

# Institutional drivers for integrating palliative care services in a hospital in a sub-Saharan African military hospital context

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## Abstract

**Background:** The growing burden of life-threatening illnesses and advancements in care interventions call for the intentional integration of palliative care services into existing care systems. The absence of active, functioning palliative care services in most hospitals in Ghana is a major concern. This study explored the factors influencing the integration of palliative care services in one of such institutions.

**Objectives:** The aim of the study was to explore the institutional drivers of palliative care integration in a military health facility.

**Design:** Exploratory qualitative study.

**Methods:** We employed a qualitative exploratory study design situated within a constructivist paradigm. A purposive sampling method was used to select and interview 11 healthcare professionals. A semistructured interview was used to conduct face-to-face, in-depth interviews with participants between April and May 2022. A thematic data analysis was done based on the Braun and Clarke analysis process with the aid of QSR NVivo-12.

**Results:** The six themes that describe the institutional driving factors for integrating palliative care services were cognitive restructuring, supportive logistics and infrastructure, staffing, healthcare professional skills, institutional policies and priorities, and utilization of focal persons. It was observed that a paradigm shift in the mindset of healthcare professionals and administrators was a major driver that would determine the integration of palliative care services. A cognitive restructuring will facilitate a more aggressive integration of palliative care services because logistics, staffing, and medication access will be prioritized.

**Conclusion:** Institutions have the responsibility of aligning with the WHO policy on palliative care service access and must invest in training, staffing, prioritizing palliative care needs and policies, procurement of essential drugs, and the provision of logistics and supportive infrastructure to scale up the implementation of palliative care services.

**Keywords:** end-of-life care, health service integration, palliative care, qualitative study

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## Introduction

Palliative care is becoming an important global healthcare concern because it serves as a critical conduit for enhancing the quality of life for patients and families grappling with life-limiting illnesses.<sup>1,2</sup> The prevalence of chronic conditions and the corresponding need for palliative care

are escalating, driven by aging populations, alterations in lifestyle, and advancements in medical technology.<sup>3,4</sup> There is a notable increase in suffering and mortality associated with the heightened sustenance of life-threatening and life-limiting illnesses affecting the quality of life of people.<sup>5</sup>

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Palliative care involves the holistic care of individuals across all ages who are experiencing serious health-related suffering due to severe illness and seeks to improve the quality of life of the patients and their families.<sup>6</sup> Access to palliative care is a fundamental aspect of the right to health and a critical component of achieving UN Sustainable Development Goal 3.8 on universal health coverage and well-being.<sup>7</sup> An estimated 56.8 million individuals would need palliative care worldwide, 31.1 million before the end of life, and 25.7 million getting to the end of their lives.<sup>8</sup> The burden of palliative care is higher in adults over 50 years (69%), and about 6% are children,<sup>8</sup> and these estimates are expected to double by the year 2060.<sup>9</sup>

The inequity in the demand and supply of palliative care services is a challenge to the global healthcare agenda. Only 14% of those in need are receiving this critical service, with 78% of these individuals residing in low- and middle-income countries (LMICs).<sup>10</sup> The situation is worse for pediatric palliative care. LMICs suffer more, but over 50% of service gaps are predominantly in Africa.<sup>8</sup> For most LMICs, the journey towards integrating and institutionalizing palliative care is fraught with challenges. The intricacies of setting up and upholding these crucial services in areas with limited resources make it particularly challenging.<sup>11</sup> Additionally, these regions often grapple with infrastructural deficits, a lack of trained professionals, and limited public awareness about the importance of palliative care.<sup>11</sup>

Ghana is among the LMICs working to achieve Universal Health Coverage by 2030, but substantial disparities in access to fundamental healthcare services remain.<sup>12</sup> Ghana, as of 2021, had a Health Service Coverage Index (SDG 3.8.1) of 48%.<sup>7</sup> Non-communicable diseases account for approximately 45% of all deaths, with cancer being a prevalent cause of morbidity and mortality.<sup>13</sup> In collaboration with WHO and other partners, the Ghanaian Ministry of Health has launched a national cancer strategy that aims to advance palliative care as a crucial component of cancer care.<sup>14</sup> Meanwhile, other diseases of palliative care including chronic renal diseases, heart problems, neurological conditions, and AIDS are competing for attention.

Despite Ghana's ambitions for healthcare advancements, palliative care services are notably scarce. Essential medications such as

opioids are available in the hospitals but kept under lock and key (for fear of addiction) and rarely used. Although some professionals are being trained in the area of palliative care, the numbers are not adequate. The general mindset of most health professionals is that when opioids are administered, patients may get addicted and request these medications unnecessarily. Some cultures also do not permit members to show pain or panic so these patients will also not confess being in pain for fear of being seen as weak. The evolution of palliative care in Ghana is still in its early stages, with specialized services localized within a few hospitals, including Komfo Anokye Teaching Hospital, Korle Bu Teaching Hospital, Tetteh Quarshie Hospital, and recently Greater Accra Regional Hospital.<sup>15,16</sup> Nevertheless, some non-governmental agencies, like COMPASS Ghana, are pioneering community-centric initiatives that aim to enhance palliative and end-of-life care in Ghana and other resource-limited settings.<sup>17</sup> Palliative care has been included in the curriculum of some universities on a general level, either as a part of a course or an introductory course. In Ghana, physicians can prescribe opioids, and nurse prescribers can do so in the absence of the physician. The Ghana College of Nurses and Midwives and the Ghana College of Physicians and Surgeons, who offer palliative care training as a specialty, are contributing to the solutions through the training of nurse and physician specialists. The Ministry of Health, Ghana Health Service, and other quasi-institutions fund the training of these specialists each year. Training these specialists without appropriate staffing norms and resources will slow the integration process.

Active integration of palliative care services includes one or more combinations of the following: a dedicated inpatient palliative care unit, outpatient/day clinics, hospital-based palliative services with home visits, and a multidisciplinary team of healthcare professionals. The increase in training of specialists and the integration of service seems slow. Given the critical need and the scarcity of palliative care services, exploring, and understanding the key drivers and barriers to establishing these services in healthcare settings is pivotal. This study sought to understand the drivers and barriers to integrating palliative care services from the perspectives of healthcare professionals. This would elicit information that would promote health

systems strengthening with explicit prioritization of palliative care services.

## Methods

### *Study design*

In this study, we adopted a qualitative exploratory study design leaning on the constructivist paradigm. This means study participants were key in generating knowledge from their experiences and worldviews. Participants' perspectives on drivers and barriers to integration of palliative care were elicited through in-depth interviews and compared to create knowledge. The decision to choose this design was based on the premise that this approach allows researchers to investigate issues that may not have received extensive attention in prior studies, and it empowers study participants to actively contribute to the generation of fresh insights within that domain.<sup>18</sup>

### *Setting*

This research was conducted at the 37 Military Hospitals, the foremost military healthcare institution in Ghana. The hospital is located in Accra, the capital of Ghana and is near the residence of the seat of government. In view of its central location, many health facilities, both private and district level, refer patients to the 37 Military Hospitals. It also serves as a teaching facility for diverse health professionals. Historically, the hospital was the 37th establishment in the British colony of West Africa.<sup>19</sup> With a bed capacity of over 500, the hospital is open to the public and receives a substantial number of referrals from other healthcare facilities. There are medical wards and an oncology department also in the hospital that have opioids, which sometimes expire after due to lack of usage. Although they do not have many palliative care specialists, all nurses and medical doctors in this facility have had a general introduction to palliative care during their professional training.

### *Population*

We focused on the personnel at the 37 Military Hospitals, particularly those in leadership roles encompassing both clinical and non-clinical positions. Clinical staff, including physicians and nurses are directly involved in patient care, while non-clinical staff, such as hospital

administrators, biostatisticians, biomedical engineers, and others, do not have direct contact with patients.

### *Sampling and sample size*

A purposive sampling technique was employed to enroll participants based on predefined inclusion criteria: (i) be a hospital administrator and leader (i.e. both military and civilian) who has worked continuously for at least 5 years at the 37 Military Hospitals; (ii) be a substantive departmental head who has worked continuously for at least 5 years at the hospital. Participants were excluded if (i) on annual, study, or sick leave, and (ii) attending operational duties. These inclusion criteria were set to ensure that the participants have sufficient experience and knowledge of the hospital's operations and culture, as well as to ensure their availability for the study. There was no predefined sample size; we operated based on data saturation. This is because we anticipated attaining saturation as the extent of palliative care services provided in Ghana was not wide. By the seventh interview, no new analytical information was emerging from the interview. However, to be certain that we had reached the point of saturation, four additional interviews were conducted. Thus, bringing our final sample size to 11 participants refer to Table 1 for a breakdown of the participants' background characteristics.

### *Data collection tool and process*

The first author (SAB) conducted the interviews under the guidance and supervision of the last author. There was no prior relationship between researchers and participants to reduce bias. Based on literature reviewed,<sup>20-23</sup> a semi-structured interview guide was developed and used as the data collection tool. The semi-structured format allowed for adaptability, encouraging dynamic dialogue during interviews, and enabling the researcher to adjust questions as needed. The two main questions were (i) why is it taking time for palliative care services to be available in the institution? and (ii) What is required to facilitate the integration of palliative care services? Our interviews were conducted face to face in participants' offices at a mutually convenient time between April and May 2022 in English. No other person except the researcher was available at the time of the interview to ensure privacy and minimal interruptions. None of the participants approached refused to participate. A few had to reschedule

**Table 1.** Participants' background characteristics.

Participants' ID	Sex	Profession	Level of education	Years of service
Participant 1	M	Psychiatry nurse/nurse educator	PhD candidate	30
Participant 2	F	Peri-operative nurse	Post graduate certificate	36
Participant 3	F	General nurse	Bachelor's degree	9
Participant 4	M	Radiologist/Health administrator	Master's degree	16
Participant 5	M	Medical doctor/Hematologist	Bachelor's degree	12
Participant 6	M	Pharmacist	Bachelor's degree	12
Participant 7	F	Biostatistician	Bachelor's degree	12
Participant 8	M	General nurse	Bachelor's degree	19
Participant 9	M	Public health officer	Master's degree	22
Participant 10	F	General nurse	Bachelor's degree	13
Participant 11	M	Senior medical officer	Master's degree	10

F, Female; M, Male.

because they had unexpected meetings. Their interviews came on as the planned. Participants first read the information sheet that detailed the purpose and process of the research. Consent forms were signed to affirm participation and permission to record. Main questions were posed followed by a probe; all interviews were audio recorded with a digital audio recorder. The interviews lasted an average of 40 min. Field notes were recorded to give context for data analysis. Participants had the right to decline or withdraw from the study at any time. No interviews were repeated except phone calls to five participants for purposes of clarifying information provided.

#### *Data analysis*

The data analysis followed the six steps recommended by Clark and Braun<sup>24</sup> namely (i) familiarization, (ii) generating initial codes, (iii) searching for themes, (iv) reviewing themes, (v) defining and naming themes, and (vi) producing the report. The interviews were transcribed into text, and two participants were made to go through transcript for confirmation and any corrections (none noticed). The text documents were imported into QSR NVivo-12 (manufactured by QSR International – Lumivero,

Burlington, MA, United States) for analysis. Initially, all authors thoroughly read the transcript multiple times to establish familiarity with its content and develop initial coding frame. Subsequently, JO performed the preliminary inductive coding utilizing the 'codes' function in QSR NVivo-12. The codes were collated to search for potential themes. The team reviewed the themes to create the thematic map. The main themes were refined and for some of the themes, additional subthemes were derived and named. We consolidated certain codes and redefined others to reconcile issues raised by all the authors. This process of deliberation continued until a consensus was reached regarding the final themes. We then extracted exemplified narrations to represent the diverse themes identified in the analysis. The COnsolidated criteria for REporting Qualitative Research (COREQ)<sup>25</sup> was adhered to in carrying out this research (Supplemental File A).

#### *Rigor*

Ensuring trustworthiness is essential in qualitative research, necessitating rigor in the methodology. As such, we first ensured that the study and its methods were credible. This was achieved by

using only verbatim quotes to reflect the perspectives and voices of the participants. Also, all participants were reached out to as a measure of member checking<sup>26</sup> to validate and ensure that the issues captured in the transcript truly reflect what they intended to communicate. None of the participants raised concerns or highlighted any discrepancy between the transcripts and what they intended to communicate. Additionally, the absence of competing interests among the authors facilitated the team's commitment to maintaining a rigorous level of reflexivity. This precautionary approach was implemented to ensure that the participants' responses remained uninfluenced by any potential personal biases or vested interests. As opined in previous studies,<sup>27,28</sup> ensuring transferability is critical in promoting trustworthiness in qualitative studies. We, therefore, provided a detailed description of the study setting and methodology to facilitate the application of the methods to similar contexts.

### Ethics

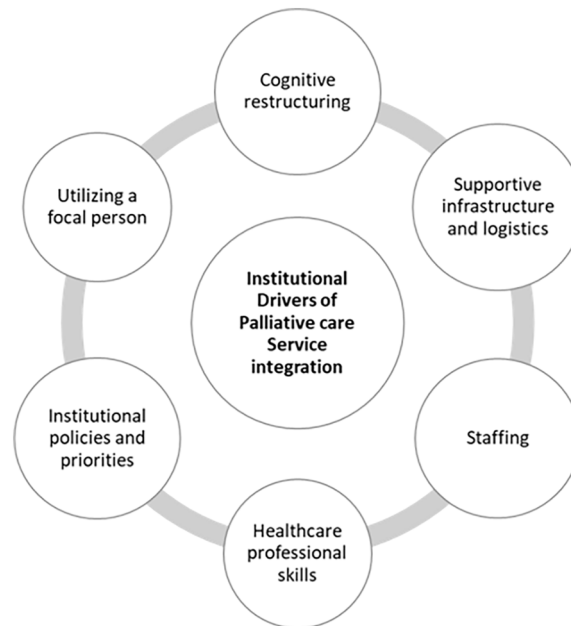
The study protocol was submitted for review and approval. Ethical approval was given by the 37 Military Hospital institutional review board (IRB) with number 37MH-IRB/FLP/IPN/608/2022. Participants right to participate or withdraw from the study at any time was obliged. Consent forms were signed by after reading the participant information sheet and accepting that purpose, benefits, and risk were understood. None of the participants withdrew from the study, and there were no adverse ethical outcomes in this study.

### Results

Our thematic analysis revealed six themes that describe the institutional driving factors necessary for the implementation of palliative care services. These drivers include cognitive restructuring, supportive infrastructure and logistics, staffing, healthcare professional skills, Institutional policies and priorities, and the utilization of focal persons (Figure 1).

#### *Cognitive restructuring*

Cognitive restructuring is the solution to the cognitive distortion observed as a barrier to the integration of palliative care service. The narratives suggested wrong attributions about the concept and goal of palliative care. The participants highlighted the common association of palliative care



**Figure 1.** Themes from thematic analysis.

with imminent death. They argued that the perception of palliative care as a service exclusively reserved for end-of-life situations may contribute to a reluctance among individuals and families to opt for such services within a hospital. The importance of unlearning and relearning perceptions surrounding this specialized form of care is expressed in the following sentiments:

Sometimes immediately we hear palliative care – everybody has some sort of notion that palliative care is for the person who is about to die. So, if we can unlearn what we know about palliative care and relearn it and the need for the institution I think that somebody can build. (Participant 3)

Palliative care, I will say, end of life management. It is when we decide to help a patient to transition this life to the next life. So, we tried to make it as much as comfortable for that patient to be able to go through the end stage of their disease which is incurable. We make sure that we help them transition from that condition to the end of it. (Participant 11)

There is a need to build a positive mindset through public education as expressed by another participant:

Well, I strongly believe that if you start this in the hospital, few Ghanaians will patronize it unless



maybe you do a lot of public education.  
(Participant 7)

The need to demystify the misconception of palliative care was further demonstrated in the conceptualization of palliative care by the professional as care provided when *medical people are stacked to the wall, and there is no way forward*<sup>7</sup> (Participant 5), or *'can't offer anything in terms of cure or treatment, and the only option is to ensure a dignified form of treatment until the person eventually passes away* (Participant 9).

#### *Availability of supportive infrastructure and logistics*

Healthcare professionals who participated in this study intimated that the hospital cannot implement an institutional palliative care service without having sufficient supportive infrastructure and logistics. The three sub-themes that emerged were creating the space, accessible equipment and supplies, and availability of affordable medications.

*Creating the space.* The participant shared sentiments about the current challenges experienced in terms of inadequate space. There were limited offices, wards, and spaces that raised concerns about how such constraints would impede the implementation of an institutional palliative care service. Consequently, they highlighted the importance of creating the needed space to support this process. One of the participants intimated:

We have infrastructural issues as in offices, wards, and spaces for expansions. That can be a challenge to this initiative. So, it is something we have to consider and make provisions for. I know you don't necessarily need a big place, but you may start by sharing with others. But eventually, we will need a separate ward and an entire unit to manage cases that require palliation. (Participant 4).

Another participant suggested setting up a palliative care unit at the facility . . . *we get such cases [patient at end of life] on our wards. So, if we can set up a unit solely for those conditions, it will really help* (Participant 10). However, for one participant all that is needed is *an atmosphere of compromise because if you won't have a new unit spring up, you could make do with even just corners in these spaces.* . . . (Participant 9).

*Availability and affordability of medications.* This study revealed that the availability of medications, particularly pain medication is critical for the hospital to set up an institutional palliative care service. From the perspective of the participants, there is often more incidence of medication shortages that tend to worsen the quality of life of patients. As such, they indicated that making pain medications readily available at all times would support the implementation of an institutional palliative care program. Not only did they highlight the availability of medications, but the participants illuminated the point that whatever medications are available to support the implementation of institutional palliative care should be affordable for patients to gain access to this specialized care. This is what one participant had to say:

Sometimes some of the opioids become difficult to get like I remember morphine. We haven't received some for some months; it is in short supply, and they were struggling to procure the imported ones because they are quite expensive, but the one that we reconstituted was very affordable. So, if we want to be able to start this palliative care in the hospital, then we have to make sure the supply of medications is intact. (Participant 6)

Another participant expressed that

We can't run hospital-based palliative care with the necessary medications to manage pain. So, if we truly desire to have this practice formalized in the hospital, then we ensure there is constant availability of medications. The medications must also be affordable else it will be like a waste of time. (Participant 8).

*Equipment and supplies.* The implementation of an effective palliative care service requires equipment and supplies. Participants lamented the available equipment and supplies were inadequate, and there were competing interests in the use of such resources. Vehicles, consumables, and other items need to be procured, but the financial resources for running the facility were not enough. The little available is concentrated on addressing emergencies. A participant lamented that

. . . equipment, money for reagents, consumables, vehicles for medical covers, are inadequate. Our facility does a lot of medical covers for exercises such as national assignments, the 6th March parade,

visiting delegations, and all that. So, you need several ambulances. (Participant 4)

The bureaucratic bottleneck in accessing the little resources available worsens the situation as reported by this participant

. . .the bureaucracy! As in everything you have to start from somewhere before it gets to the intended person, to get the support you need for you to implement it. And then . . . equipment's to use for effective and quality service, that is the issue because whenever you send a request, we'll tell you oh, they don't have the means. (Participant 7)

I think the only challenge that we will have is maybe going through the necessary bureaucratic processes. I mean, because it's a military facility, we need to go through a lot of barriers to be able to get approval. (Participant 11)

The integration of palliative care services can be realized by creating the right space, procuring the medicines, consumables, equipment, and other items the staff would need to provide quality palliative care services.

### *Staffing*

The analysis also revealed management must invest in improving the staff strength. The participants indicated that the current staff strength at the hospital is inadequate to support the plan to establish an institutional palliative care service. From their accounts, the current staff strength is not only low, but there is also a lack of specialists to constitute a palliative care team. Therefore, any attempts to establish institutional palliative care must work on increasing staff strength while attracting more specialists. This assertion is reflected in the quote below:

We don't have enough staff. We need a number of nurses to deploy outside the hospital and the same numbers to deploy within the hospital. That is going to be challenging if we want to establish this palliative care program. The government will have to give clearance for the hospital to recruit more specialists. Also, the hospital administration can encourage us to take up specializations in palliative care. It can be through workshops or going back to school. (Participant 2)

One of the participants also reported that

Just as I said before, we don't have enough staff. Even with those available, most of them are not specialized in any field. Most of the doctors are general practitioners while most of the nurses operate generally. But we need a multidisciplinary team for this to work. We need to attract geriatric nurses, clinical psychologists, palliative care doctors, and others. That is what we must do first before we start with this plan. (Participant 10)

### *Healthcare professional skills*

The integration of palliative care services is dependent on having the right skill mix of staff who are competent and confident. Participants acknowledged the limitations in breaking bad news, lack of confidence in prescribing opioids, and contextualizing values.

*Communication skills: Breaking bad news.* Participants opined that communicating with clients about poor prognosis was challenging. Mentioning death or starting conversations with death means you are telling the family to give up on the sick person. Hence, some used avoidance to escape disclosing poor prognosis. One participant commented that

Communication is a little bit difficult. Because sometimes, when you look at the patient's outlook, you feel even though they have the right to information, the information should not be presented in such a way that tells you that you are eventually going to die. We turned to use nice words to cover up the reality, saying please, let us pray your condition can be healed. We don't tell them that in a few months or years, you are going to die. No! We don't do that. We empathize by not telling them the whole truth. (Participant 3)

Some health professionals are hesitant discussing end-of-life care issues for fear of not being able to manage the reaction of the patient. Others worry about being perceived as a professional who instead of providing hope and cure are discouraging the patient. Breaking bad news was considered difficult, but much easier when dealing with only the family members.

*Confidence in prescribing opioids.* There were concerns about the perceived fear among prescribers when they prescribe opioids to patients. On some occasions the opioids are prescribed, the process of getting the medication for the patient is delayed:

We have the culture of waiting on doctors to prescribe pain medication, especially the hard ones like pethidine. Otherwise, it won't be given. Our doctors fear giving hard painkillers like opioids . . . so in such cases, they will rather give you tramadol or diclofenac. (Participant 3)

You will also have a challenge with the staff, and most health workers are uncomfortable working with opioids . . . . . I am a culprit myself, and it is because of the side effects that come with it. (Participant 10)

This suggests the need to boost the confidence of healthcare professionals. The hesitancy in prescribing opioids would best be resolved with well-implemented palliative care services. In instances that there is the will to prescribe, there is still the fear of addiction factor as shown in this participant's narrative:

In terms of pain management, we know that pain management is one of the most difficult areas of treatment, when treating patients with chronic pain, it becomes a difficult task for any clinician. So as a clinician, I try to give the maximum supports. At the same time, we try to prevent the patient from being dependent on pain medication. (Participant 11)

*Values.* Healthcare professionals equipped with the relevant values are important to the process of service integration. Empathy, discipline, honesty, and resilience were identified as values relevant to institutionalizing palliative care. Some participants believe that soldiers have special training which is to achieve tasks assigned. This special training soldiers received have an effect on how they perform their various roles. Participants consider the strong value system of discipline as good for service integration:

. . .military background affects what I do. . . . If I am tasked to execute a task, I believe my bosses know my capabilities and trust me to deliver, so I make sure I do my best even at the peril of my life. . . . So, if I am asked to help establish and is a lawful command, why not? (Participant 9)

. . . when it comes to the civil street, our military discipline and tactics also play a role in distinguishing us from other counterparts . . . . . getting the job done in an orderly and uniform manner. (Participant 4)

On the other hand, some narratives suggest the display of sympathy instead of empathy and the need to realign feelings when caring for patients at the end of life:

When giving medication and the patient is not getting well, you become worried, and most of the time, you have to do more for the patient to make sure the patient survives. Sometimes too, when you keep doing everything you can, and the patient still deteriorates, it sort of demoralizes you a little because you feel like all that you have done has been in vain. Sometimes too, you also feel for the relatives, they keep writing things, and you know that there is no way the patient will get better, but you can't also leave the patient since the patient is not getting better, so don't buy anything. You will feel like they are pouring money into the sea, and you won't get it back, so it is difficult. (Participant 3)

The value crises are the results of a lack of openness birthed from cultural limitations regarding discussing death. Good communication skills, confidence in prescribing opioids, and appreciating value systems are important to developing quality and efficient palliative care services.

#### *Institutional policies and priorities*

The integration process was observed to be slowed because of competing demands. However, the Ministry of Health in partnership with the Ministry of Defence, and the institution are working together to prioritize palliative care services. A participant mentioned that there is a policy document that when implemented would improve the availability of palliative care services:

I don't know if you have seen the 2020 Ministry of health policy. I have forgotten the main theme, but they had Palliative Care and Rehabilitation as part of the term objectives. So when you look at this, it means very soon there will be Palliative Care embedded in care services, and this will bring some competition in the health sector as everyone will now try to include it, even the private facilities. . . the government is going to help equip facilities with technology and equipment to achieve this millstone. (Participant 1)

Another participant added:

. . .now that we have formed a multidisciplinary team for Oncology, it makes it easier. So, we are



going to run it together. . .the oncology and palliative teams will work together. So already, a vehicle is moving, so they only hop onto the vehicle and go alongside. So I don't think setting it up will be difficult. (Participant 5)

The inclusion of palliative care services in the National Health Insurance Scheme (NHIS) coverage was mentioned as a measure that would encourage service utilization; however, there were also concerns about low enrolment among some service users and the coverage:

Interestingly, for civilians, it works. It doesn't work on the drugs. . .as far as I'm concerned, it was only for admission; when you are discharged, it takes off or waives some of the number of days that you spent on admission, but then for laboratory investigations, you pay. . . some people have special private insurance, they end up not paying because, for the private insurance, they pay so much to the facility. (Participant 1)

A participant added that coverage of palliative care services in the NHIS would promote service utilization:

. . . maybe if it is captured in the health insurance and is free for all, the patronage may increase, and people will have that nice end-time care. I know it is a bigger fight, but it is attainable. (Participant 7)

Supporting the training of specialists needs to be given priority, and this will facilitate developing the professionals for the multidisciplinary team. Notably, opportunities are available for health professionals interested in palliative care:

The hospital gives something we call course bid, with a list of programs, specialties, and higher education programs . . .now it comes every three years, if you qualify, by virtue of how many years you have served, your educational and experience requirements, or if the hospital needs it, they will shortlist you and make you go and study. (Participant 8)

A participant mentioned that

The leaders think about palliative care services. So, when the people who are undergoing training. . . finish then there will be a full complement of at least the core people needed in the Palliative care unit.

#### *Utilization of a focal person*

Almost all of the participants raised concerns about how the identification and utilization of a focal person would significantly facilitate efforts to implement an institutional palliative care service in the hospital. According to healthcare professionals, the implementation of palliative care services is likely to be successful when it is spearheaded by doctors who express genuine interest in palliative care. They asserted that having a focal person with a strong medical background, particularly as a doctor, brings advantages due to their historical roles as heads of departments and health teams within the hospital. This assertion is evidenced in a quote from one of the participants:

Get doctors who are interested. When it comes from that side, then you are likely to succeed. But when you start from the point of view of a nurse, I'm sorry it won't reach anywhere. Your own nurses will say it won't work. What you need to do is write a paper, write the proposal, argue out, give it to a doctor, an influential doctor let him look like he is starting to be backed by nurses; it will work. (Participant 1)

Another participant shared similar views:

The most important thing is to get a focal person with rich knowledge about palliative care or someone knowledgeable and influential. It will be advantageous if the person is a seasoned doctor or specialist. A doctor because doctors have been heads of departments and health teams in this hospital. (Participant 4)

#### **Discussion**

This study aimed to qualitatively explore the institutional drivers for the integration of palliative care services in a military hospital setup. A major factor that emerged from the findings was the issue of having a paradigm shift in how palliative care is understood by healthcare providers. The result suggests that there are currently some misperceptions and knowledge deficits regarding palliative care, a result that is synonymous with a previous study conducted in Ghana<sup>26</sup> that identified misconceptions about palliative care as a significant barrier to the implementation of palliative care services. This is also consistent with Cromwell *et al.*<sup>29</sup> whose study identified a knowledge deficit as a barrier to implementing palliative care services in veteran health administration hospitals. The cognitive distortion associated with

palliative care affected the integration process by slowing down the mobilization of resources and the development of policies that facilitate the uptake of palliative care. The presumption of palliative care narrowly as end-of-life care affected the prioritization of this service. There is a need for healthcare professionals to gain an understanding of palliative care in the broader scope of care that improves the quality of life of individuals and families facing life-threatening illnesses. This includes early identification precursors, prompt intervention throughout the illness trajectory, and bereavement care that cannot be overemphasized. Consequently, this impedes health practitioners' willingness and readiness to support the implementation of institutional palliative care.

Space, equipment, and adequate medications are essential to palliative care integration. Consistent with extant literature,<sup>30-32</sup> we identified concerns about the availability and affordability of medications as another driver of implementing institutional palliative care. A key aspect of palliative care is pain management, and this requires medications such as opioids.<sup>33</sup> This implies that any shortages in the supply of these medications would undermine the capacity of healthcare providers to deliver palliative care services. Similarly, high costs may hinder access to essential medications, potentially compromising the quality of palliative care delivered. Furthermore, the hesitancy of health professionals to prescribe certain opioids was found to be a hindrance to palliative care implementation. This agrees with reports from earlier studies within and outside Africa. It is expected that with better training and education, this can be changed. The poor quality of palliative care would also be a disincentive for leaders in the hospital to buy into the idea of investing in the necessary supportive infrastructure.

The study identified staffing as another important driver that influences the implementation of institutional palliative care. There are a few healthcare professionals with expertise in palliative care. This is similar to Norton *et al.*'s.<sup>25,34,35</sup> study that revealed that staffing was a major challenge to forming a palliative care team in nursing homes due to high levels of turnover and attrition. This particular result is expected as the level of staff strength directly correlates with the capacity of an institution to deliver comprehensive palliative care services. A robust workforce ensures that the necessary personnel, including

medical professionals, nurses, social workers, and other support staff, are available to meet the diverse needs of patients requiring palliative care.<sup>36</sup> In contrast, inadequate staffing levels can strain resources and hinder the implementation process.<sup>26</sup> The staffing levels are also linked to the skills set for service delivery.<sup>37</sup>

Palliative care service must be included in the policies and priorities of hospitals to attract the requisite investment. One strategy relevant to this process is identifying and leveraging palliative care champions or focal persons in the implementation processes. They will act as change agents and be the pivot for directing policies, programs, and interventions to facilitate palliative care service integration. We found that the implementation of institutional palliative care is most likely to be possible when such focal persons are identified early in the process so that they will help to garner support, overcome resistance, and bridge communication gaps among various stakeholders. This finding is corroborated by Kamal *et al.*<sup>38</sup> who argue that palliative care champions are necessary in situations where specialty care is not available. Sommerbakk *et al.*<sup>22</sup> have also argued that the existence of local champions can streamline the process of implementing quality improvements in palliative care. These champions are often individuals who possess not only a deep understanding of palliative care but also strong leadership and communication skills. By involving them early, the implementation process can benefit from their influence in shaping positive attitudes, dispelling misconceptions, and fostering a culture that embraces the principles of palliative care.

### Limitations

A strength of this study lies in its methodological rigor. We ensured that member checking was done for all our participants. Thus, allowing us to validate the findings from the study. Also, by targeting people in leadership at the hospital, the findings reflect the perspective of persons who are at the helm of affairs and can easily influence change. This notwithstanding is also a limitation as the findings do not represent patients and other healthcare professionals who are not in leadership positions at the hospital. The findings are peculiar to military hospitals but transferable to similar institutions intending to integrate palliative care services. Future studies could delve into the patient and family characteristics

driving palliative care integration. We further recommend the evaluation of health institutions that have achieved effective service integration to highlight the drivers of integration. Additionally, future studies could expand the scope of study to multiple settings and employ quantitative approaches to measure drivers and predictors of palliative care integration.

## Conclusion

This study highlighted the institutional drivers of integrating palliative care in military health setting of a sub-Saharan African country. It was observed that there is a need for a paradigm shift in the mindset of healthcare professionals and administrators in recognizing the relevance of instituting palliative care services. This calls for targeted educational interventions and awareness campaigns to dispel misconceptions and foster a more empathetic understanding of palliative care as an integral component of holistic patient care and not just at end of life. This would then create the opportunity for prioritizing palliative care service and investing infrastructure and logistics including essential medicines while minimizing bureaucratic processes. Additionally, health facilities should designate and empower focal persons to champion palliative care initiatives within their settings, while investing in staff training and development of strategic policies for effective and efficient palliative care service delivery.

## Declarations

### *Ethics approval and consent to participate*

Ethics approval was obtained from the 37 Military Hospital institutional review board (IRB) (37MH-IRB/FLP/IPN/608/2022). Both written and verbal informed consent was obtained from study participants after they had read and demonstrated an understanding of their rights and responsibilities as participants. Participants were informed that their involvement in the study was strictly voluntary. They were also assured of confidentiality and the right to exit the interview at any time. To protect the identities of the participants, the data were anonymized by using descriptors such as 'Participant 1, Participant 2, etc.' instead of the real identities.

### *Consent for publication*

Not applicable.

### *Author contributions*

**Samuel Asamoah Boateng:** Conceptualization; Data curation; Formal analysis; Investigation; Methodology; Project administration; Resources; Supervision; Validation; Writing – original draft; Writing – review & editing.

**Joshua Okyere:** Data curation; Formal analysis; Investigation; Methodology; Software; Writing – original draft; Writing – review & editing.

**Priscilla Y. A. Attafuah:** Data curation; Methodology; Supervision; Validation; Writing – review & editing.

**Gladys Dzansi:** Conceptualization; Data curation; Formal analysis; Methodology; Project administration; Resources; Supervision; Validation; Writing – original draft; Writing – review & editing.

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### *Competing interests*

The authors declare that there is no conflict of interest.

### *Availability of data and materials*

Due to ethical reasons, the data are not accessible to the public. However, this can be obtained upon request from the first author.

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### **Supplemental material**

Supplemental material for this article is available online.

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## Appendix

### Abbreviations

- LMICs low-and-middle-income countries  
 MOH Ministry of Health  
 NCDs non-communicable diseases

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