted, involving 61 healthcare professionals at a paediatric hospital in Palestine. Data collection consisted of 58 participants completing an electronic survey, while three healthcare professionals participated in semi-structured interviews. Ethical approval was obtained prior to data collection. **Results:** The study identified significant barriers to paediatric palliative care, categorised into patient-family, healthcare professional and organisational domains. Quantitative data from 58 healthcare professionals revealed family resistance to a palliative prognosis and inadequate training for healthcare professionals, with mean barrier scores ranging from 3.09 to 4.00 (maximum=5.00). Qualitative insights from interviews and open-ended survey questions complemented these findings, highlighting the need for effective communication, educational enhancement and organisational support to improve the quality of care. **Conclusion:** The study identified barriers to the implementation of effective paediatric palliative care, underscoring the need for emotional support, better clinical guidance, more education and training and stronger interdisciplinary collaboration.

Key words: ● barriers ● gaps in care provision ● low-to-middle income countries ● paediatric palliative care

Paediatric palliative care (PPC) is a holistic approach focused on the physical, emotional and spiritual wellbeing of children, while also providing support to their families (Verberne et al, 2018; Akard et al, 2019). PPC plays a vital role in improving the quality of life for children with life-threatening or life-limiting illnesses and their families (Lo et al, 2022).

This study builds on a global concern of inadequate access to palliative care for children, primarily affecting low-middle income countries (LMICs) where PPC remains a challenge (Arias-Casais et al, 2020; Garcia-Quintero et al, 2020). Importantly, PPC extends beyond end-of-life care and can offer a range of benefits, including improved symptom management, comprehensive psychosocial support, better care co-ordination, reduced ICU-related mortality, and enhanced quality of life for children and

families (Haines et al, 2018).

This study aims to identify the gaps in the PPC provision in one Palestinian paediatric hospital and understand the reasons for these, increase awareness of the need for and importance of PPC, make recommendations for improving PPC in Palestinian paediatric hospitals, influence funding decisions and policy-making regarding PPC, and to serve as a foundation for future research on PPC in LMICs.

Background

The West Bank has a single specialised children's hospital, providing care to all children regardless of ethnicity or religion. Researching the barriers to PPC in this setting is essential to help inform effective interventions (Jakob et al, 2023; Vossel, 2024). Understanding the unique needs of children and families in this context is also essential for ensuring culturally appropriate

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palliative care and addressing the region's distinct social and economic challenges (Saad et al, 2022). Such efforts have the potential to improve the quality of life of children with life-limiting conditions and their families (O'Shea and Kanarek, 2013; Dalberg et al, 2018).

Cultural competence theory, encompassing awareness of one's cultural viewpoint, attitude toward cultural differences, knowledge of different cultural practices and acquisition of cultural skills, plays a crucial role in this issue (Brouwer et al, 2020; Ashkinazy, 2021). While global disparities in PPC provision are acknowledged, the specific barriers encountered in Palestinian paediatric hospitals remain underrepresented in the research literature. This study bridges that gap by examining healthcare professionals' (HCP) perceived barriers and offering context-specific insights into these challenges within a specific LMIC setting. Importantly, the study took place immediately prior to events between Israel and the occupied Palestinian territory, which to date has caused large numbers of civilian deaths, including children.

Literature review

Despite recognising the importance of PPC, its implementation faces multiple hurdles. A study by Kang et al (2022), identified a critical lack of attention and systematic support for the experience and quality of life of children and their families post-diagnosis, emphasising the need to minimise adverse side effects. Their research recommends enhancing perceptions of PPC, establishing appropriate systems and training professional care providers to sustain PPC services. However, they also acknowledge the limitations of their study due to a small participant sample, which may restrict the broader applicability of their findings (Kang et al, 2022).

In many low-income countries, access to PPC is limited or completely absent, posing significant challenges for healthcare provision. Ehrlich et al's (2020) study marked a significant exploration into this issue. Their research, which is the first to evaluate the opinions of physicians across 11 low-middle income Eurasian countries, focuses on the delayed integration of palliative care into paediatric services. They pinpoint limited access to palliative care resources, insufficient physician education and perceived family resistance as the primary obstacles to timely PPC consultations (Ehrlich et al, 2020).

Garcia-Quintero et al (2020) discussed the implementation of a PPC programme, 'Taking

Care of You' in Cali, Colombia, highlighting the challenges faced in LMICs. Despite limited resources, the programme successfully provided coordinated, multidisciplinary and compassionate care to children with life-limiting conditions, addressing an unaddressed gap in healthcare. Key strategies included institutional support, educational outreach and the integration of PPC into hospital services. This case serves as a model for other LMICs to improve paediatric palliative care services, though barriers like late referrals and lack of home-based care remain.

Caruso et al (2014) provided a comprehensive review of PPC services available in LMICs. The study systematically reviewed existing literature to assess the availability of PPC and identify significant gaps in service provision in these countries. It revealed that comprehensive PPC is feasible in resource-limited settings, but challenges such as a lack of national health system support, limited specialised training and insufficient opioid access persist.

PPC in the Middle East is an emerging field, and it faces many challenges. According to a systematic review by Mojen et al (2017), the main challenges include insufficient infrastructure for healthcare generally, limited access to specialised care and medications, and cultural attitudes towards death and dying. Despite these challenges, there have been efforts to improve PPC in the region in recent years. Silbermann et al (2012) reported that while palliative care is gaining recognition in the Middle East, the availability of PPC services is limited, with only a few specialised centres in the region.

They emphasised the need for further investment and development of PPC services in the region. In their book, Al-Shamsi et al (2022) stressed the importance of PPC in the Middle East and highlighted the need for collaboration between HCPs, policymakers and families to improve the availability and quality of PPC services. These studies demonstrate that while there are challenges to the development of PPC in the Middle East, there is also a growing recognition of its importance and efforts are being made to improve the situation.

The study by Khraisat et al (2017) identified barriers and facilitators in providing paediatric end-of-life care in Jordan. Key barriers included dealing with emotional family members, disagreements among HCPs and lack of organisational support, such as the availability of social workers. Facilitators that aid in care delivery included the family's acceptance of the patient's condition, consensus among physicians on the direction of care and giving families

private time after a patient’s death. The research also highlights the need for better training for nurses and the importance of interdisciplinary support to enhance care quality.

The present study aims to specifically investigate the barriers to PPC provision in Palestine, examining the viewpoints of HCPs in one paediatric hospital. This research intends to identify practical solutions to overcome these barriers and improve the overall standard of palliative care for children in this unique setting, emphasising the urgent need to enhance the quality of care for future generations.

Methods

A mixed-method approach was chosen to combine both qualitative and quantitative data in a single exploratory study. This was intended to produce a more comprehensive understanding of the situation regarding perceptions of PPC by HCPs in the West Bank (Bhat, 2022). A mixed-methods approach was used because it allows for a deeper exploration of complex issues by integrating numerical data from surveys with the detailed insights provided by qualitative interviews. This combination enables confirmation and corroboration of data through triangulation from different sources (Ahmed et al, 2024).

A cross-sectional sample of HCPs employed in a Palestinian paediatric hospital were recruited using a convenience network sampling approach.

Inclusion criteria

- Those working in an in-patient area that cares for children or young people in the terminal phase of illness aged between birth and 18 years
- Professionals employed as registered nurses, resident doctors or paediatricians.

Exclusion criteria

- Those working in outpatient departments
- Other professions (Figure 1).

The total sample of 92 consisted of 74 nurses, 13 resident doctors and five

paediatricians (Table 1).

Ethical approval

The Institutional Review Board and the Executive and Research Committee at the hospital reviewed and approved the study. Data were stored securely both during and after the study and no identifying names or details were used when presenting the findings.

Data collection

This study employed semi-structured interviews and an electronic survey. The choice not to give questionnaires to interview participants was intended to avoid response fatigue and to ensure that each data collection method targeted specific insights effectively. For the interviews, experienced HCPs who work with children requiring PPC were recruited. Four open-ended questions were used to explore their perspectives on PPC, including views on institutional attitudes, communication with parents and perceived barriers. The interview locations used were based on participants’ preferences, ensuring a comfortable and private setting. This study enhanced trustworthiness through the purposive selection of participants, use of interview questions grounded in existing research literature and the clinical expertise of the first author, as well as recording and transcribing the interviews accurately.

Questionnaires were distributed electronically to enable consistent data collection and to facilitate statistical analysis. An electronic survey was conducted to capture further insight from a larger group of HCPs into perceived barriers towards PPC in the West Bank. The survey presented bilingual options, so that participants had the option to choose between Arabic and English. The survey consisted of 29 questions, including 21 employing Likert scale choices, seven multiple-choice options and one open-ended question at the end to gather suggestions for improving PPC. The online survey was designed to enhance reliability by using the same instrument and distribution strategy for all participants. Google Forms

Table 1. Sample size (number of participants included in this study from each department and profession)

		Department		
		Paediatric wards	Neonatal ward	Intensive care units
Profession	Nurses	36	19	19
	Resident doctors	6	3	4
	Paediatricians	3	1	1
Total		45	23	24

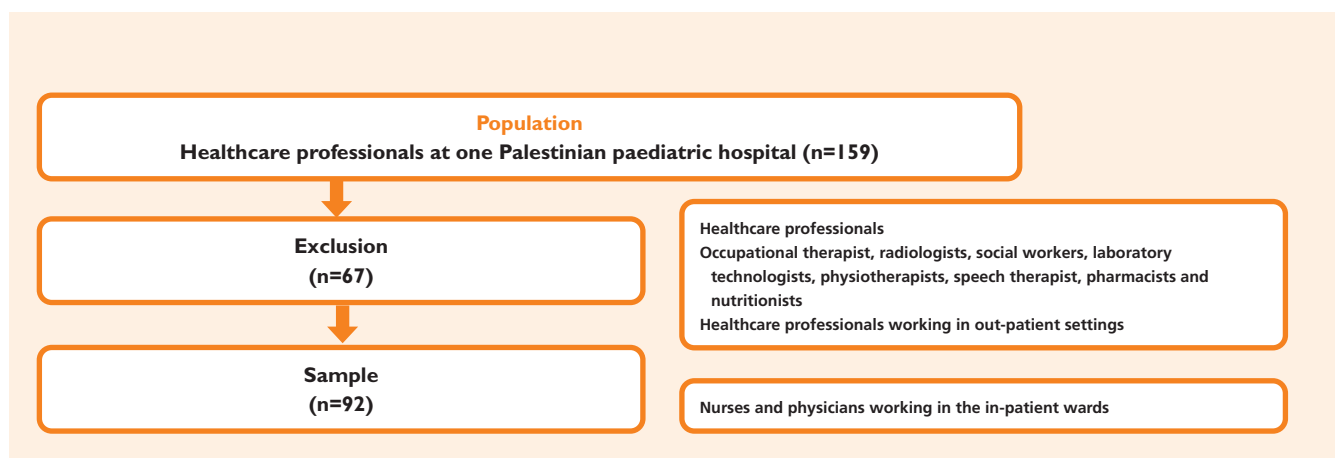


Figure 1. Sampling–exclusion and inclusion criteria

was used for distribution, guaranteeing data consistency and security. Clear instructions guided participants on how to accurately complete the survey.

Two distribution methods were used: sharing a general invitation via the hospital's computer system and sending questionnaires individually to potential participants via email. The survey took between 10–15 minutes to complete as HCPs are known to be busy. Before distribution, the survey also underwent pilot testing with two clinical colleagues and the quality and patient safety director of the paediatric hospital to check for construct validity in both languages. Amendments were made based on feedback and distribution took place over a period of 2 weeks in 2023.

The validity and reliability of the questionnaire were ensured through pre-launch pilot testing and language validation checks, while the trustworthiness of the qualitative data was supported by detailed documentation and adherence to methodological rigour throughout the data collection and analysis stages.

Data analysis

To facilitate qualitative analysis, all interviews were audio-recorded. They were transcribed verbatim in the language of the interviewee (English or Arabic) using an online transcription tool (Transkriptor, 2022). Interviews in Arabic were translated into English. Afterwards a full revision of all transcripts was carried out to ensure accuracy. Reflexive thematic analysis as proposed by Braun and Clarke (2006) was used to analyse the interview transcripts. This included first gaining an understanding of the data, creating codes and then generating themes, identifying commonality across the themes, naming and labelling these and then providing a

report. The study's applied focus, which entailed identifying barriers that can be used to enhance PPC provision was well suited to this approach.

The Windows version of STATA 10.0 and Microsoft Excel 2016 were used for survey data analysis. Barriers to implementing the PPC, as reported by HCPs, were assessed using descriptive statistics, such as range, mean, standard deviation and percentages. Free-text responses to the open-ended question in the survey asked about ways to improve the provision of PPC. These responses were translated into English and then analysed by reading the responses to obtain a general sense of the content, developing a coding category that captured the themes that emerged from these responses, coding each response into one or more categories based on the coding category, and finally counting the number of responses in each category to determine the frequency of each theme.

Findings

Quantitative results

The quantitative results address the survey questions about participant characteristics and Likert scale responses that assessed participants' agreement with statements regarding barriers to PPC provision.

Participants' characteristics

Of the eligible 92 HCPs in the hospital, 58 completed the survey, resulting in an overall response rate of 63%. The response rate for physicians was 39%, with seven out of 18 completing the survey, while nurses had a higher response rate at 69%, with 51 out of 74 participants. The majority of participants (51) were nurses, while the rest comprised physicians, including paediatricians and resident

doctors. Characteristics of the participants are summarised in *Table 2*.

Healthcare professionals' perceptions of barriers to PPC

Barriers were categorised into three domains: patient and family, HCPs and organisational problems (*Table 3*). In the patient and family category, participants most often agreed that barriers included 'family not accepting patient poor prognosis,' 'poor design of units not allowing for privacy or grieving,' and 'dealing with cultural differences that families employ.' Out of a maximum score of 5, they rated these barriers with mean scores of 3.83, 3.72 and 3.72, respectively. The item with the least agreement as a barrier to PPC was 'Not enough time to provide palliative care,' with a mean score of 3.21.

In the HCPs category, the highest-rated barrier was 'lack of HCPs' education and training regarding family grieving and improving the patient's quality of life' with a mean score of 4.00, while the lowest-rated barrier in this category was 'paediatricians who will not allow the patient to die from the disease process' with a mean score of 3.09.

A 'lack of hospital resources for delivering optimum palliative care' was the highest-rated barrier for the organisational problems, category with a mean score of 3.60. The next category was 'issues regarding the availability or effectiveness of the ethical committee' and this had a mean score of 3.55. The statement 'unit visiting hours are too restrictive' received the lowest mean score of 2.86. The patient and family category had the highest overall mean score at 3.75, followed by the HCPs category with a mean score of 3.51 and the organisational category with a mean score of 3.33.

Qualitative results

Qualitative results included responses to the open-ended survey question and insights from interviews with one paediatrician, one resident doctor and one ICU nurse, hereinafter identified as 'N1,' 'R2,' and 'P3.'

Open-ended question data

Table 4 lists the terms most frequently mentioned in response to the open-ended questions in the questionnaire. In response to the question 'what would improve paediatric palliative care', participants' answers fell into three categories.

Patient and family

Participants emphasised the importance of a

family's acceptance of palliative care as a means of supporting the child and improving their quality of life. Clear communication and support for families, particularly understanding the child's needs, were seen as essential.

Healthcare professionals

Participants highlighted the need for knowledgeable and competent HCPs, emphasising the importance of honesty in communication. The concept of dignity in care was also mentioned here, as well as the role of palliative care co-ordinators and the importance of continuity of care.

Organisational problems

Respondents noted the significance of multidisciplinary teams in paediatric palliative care, a strong infrastructure and considerations of healthcare expenditure. The importance of home-based care and creating a safe and welcoming environment for children requiring palliative care was highlighted. Participants stressed the need for skilled and compassionate HCPs and an interdisciplinary team approach to achieve the best outcomes.

Interview data

In interviews, participants provided further insights into the issues highlighted in the open-ended survey question.

Patient and family

A nurse (N1) discussed how unrealistic expectations and cultural beliefs could lead to family barriers towards palliative care:

'Families may refuse comfort care (palliative care) because they culturally believe they should fight illness to the very end, in addition to having high expectations.'

A paediatrician (P3) emphasised the role of clerics in supporting families in such situations:

'Some families may hold strong religious beliefs that influence their views on illness and death. They may believe that a cure or miracle is possible through faith or prayer.'

Additionally, a resident doctor (R2) described the evolving mindset of families as their child's condition deteriorated:

'Hope transformed into acceptance as their child's illness progressed.'

Table 2. Characteristics of HCPs participating in the study (n=58)

Characteristics	Number of respondents (%)		
	Total (n=58)	Nurses (n=51)	Physicians (n=7)
Gender			
Female	37 (63.8)	35 (68.6)	2 (28.6)
Male	21 (36.2)	16 (31.4)	
Age			
18–24 years old	11 (19)	11 (21.6)	0 (0)
25–34 years old	31 (53.4)	26 (51)	5 (71.4)
35–44 years old	5 (8.6)	5 (9.8)	0 (0)
More than 44 years old	11 (19)	9 (17.6)	2 (28.6)
Having children			
Yes	36 (62.1)	30 (58.8)	6 (85.7)
No	22 (37.9)	21 (41.2)	1 (14.3)
Experience with paediatrics			
Less than 5 years	27 (46.6)	22 (43.1)	5 (71.4)
5–10 years	13 (22.4)	13 (25.5)	0 (0)
10–15 years	4 (6.9)	4 (7.8)	0 (0)
15–20 years	5 (8.6)	5 (9.8)	0 (0)
More than 20 years	9 (15.5)	7 (13.7)	2 (28.6)
Department			
Paediatric wards	31 (53.4)	28 (54.9)	3 (42.9)
Intensive care unit	21 (36.2)	18 (35.3)	3 (42.9)
Neonatal ward	6 (10.3)	5 (9.8)	1 (14.3)
Experience with palliative care			
Yes	20 (34.5)	17 (33.3)	3 (42.9)
Maybe	19 (32.8)	17 (33.3)	2 (28.6)
No	19 (32.8)	17 (33.3)	2 (28.6)

Healthcare professionals

‘Palliative care isn’t just about medicine. It’s about treating the whole person with honesty and respect. We need training to truly understand each patient’s unique needs and provide them with dignity.’ Nurse (N1)

Here, the nurse stressed that palliative care extends beyond simple healthcare services and should address the whole person and their unique needs. Honesty, dignity and the necessity for HCP training were also emphasised.

The importance of teamwork and continuity of care were highlighted by a resident doctor (R2):

‘Healthcare professionals need training, knowledge and experience.’

‘In addition to addressing the whole person’s needs, palliative care thrives on effective teamwork and continuity of care.’ Paediatrician (P3).

‘It’s not just about individual healthcare professionals; it’s about how we work together seamlessly to support patients and their families through every stage of their journey. This requires ongoing training, knowledge sharing and a commitment to interdisciplinary collaboration.’

Organisational problems

Participants discussed the cost considerations in palliative care, including specialised training, equipment and medications.

‘In addition to cost considerations, systemic challenges, such as resource constraints and political instability, were identified as significant barriers to effective palliative care.’ Nurse (N1).

A resident doctor (R2) stated:

‘A child was admitted to our hospital. The patient stayed as an inpatient in the hospital for about 15 days at the expense of the family, and as much as we tried to get them financial

Table 3. Healthcare professionals' mean response to PPC barriers

Patient and family	Mean answers	Standard deviation
Family not accepting a patient's poor prognosis	3.83	0.93
Dealing with cultural differences	3.72	0.95
Poor design of units which do not allow for privacy or grieving	3.72	1.12
Intra-family fighting about whether to continue or stop life support	3.60	0.93
Dealing with angry/distraught family members	3.52	1.04
No designated family member to contact with information	3.40	1.00
Not enough time to provide palliative care	3.21	1.25
Healthcare professionals	Mean answers	Standard deviation
Lack of healthcare providers' education and training regarding family grieving and improving patient's quality of life	4.00	0.79
Multiple paediatricians, involved with one patient, who differ in opinion about the direction of care	3.79	0.96
Continuing treatments even though the treatments are futile, or cause the patient pain or discomfort	3.55	1.20
Not knowing child's wishes regarding continuing with treatments because of the inability to communicate due to a depressed neurological status or his/her developmental stage	3.55	1.07
Doctors who are evasive and avoid having conversations with family members	3.52	1.31
Continuing intensive care for a child with a poor prognosis because of the real or imagined threat of future legal action by the patient's family	3.50	1.15
Paediatricians who are overly optimistic to the family about the patient surviving	3.36	1.18
When nurses' opinions about the direction of patient care are not requested, not valued or not considered	3.22	1.22
Paediatricians who will not allow the patient to die from the disease process	3.09	1.15
Organisational-related category	Mean answers	Standard deviation
Lack of hospital resources for delivering optimum palliative care needed	3.60	1.13
Issues regarding the availability or effectiveness of the ethical committee	3.55	0.99
Being called away from the patient and family because of the need to help with a new admission	3.45	1.12
No available support person for the family, such as a social worker or religious leader	3.21	1.37
Unit visiting hours are too restrictive	2.86	1.20

Table 4. Most mentioned terms related to paediatric palliative care provision in response to the open-ended question

Term	Frequency	Term	Frequency
Palliative care team	5	Knowledge	3
Health expenditure	5	Acceptance	2
Competent providers	4	Home care	2
Hospitals' infrastructure	4	Continuity of care	2
Communication	3	Suitable environment	2
Education	3	Advocacy	1
Family-centered care	3	Honesty	1
Time	3	Dignity	1

coverage from either private or governmental insurance, we failed. So, families in general are rushed to be discharged because they can't afford that much money.'

Challenges related to home-based care were attributed to resource constraints and political instability. The need for a specialised department and private rooms for PPC, a multidisciplinary palliative care team and guidelines for PPC were also mentioned.

'To ensure optimal PPC care, clear guidelines are essential.' (Patient 3)

'Providing PPC at home can be tough when there aren't enough resources or things are politically shaky. Ideally, there would be a dedicated PPC department with private rooms for patients, a team of experts working together, and clear guidelines to follow.' Nurse (N1)

Overall, these data highlighted various barriers to paediatric palliative care, emphasising the importance of factors related to the patient-family, HCPs and the organisation. Strategies to improve PPC need to consider each of these aspects to enhance the quality of care for children with life-limiting conditions and their families.

Discussion

This study addresses gaps in the evidence of perceptions of PPC barriers in the West Bank. Notable barriers to PPC include the family's acceptance of PPC, the emotional burden on HCPs of PPC and lack of education about the topic. The findings have emphasised the importance of interdisciplinary teamwork, the key role of nurses and the holistic nature of PPC. This is consistent with findings from Laronne et al (2021), who also highlighted the emotional burden for HCPs and lack of training as significant barriers.

Recommendations to improve PPC for HCPs in the Palestinian West Bank include providing ongoing education and training, establishing and encouraging improved multidisciplinary team working, securing systems for the coordination and continuity of care between the different HCPs and services involved, as well as raising awareness about the importance of PPC among HCPs more generally. Similar recommendations were made by Garcia-Quintero et al (2020), who emphasised the feasibility and benefits of ethical committees in PPC, especially in LMICs. The

insights from recent studies by Kang et al (2022) and Rost et al (2020) further underline the significance of such measures, noting challenges like high uncertainty, cultural gaps and financial issues adversely affecting PPC delivery.

Organisational-level recommendations to improve PPC in the West Bank include increasing the availability of palliative services, developing palliative care protocols and guidelines to improve the quality and consistency of care provided to children with life-limiting conditions. It is also important to create partnerships and collaborations between HCPs, non-governmental organisations and community representatives that can help improve access to palliative care services and provide direct support to families. While PPC may involve higher costs in the short-term, it has been shown that it can lead to financial savings in the long-term due to reduced hospitalisations and fewer emergency room visits and other medical interventions (Kang et al, 2022). This is also reflected by Lo et al (2022), who also found long-term cost savings as a significant benefit of effective PPC implementation. An emerging perspective from Mojen et al (2017) and Silbermann et al (2012) emphasised the pressing need to address the infrastructural and cultural barriers in the Middle East, specifically in PPC services provision.

This new information might impact nursing practice in a positive manner by providing a better understanding of the cultural and societal factors that may act as barriers to palliative care, so that children requiring PPC can be supported with greater sensitivity. Altarawneh et al (2023) suggested that palliative care education tailored to cultural competencies can significantly improve patient and family relations in palliative settings. HCPs could also tailor communication and PPC interventions to align with the cultural beliefs and values of patients and families, so fostering better trust and co-operation. These findings also underscore the importance of family acceptance and involvement in palliative care decision making. The complexity of family involvement in advance care planning has been shown to enhance the engagement of families in making critical decisions, which in turn supports more informed, family-centered care (Kishino et al, 2023). HCPs have the opportunity to prioritise family-centered care by actively engaging with families, addressing their concerns appropriately and involving them in care planning. This collaborative approach could result in more informed and child-centric decisions.

By recognising the organisational and resource-related barriers highlighted in the study, HCPs can advocate for improved resource allocation within their institutions. They could work more collaboratively with hospital administrators, policymakers and international charities to secure the necessary resources. The role of oncology nurses, as indicated in recent research, is pivotal in educating patients and their families about the goals of paediatric palliative and hospice care, which is essential for ensuring that these resources are used effectively (Pyke-Grimm et al, 2021). The call for education and training for HCPs' points to a need for continuous learning in the field of PPC, and individuals could identify opportunities to enhance their knowledge and skills in this specialised area. These findings have emphasised the importance of interdisciplinary collaboration. Nurses have a key responsibility to engage with other HCPs, such as physicians, social workers and psychologists, to ensure a comprehensive and coordinated approach to PPC.

Strengths and limitations

This study showcases significant strengths, particularly in its mixed-method approach that effectively combines quantitative and qualitative data for a comprehensive analysis. The use of interviews and open-ended questions within the questionnaire is a notable strength, as it allows for an in-depth exploration of complex and sensitive issues

that are often not fully captured through survey methods alone. These methods provided rich, narrative data that bring personal experiences and insights to the forefront, highlighting the emotional and practical challenges faced by HCPs in delivering PPC.

Despite its strengths, the study also faced some limitations, mainly due to setting and sample size. Conducted in a single paediatric hospital, the findings may not be generalisable to other regions or healthcare settings, especially those with different cultural or organisational contexts. Additionally, the sample size, although adequate for initial exploratory research, is relatively small and might not capture all possible perspectives from the hospital's staff.

Conclusion

This study provides important new insights into the perceptions of HCPs about PPC in the West Bank. Different perspectives emerged from these participants, all of whom shared the goal of providing excellent PPC, but differed on how to best achieve this, despite working in the same healthcare teams. Future research should address how the barriers identified here could be addressed to ensure effective palliative care provision for all children living in the West Bank with chronic, life-threatening, or life-limiting conditions. *IJPN*

Statement of interest: None

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CPD reflective questions

- Why is paediatric palliative care (PPC) important?
- What are the barriers to PPC?
- How can PPC be improved in Palestine?

Key points

- Barriers to paediatric palliative care (PPC) include the acceptance of the need for PPC by the patient's family, the emotional burden on healthcare professionals of providing such care and a lack of education on PPC
- Ongoing education and training is needed to improve PPC in the West Bank
- PPC services also need to be made more available to those who need them
- Palliative care protocols and guidelines must be developed to improve the quality and consistency of care provided to children with life-limiting conditions

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