

# 'There is no such word as palliative care for us at the moment': A mixed-method study exploring the perceptions of healthcare professionals on the need for palliative care in Bhutan

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## Abstract

**Background:** The need for palliative care is ever-increasing globally. However, it is least developed or not available in most low-and-middle-income-countries including Bhutan.

**Objective:** This study was aimed at exploring the perspectives of Bhutanese healthcare professionals on the need for palliative care in the country.

**Design:** This is a cross-sectional, mixed-method study.

**Setting/subjects:** The study sites included all levels of healthcare in Bhutan and involved doctors, nurses, physiotherapists, pharmacists, health assistants and *Drungtshos* (traditional physicians). Data were collected through surveys, focus group discussions and in-depth interviews.

**Results:** While the majority of the participants were directly involved in taking care of terminally ill and dying patients, only 14% had received some form of palliative care training for a duration ranging from 1 day to 6 weeks. Ninety-five percent of the participants reported that they faced challenges related to lack of palliative care knowledge and skills; limited resources including analgesics; shortage of doctors and nurses and lack of a palliative care team; issues with low illiteracy and financial challenges among patients; and policies and other systemic issues. The qualitative data generated four major themes: past adverse experiences; unique and complex needs for palliative care; challenges faced while caring for terminally ill and dying patients; and the urgent need for palliative care in Bhutan.

**Conclusion:** Bhutanese healthcare professionals had very limited exposure to palliative care. This study identified a crucial need for palliative care and informs the development of an appropriate palliative care model for Bhutan.

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## Plain language summary

### 'There is no such word as palliative care for us at the moment': A study exploring the perceptions of healthcare professionals on the need for palliative care in Bhutan

Palliative care is least developed in most low-and-middle-income-countries. This study was aimed at exploring the perspectives of healthcare professionals on the need for palliative care in Bhutan. Utilising both quantitative and qualitative approaches, the study sites included all levels of healthcare in Bhutan and involved doctors, nurses, physiotherapists, pharmacists, health assistants and *Drungtshos* (traditional physicians). Data were collected through surveys, focus group discussions and in-depth interviews. While the majority of the participants were directly involved in taking care of terminally ill and dying patients, only 14% had received some form of palliative care training for a duration ranging from one day to six weeks. Ninety five percent of the participants

reported that they faced challenges related to lack of palliative care knowledge and skills; limited resources including analgesics; shortage of doctors and nurses and lack of a palliative care team; issues with low illiteracy and financial challenges among patients; and policies and other systemic issues. The qualitative data generated four major themes: past adverse experiences; unique and complex needs for palliative care; challenges faced while caring for terminally ill and dying patients; and the urgent need for palliative care in Bhutan. Bhutanese healthcare professionals had very limited exposure to palliative care. This study identified a crucial need for palliative care and informs the development of an appropriate palliative care model for Bhutan.

**Keywords:** Bhutan, healthcare professionals, mixed-method study, needs, palliative care

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### Introduction

The need for palliative care (PC) is ever-increasing worldwide.<sup>1</sup> By 2025, it is estimated that there will be 1200 million people above 60 years of age with an associated increase in chronic diseases.<sup>2</sup> Although identified as a fundamental human right,<sup>3</sup> PC has not received the required attention, particularly in low- and middle-income countries (LMICs).<sup>4</sup> Almost 80% of global PC needs are in the LMICs, where it is either non-existent or minimally developed.<sup>5</sup> In 2014, the World Health Assembly declared that PC must be integrated into national health systems and that it is the ethical responsibility of all healthcare providers.<sup>6</sup> The World Health Organization has recommended four important public health strategies for PC: policies; essential medicines (including opioids); education, training and awareness; and implementation and integration of these strategies according to the socio-cultural and spiritual context of every country.<sup>7</sup>

Bhutan, a tiny kingdom in Southeast Asia, has a population of 786,374 (2022).<sup>8</sup> Bhutan is known to the world for Gross National Happiness – a concept where the country's development is not restricted to economic progress only but to holistic well-being of its people.<sup>9</sup> Healthcare is delivered through a three-tiered system where Primary Health Centres (PHCs) function at the primary level, district and community hospitals at the secondary level, and the regional and national referral hospitals at tertiary levels.<sup>10</sup> Traditional medicine is integrated with the national health system.<sup>10</sup>

As the country developed, life expectancy of Bhutanese people more than doubled from 35 years in 1960s to 72 in 2021.<sup>11</sup> However, like in many

LMICs, Bhutan is challenged by the double burden of diseases. While HIV/AIDS, dengue fever and multidrug-resistant tuberculosis (MDR-TB) continue to exist, non-communicable diseases such as cancer, organ failure, dementia and motor neuron disease are increasing every year.<sup>12</sup>

Despite tremendous progress in healthcare in the last six decades, PC remains at a nascent stage in Bhutan. Besides a limited home PC service established in 2018 at the Jigme Dorji Wangchuck National Referral Hospital (JDWRH), there is no other PC service in place. However, the Bhutan cancer control strategy (2019–2025) has recognized PC as an essential need.<sup>13</sup> Laabar and team in 2019 have explored the need for PC among Bhutanese patients diagnosed with advanced illness and the support needs of their family members.<sup>14,15</sup> In 2020, a PC service package to integrate traditional medicine with PC was launched by the Ministry of Health.<sup>16</sup> While PC was not included in the national health policy (2015),<sup>17</sup> it is now added in the current revision.

This study aimed to explore the need for PC in Bhutan from the healthcare professionals perspectives. Along with other simultaneous studies of patients with life-limiting illnesses and their families,<sup>14,15</sup> it is a component of a larger research programme aimed at developing a suitable PC model in the country.

### Methods

#### *Study design and setting*

This cross-sectional, mixed-method study involved integration of both quantitative and

qualitative data in a single study providing a firm foundation for drawing inferences.<sup>18,19</sup> Data collection, involving a survey, focus group discussions (FGDs) and in-depth interviews, was done between May and August 2019. The study was conducted at 12 sites and included the JDWNRH, the two regional referral hospitals, four district hospitals, two community hospitals, the traditional hospital and two PHCs spread across the country. The reporting of this study conforms to the Consolidated criteria for reporting qualitative research (COREQ) statement (Supplemental File).<sup>20</sup>

### *Study population and sampling*

Healthcare professionals (HCPs) were approached and explained about the research on the need for PC in Bhutan. Participants were included if they were either a doctor, nurse, physiotherapist, pharmacist, health assistant or a *Drungtsho* (traditional physician) practicing in the identified study sites. *Drungtshos* often play a critical role in alleviating severe health-related suffering by providing healing therapies, including massage, hot compression, herbal baths, acupuncture, yoga and meditation.<sup>16</sup> A participant information form was handed to those who were interested and were followed up the next day. Of 137 HCPs who expressed an interest, 118 completed the survey. Using purposeful sampling, interested survey participants were enrolled for FGDs and in-depth interviews. At least one of each of the above categories of HCPs from the 12 study sites was included in the FGDs. Altogether 63 HCPs participated in the FGDs. At two sites there was only one eligible participant with whom in-depth interviews were conducted.

### *Data collection tools*

For the quantitative survey, a structured questionnaire (Supplemental Appendix 1) was developed which included questions about participants' sociodemographic characteristics, information on PC training, involvement in caring for terminally ill and dying patients, and the challenges they faced while caring for those patients.

For FGDs and in-depth interviews, a semi-structured guide (Supplemental Appendix 2) was used to understand participants' views about the need for PC in Bhutan. The interview guide was developed by the principal author (TDL) based on her experiences as a clinical nurse in some of the

study sites and on her review of the literature on PC delivery in LMICs.<sup>21</sup> The guide was reviewed by authors CJ, KA and CS. Discussions and interviews were conducted by TDL, a lecturer at the medical university in Bhutan, who had past experiences conducting qualitative interviews.

### *Data collection*

Field notes were maintained to record experiences and challenges faced during data collection. Although not every HCP understood exactly what PC is, when informed, most eligible participants approached were interested. Participants were requested to return the survey, either to the nurse in-charge, the chief medical officer, or to the researcher, within 3 days. Interviews and FGDs were conducted after completing the survey.

Each FGD and interview was audio recorded with prior consent from the participants. Most of the discussions were in English as it is the medium of educational instruction in Bhutan. *Dzongkha*, the national language, and other local dialects were occasionally used and TDL, fluent in these dialects, translated to English during transcription. Achieving data saturation was not considered because immediate data transcription and analysis was not possible as TDL was simultaneously collecting data (quantitative and qualitative) among patients and their families as part of the broader research programme.

### *Data analysis*

The quantitative data were analysed using Statistical Analysis System (SAS) software, version 9.4,<sup>22</sup> where descriptive statistics (frequency, percentage, means and standard deviation) were calculated. The responses to the open-ended questions in the survey regarding the challenges faced were coded and the frequencies were reported. For the qualitative data, TDL listened to each recording several times before transcribing it verbatim. For those in local languages, a careful translation was done before transcribing in English. When required, TDL sought assistance from her Bhutanese academic colleagues to ensure accurate translation. Each transcript was read several times to familiarize with the data. The initial codes were identified using a qualitative data analysis software package, NVivo version 12. Thematic analysis was undertaken using the steps described by Braun and Clarke.<sup>23</sup> The

transcripts were read by all the co-authors who discussed and reached consensus on the themes.

## Results

### Quantitative results

Out of 137 HCPs who took the survey, 118 (86%) were included for analysis. Eight participants did not return the questionnaire and 11 were excluded because >50% of information was missing. The age of participants ranged from 23 to 62 years (mean 33.6, SD 7.6). The sociodemographic characteristics of participants are presented in Table 1.

### Training in PC and involvement in patient care

Out of 118 participants, only 17 (14%) had received some form of PC training for a duration ranging from 1 day to 6 weeks. Twelve (71%) of them had attended one or two workshops in Bhutan, two had travelled to Kerala in India for the 6-week training and three participants were introduced to PC during their medical residency programme in other Asian countries. Most participants ( $n=103$ ; 87%) were directly involved in taking care of patients with advanced illnesses including cancer, organ failure, dementia and MDR-TB, and 95 (81%) were involved in caring for dying patients.

### Challenges encountered by participants in caring for terminally ill patients

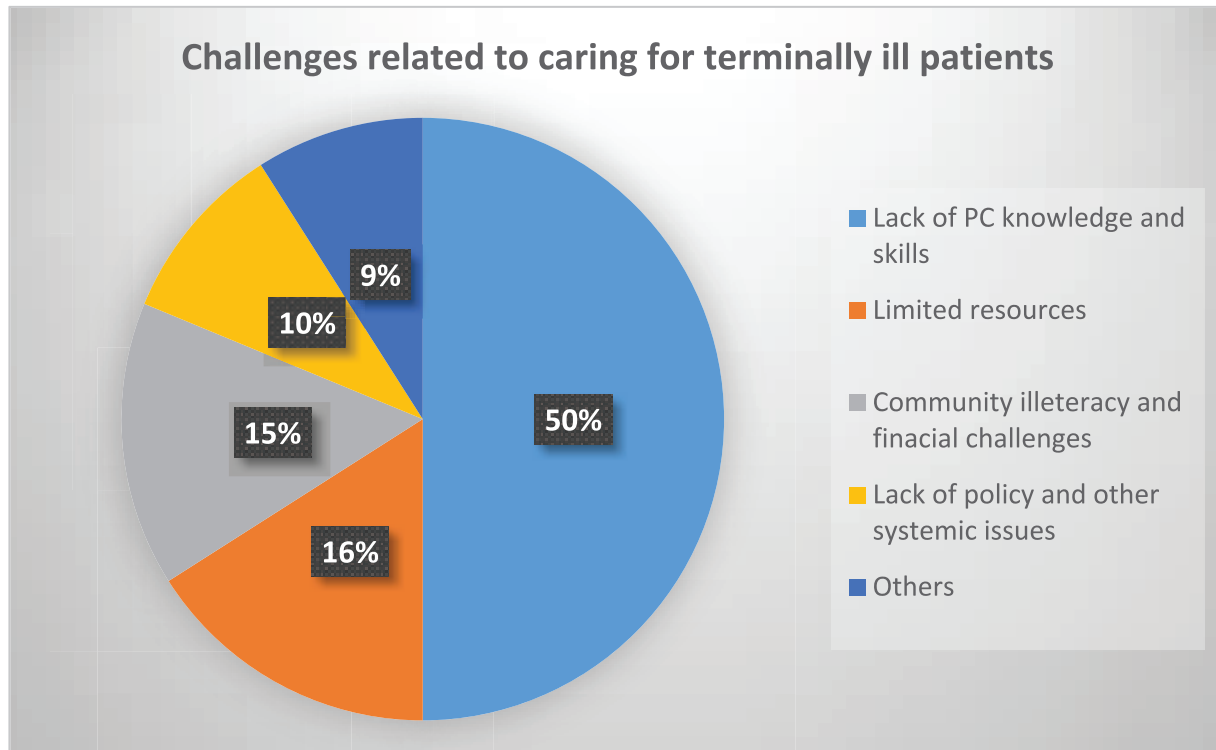
Most participants ( $n=115$ ; 97%) reported open comments related to the challenges they faced caring for terminally ill and dying patients. While the majority related their challenges to lack of knowledge and skills in PC leading to inadequate pain relief, poor communication and not being able to provide holistic care; others reported on limited resources including inadequate analgesics, shortage of doctors and nurses and lack of PC team; patients' concerns such as illiteracy and financial challenges; lack of supportive policies and other systemic issues (Figure 1).

### Qualitative data analysis

Sixty-three of the survey participants took part in the FGDs and in-depth interviews. Eleven FGDs and two in-depth interviews were conducted, one at each study site. In Thimphu, the capital city, three separate FGDs were conducted – one with

**Table 1.** Sociodemographic characteristics of healthcare workers.

Healthcare workers (n = 118)		
	N	%
Gender		
Male	75	63.6
Female	43	36.4
Occupation		
Nurse	61	51.7
Doctor	27	22.9
Drungtsho*	9	7.6
Pharmacist	8	6.8
Physiotherapist	8	6.8
Health assistant	5	4.2
Qualification		
Certificate	10	8.5
Diploma	40	33.9
Bachelor's degree	47	39.8
Masters and above	21	17.8
Specialty		
General	49	41.5
Pharmacy	8	6.8
Physiotherapy	8	6.8
Intensive care unit	7	6.0
Gynaecology/Obstetrics	4	3.4
Surgery	3	2.6
Medicine	1	0.9
Community	4	3.4
Traditional medicine	8	6.8
Others	26	22.2
Years in service		
0–5 years	58	49.2
6–10 years	22	18.6
11–15 years	15	12.7
16–20 years	14	11.9
>20 years	9	7.6
*Traditional physician.		



**Figure 1.** Challenges faced in caring for terminally ill patients.

the Home PC group, one among other HCPs at the JDWNRH and one with *Drungtshos* at the traditional hospital. In-depth interviews were conducted in one of the community hospitals and a PHC.

Four major themes were generated from the analysis: (1) past adverse experiences; (2) unique and complex needs for PC; (3) challenges faced while caring for terminally ill and dying patients and (4) the urgent need for PC in Bhutan.

### *Theme 1: Past adverse experiences*

Participants had varied adverse patient care experiences. Some reminisced that most of their patients who have died did not receive adequate care.

I have come across so many cases [with advanced illness] but the service or whatever the patient required or deserved was absolutely not enough. (Specialist 30)

I feel that those people who have died so far really suffered with pain. We were not able to manage pain appropriately and adequately, you know. (Doctor 39)

Given that many of the participants were not aware of PC, they found it confronting to witness patients suffering at the end of life.

She [patient] was in such a pathetic condition (with complex problems) that even for us to witness her situation was very difficult. I felt like it is better not to be born than to suffer like that. (Health Assistant 58)

Participants discussed how they struggled to manage patients' symptoms adequately.

I have quite a number of experiences seeing patients with advance cancer but, to be frank, with very limited knowledge apart from managing pain but that was also very difficult. (Specialist 30)

Some participants realised that at times they caused more distress to their critically ill patients.

I once had a breast cancer patient. Her cancer had involved her lungs and she was oxygen dependent and one time I had a quarrel with her because she was consuming one cylinder of oxygen every day and we were running out of oxygen stock. So, I told her that she has to go to Thimphu

[JDWNRH] [Laughs. . .] and patient felt very bad. (Specialist 31)

### *Theme 2: Unique and complex needs for PC*

Participants discussed that PC needs could be unique to each patient and their family and that care should be provided accordingly.

Different patients have different needs. . . some need financial support, some have social issues like they don't have children and they don't have anyone to look after them and some have severe pain. (Doctor 37)

The needs for PC patients are different from the needs for other patients but in Bhutan we do not have separate PC units. So, everyone is kept together, all mixed, and we [often] miss those who need priority care. (Nurse 35)

While some participants identified adequate physical symptom management as one of the main needs of patients with advanced illness, others emphasized that listening to the patients and attending to their basic needs were essential.

The main needs are psychological support and proper symptom control. There should be someone who can control the symptoms without fear and repercussion. (Specialist 13)

The biggest needs are addressing those basic needs – their personal hygiene, their elimination needs, nutritional needs, position changing and so on. First thing we have to address is how we can take care of those basic things [needs]. (Specialist 30).

One participant reported that patients on dialysis, particularly those living in the patient guesthouse, had poor quality of life and realized that PC could help them.

Most of them are not able to avail kidney transplant and I think this is one reason why they are frustrated. They are often moody, sad and they often throw temper tantrums to the nurses. I think they feel that nothing much can be done here after all. May be PC might help these patients. (Nurse 36)

Participants discussed that most patients and their families needed comprehensive

information to understand their illness and its prognosis.

Patients and families do not have adequate knowledge or information about the disease process, why the disease is not treatable or curable. (Specialist 30)

For an innocent villager (who has never been to school) he/she will not even know what cancer actually is. So, it is very important to help them understand. (Drungtsho 99)

Some participants were caring for terminally ill and dying patients for many years and the discussion highlighted the vital need for psychological, social and spiritual support.

That patient, who was admitted here (at the PHC), had so much of mental issues because she wanted to go home but could not go on her own. . . .she was not happy because her children from her first husband did not come to see her. (Health Assistant 58)

Patients become psychologically better once they get social and financial support. (Doctor 23)

Patients with advanced illness need lot of support. One thing we forget is their spiritual needs which is more important. Most of our patients are very religious. Spiritual support in the home-based settings and in our facilities, when they are admitted, is very important. (Doctor 55)

Some participants also discussed the need to support family members and caregivers for the complex issues they face when caring for their loved ones over an extended period.

We always treat the patients but we forget to treat the caregiver who is already so much stressed and traumatized. They have to do everything to take care of the patient and in the wards, they don't [even] have a proper place to rest. The other is follow-up which is the most difficult thing in our country. One reason is due to financial constraints, other is because of the geography, then the monsoon season where there are rampant roadblocks. (Specialist 12)

The needs of the family members depend on their socio-economic background. If you have families with low socio-economic status and who do not have [much] knowledge, their needs are complex. (Specialist 30).

### *Theme 3: Challenges faced while caring for terminally ill and dying patients*

Participants elaborated on numerous challenges faced while caring for critically ill and dying patients. Lack of staff and time available for such patients was one of them.

We do not have enough nursing staff to give adequate care to those kind of patients [requiring PC]. (Specialist 30)

The participants acknowledged their lack of skills in communication, complex end-of-life decision-making and symptom control.

For me personally breaking bad news is very challenging. (General Doctor 55)

One aspect of palliation is in the ICU, in a patient who is already brain dead . . . , the issue we face is when to withdraw the ventilator. The challenge is we do not feel confident to withdraw and stop the breathing. (Specialist 34)

Our knowledge in pain management is very limited. (Specialist 116)

While some participants expressed that because their practice was hospital-based they were unable to reach patients in their homes.

We cannot make home visits because our policies does not support. It could be because of the financial implication. (Doctor 111)

Other participants gave examples of how patients' circumstances also resulted in challenges to delivery of care at home.

We can manage [their] pain and other symptoms but there are so many obstacles for them to die at home. The house owners (for patients who live in rented apartment) do not allow deaths to happen in their house. So, most of our palliative patients are admitted in the hospital only to die. (Home PC Group Member 61)

Some discussed the difficulty in helping patients and families understand the seriousness and the incurable nature of the illness.

To make everyone [in the family] understand is very difficult because one thing is they are uneducated and so do not understand about the nature of the illness. (Health Assistant 45)

Home PC members reported challenges in caring for patients who did not know about their diagnosis.

Most of the time the family members want us to conceal the truth [about the diagnosis]. In such cases we face difficulties to manage at home because when patients do not know the diagnosis their expectation is different. Whereas, patients who know their diagnosis can make decisions and we can ask them to express their wishes. There are many wishes after medical treatment is no more useful – like spiritual wishes. That way patients are more at peace and some patients even go back to their village. (Home PC Group member 75)

### *Theme 4: The urgent need for PC in Bhutan*

Many participants stated that currently the phrase 'palliative care' does not exist in Bhutanese clinical practice but acknowledged the need for help in providing care to dying patients.

There is no such word as 'palliative care' for us at the moment. (Doctor 55)

Since we are seeing an increasing number of chronic illnesses, I think PC is very important. This is one area where patients are receiving sub-optimal care. (Doctor 37)

The Home PC group, on the other hand, recounted the benefits of PC.

Palliative care is very important. Even if there is no cure, if we control [their] pain and other symptoms, then even for few days patients can live happily. There is quality of life and patients are so much thankful. (Home PC Group member 72)

When I visited patients at home for the first time, I wondered why resources were not used for this kind of service (in the past)? Patients were happy, families were happy, communities were happy. Even we are also satisfied. (Home PC team member 61)

Some participants also reported that PC could bring about health economic benefits besides comfort.

PC can really reduce bed occupancy rates in the hospital and it can even make patients and families comfortable. (Doctor 55)

Although the concept of PC was initially new to many participants, their understanding broadened during the discussion and some emphasized its integration into the national health system.

We have come a long way with primary health care, and we are now at a stage where we need to focus on PC. We have lot of chronic patients with cancer, COPD, MDR-TB. Basically, we want our patients to die without pain and with dignity. (Doctor 111)

Some participants highlighted the need for separate PC units, especially at the national referral hospital, or even a PC hospital.

For a centre like JDWNRH (the national referral hospital) we really need a hospice where we can properly take care of those terminally ill patients who need proper care. Not in a general ward setting where our staff, even the physician, will lose focus and, in a way, patient will be neglected. (Specialist 116)

### Discussion

In this mixed-method study, the HCPs in Bhutan have identified multiple areas of need for PC in the country. The survey reported lack of PC knowledge and skills, limited resources, illiterate communities and lack of suitable policies and other systemic issues as some of the barriers to HCPs currently caring for the dying patients. The interviews and FGDs which explored HCPs perceptions of the need for PC in Bhutan identified four themes – past adverse experiences, unique and complex PC needs, challenges in caring for terminally ill and dying patients and an urgent need for PC in Bhutan. These findings are consistent with the recent evidence from other LMICs where lack of adequate education and training among the HCPs and other resource limitations hindered adequate PC provision.<sup>24</sup>

The concept of ‘palliative care’ was initially new to many participants but the process of being involved in this research transformed many into strong supporters for timely implementation of such care into the national health system. In Africa, education and training – a vital component of public health PC approach,<sup>7</sup> has improved knowledge and skills, changed attitudes toward the care of very ill and dying patients and enabled better symptom management.<sup>25,26</sup> At the time of the study (2019), only a handful of Bhutanese doctors and nurses were trained in PC through

short courses. Today (5 years later), PC components are integrated into the nursing and community health curriculum at the Faculty of Nursing and Public Health and virtual and face-to-face in-service educational programmes are regularly organised for HCPs.

The participants in our study reported not being able to provide adequate pain relief to their patients who were often diagnosed at an advanced stage of illness. This is consistent with the concurrent study of patients by Laabar et al.,<sup>14</sup> where pain was one of the most distressing, unaddressed issues among patients with advanced illnesses. Pain, one of the most common and feared symptoms, can significantly influence the quality of life of both patients and their families.<sup>27</sup> Patients experiencing moderate to severe pain must be prescribed opioid analgesics.<sup>5</sup> While participants acknowledged their lack of knowledge and skills in pain management, they also identified lack of access to suitable analgesia as a major concern. In Bhutan, morphine is supplied, in limited stock, to the community hospitals, but not to community health centres.<sup>28</sup> Adequate availability of opioids, particularly morphine, is one factor that determines the country’s capability to provide adequate PC.<sup>29</sup> Access to opioids, especially morphine, is crucial in enabling adequate pain relief for patients with advanced illnesses in LMICs.<sup>5</sup>

HCPs in this study recognised the broad extent of PC needs among patients, which ranged from basic needs – personal hygiene, nutritional and elimination needs – to physical symptom control, psycho-social and spiritual needs, informational needs and the complex needs of family members. Our concurrent studies among Bhutanese patients and families found that financial issues were one of the main concerns.<sup>14,15</sup> In contrast, evidence from other LMICs report that PC needs also include reproductive health issues such as managing pregnancy and breastfeeding, preventing disease transmission, worry about medical bills, isolation, stigma and discrimination, respite support for families, essential services such as food, clean drinking water, sanitation, children’s school fees and cultural and spiritual support.<sup>30,31</sup>

This study found that low educational levels in the community were another complicating factor. Adult literacy in Bhutan is 66.6%.<sup>32</sup> The low level of education among patients, especially in the elderly and rural Bhutan, indicates a need for



HCPs to be skilled in communication and delivery of comprehensive information about the disease, treatment options and the expected trajectory in an empathic way.<sup>27</sup>

The participants in this study identified the challenge of providing adequate PC posed by patients' lack of knowledge of their diagnosis – usually because of their families' decision not to disclose. The PC team, however, reported that those who knew about their terminal diagnosis had better outcomes. In the concurrent studies by Laabar *et al.*, all patient participants wanted to know the truth about their diagnosis,<sup>14</sup> however, some family members feared that the truth will cause further distress and hopelessness.<sup>15</sup> Although disclosing the truth about diagnosis is believed to be driven by social, cultural and family norms,<sup>33</sup> even in culture-sensitive and family-connected societies,<sup>34</sup> patients preferred truthful disclosure about their terminal prognosis.<sup>35</sup>

The participants recognised that PC could benefit patients with chronic illnesses other than cancer patients. Laabar *et al.*,<sup>14</sup> found that 58% of the patients in their study had non-malignant conditions. Ideally, the delivery of PC is based on the needs of patients and families irrespective of diagnosis, geographical location or ability to pay.<sup>36</sup>

The participants in this study recognised that PC could reduce healthcare costs while improving the quality of life of patients and families. Effective PC services can avoid repeated, often unnecessary, visits to emergency departments at the end of life and further reduce long-term hospital admissions and referrals abroad.<sup>5–7</sup> The escalating healthcare costs is a recognised challenge to the Bhutanese government's efforts to provide universal health coverage.<sup>10</sup> Given the increasing trend of chronic disease and limited available curative options, development of PC in Bhutan is crucial.

Inadequate manpower and lack of PC policies were additional challenges reported by participants while caring for patients with advanced illness and those at end of life. Policy is an integral component of the public health approach to PC and it will determine other factors including education, drugs and manpower.<sup>2</sup> Several other LMICs with suitable PC policies have enabled adequate provision of PC services.<sup>37</sup> Currently in Bhutan, the cancer control strategy (2019–2025)

has emphasized the importance of integrating PC.<sup>13</sup> Recently, the Ministry of Health in Bhutan finalized the national PC guideline and the national health policy (currently under revision) includes PC – a mandate for universal health coverage.<sup>5</sup>

### Strengths and limitation

Data for this study were collected from all levels of healthcare ranging from the national referral hospital to the PHCs in the rural communities. Various categories of HCPs have participated. While some participants had never previously heard of PC, they were experts in understanding the challenges associated with providing good end-of-life care in Bhutan. Some healthcare facilities just had a lone eligible participant. However, we used a purposive sampling strategy to engage a diverse range of participants from 12 health services across Bhutan with an in-depth knowledge of the issues and concerns related to caring for people with life-limiting illnesses.

### Conclusion

This study aimed to explore the need for PC in Bhutan from the HCPs' perspective. HCPs reported past adverse experiences and challenges faced while caring for patients with terminal illnesses. While lack of PC knowledge and skills among the HCPs poses a significant barrier to providing PC in Bhutan, other systemic factors such as limited resources, community illiteracy and policy also led to inadequate provision of holistic care to patients with life-limiting illnesses and their families. These unique and complex experiences highlight the urgent need to develop PC in Bhutan. Findings from this study are expected to inform policymakers and other relevant stakeholders on the need for PC in Bhutan.

### Declarations

#### *Ethics approval and consent to participate*

Ethical approval was provided by the Human Research Ethics Committee at the University of Western Australia and the Research Ethics Board of Health in Bhutan with Reference numbers, RA/4/20/4990 and REBH/Approval/2018/097, respectively. Informed consent was taken from every participant in the form of signature.

*Consent for publication*

Not applicable.

*Author contributions*

**Tara Devi Laabar:** Conceptualization; Data curation; Formal analysis; Investigation; Methodology; Writing – original draft.

**Christobel Saunders:** Supervision; Writing – review & editing.

**Kirsten Auret:** Supervision; Writing – review & editing.

**Claire E. Johnson:** Supervision; Writing – review & editing.

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*Competing interests*

The authors declare that there is no conflict of interest.

*Availability of data and materials*

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy and ethical reasons.

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**Supplemental material**

Supplemental material for this article is available online.

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