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Original Article

Perceptions of Healthcare Providers about Palliative Care Need Among Patients Attending Ndera Neuropsychiatric Teaching Hospital, Rwanda

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Abstract

Background: Palliative care is designed to offer holistic assistance to individuals living with chronic or life-threatening conditions, with the goal of easing various forms of distress. The perspectives of healthcare professionals are pivotal in shaping and delivering appropriate palliative care, especially in mental health institutions.

Objectives: This research sought to explore how healthcare professionals perceive the need for palliative care among patients treated at Ndera Neuropsychiatric Teaching Hospital in Rwanda.

Methods: A cross-sectional quantitative study was implemented at Ndera Neuropsychiatric Teaching Hospital, involving 112 healthcare professionals, including doctors, nurses, and other allied personnel. Participants were chosen through a stratified random sampling technique across different professional roles. Data collection was accomplished using a structured, self-completed questionnaire. Statistical analysis was performed using SPSS version 25, with findings summarized through descriptive statistics and presented in tabular format.

Results: The study demonstrated a moderate to strong recognition of the necessity for palliative care (mean scores: 2.71–3.28), particularly for patients with dementia, amyotrophic lateral sclerosis, and serious psychiatric illnesses like major depression, bipolar disorder, and anxiety. While healthcare providers displayed moderately favorable attitudes toward integrating palliative care into practice (mean scores: 2.93–3.57), a notable misunderstanding between palliative and hospice care was evident, with 65% to 100% viewing hospice as a place of hopelessness. Moreover, several institutional limitations were identified, such as absent policy frameworks (reported by nearly all respondents), inadequate communication systems, limited material resources, and financial constraints. Statistically significant correlations were found between the perceived need for palliative care and both the age ($p = 0.001$) and work experience ($p = 0.001$) of respondents.

Conclusions: Findings reflect a widespread acknowledgement of the importance of palliative care within the neuropsychiatric context. However, major obstacles ranging from lack of institutional support and policy guidelines to resource shortages and misconceptions continue to hinder its effective integration. Addressing these barriers is critical to advancing quality palliative care for individuals with complex neuropsychiatric conditions.

Keywords: Palliative Care, Health Personnel, Mental Health Services, Hospitals, Psychiatric, Rwanda

Introduction

Neurological conditions are now the leading cause of ill health and disability globally, affecting over 3.4 billion people (≈ 43% of the world's population in 2021) and accounting for approximately 443 million DALYs—a greater burden than cardiovascular diseases (Brooks, 2024; Lancet Neurology via WHO, 2024). In addition, psychiatric disorders such as major depressive disorder are among the most disabling mental conditions worldwide, contributing tens of millions of DALYs annually (Global Burden of Disease Study, 2021; BrainFacts, 2014). These conditions often lead to significant cognitive, emotional, and functional impairments, and in many cases, result in premature death (World Health Organization [WHO], 2020). In Rwanda, Ndera Neuropsychiatric Teaching Hospital (NNPTH), the national referral center for mental health and neurological conditions, has reported a steady increase in the number of patients presenting with advanced-stage neurological and psychiatric disorders. According to hospital records, schizophrenia accounts for 21% of cases, followed by bipolar disorder (9%), depression (8%), Parkinson's disease (5%), and nerve root and plexus disorders (3%), while the remaining 43% includes other complex neurological conditions (NNPTH, 2024). Although these illnesses are chronic and often progressive, access to appropriate palliative care for patients with such conditions remains limited. Palliative care, as defined by WHO (2020), is an approach that improves the quality of life of patients and their families facing life-threatening illness by preventing and relieving suffering through early identification and comprehensive treatment of pain and other psychosocial, physical, and spiritual problems. In Rwanda, efforts to integrate palliative care into the health system have included the development of policies, training programs, and service delivery models at various levels of care (Ministry of Health [MoH], 2021). These national initiatives have aimed to equip healthcare providers with the knowledge and skills to deliver compassionate and holistic care. Despite these advancements, the implementation of palliative care in neuropsychiatric settings like NNPTH remains underdeveloped. The unique nature of suffering experienced by patients with mental and neurological disorders often requires specialized, interdisciplinary palliative approaches that are not yet fully established within existing health systems (Downar et al., 2019). Many of these patient's experience repeated hospital visits, persistent symptoms, and limited improvement in functional status, highlighting a gap in comprehensive support for psychosocial and existential suffering (Knaul et al., 2018). Research has shown that perceptions of healthcare providers are critical in shaping the scope and effectiveness of palliative care delivery (Quill & Abernethy, 2013). Studies in similar low- and middle-income settings suggest that a lack of knowledge, misconceptions about palliative care, and inadequate institutional support contribute to poor integration of palliative services into mental health care (Stjernswärd et al., 2007). Additionally, healthcare providers in Rwanda often face emotional and moral distress when managing patients with terminal conditions without sufficient resources or referral options for palliative care (Mukeshimana & Brysiewicz, 2018). At NNPTH, it has been observed that patients frequently return to the hospital seeking cure-oriented treatments, often investing significant personal resources with little clinical improvement. In the absence of structured palliative care services, this leads to avoidable suffering, loss of dignity, and emotional exhaustion among patients, families, and staff (Riley & Varner, 2020). These challenges point to the urgent need to assess the perceptions of frontline healthcare providers regarding the need for palliative care among their patients.

This study therefore seeks to ~~explore~~ assess the perspectives of healthcare professionals at NNPTH concerning the palliative care needs of patients with advanced neurological and psychiatric conditions. Understanding their experiences and viewpoints will help identify gaps in care, inform institutional policies, and contribute to the development of more responsive and humane healthcare services for this vulnerable population.

Methods

Research Design

This investigation utilized a quantitative cross-sectional design aimed at evaluating healthcare providers' perceptions concerning the need of palliative care for patients at Ndera Neuropsychiatric Teaching Hospital (NNPTH). The cross-sectional approach was selected because it permits data collection at one specific time, thus offering an immediate overview of current views on need for palliative care.

Study Population

The research targeted all healthcare workers available at NNPTH from December 15, 2024, to January 30, 2025. This encompassed clinical personnel across multiple units, including registered nurses and mental health nurses, medical doctors ranging from general practitioners to specialists, as well as allied health professionals such as psychologists, social workers, occupational therapists, and physiotherapists.

Inclusion and Exclusion Criteria

Eligible participants were registered healthcare professionals who had served at the hospital for at least one year and were actively engaged in daily care of patients with neurological or psychiatric disorders. Excluded from participation were those on leave or absent during the study period, healthcare providers with under one year of experience, and individuals whose roles were primarily administrative rather than clinical.

Sampling

Sampling refers to the process of selecting representative individuals from the entire population under study. Following recommendations by Kiani et al. (2021), factors such as population characteristics and statistical needs were carefully considered to ensure appropriate representation.

Sampling Technique

To capture a diverse range of perspectives, a stratified sampling method was adopted. This approach segmented healthcare providers into subgroups nurses, physicians, and allied health workers allowing proportional representation while minimizing potential biases.

Determination of Sample Size

The sample size was calculated using Cochran's formula (1977), which is effective for estimating adequate sample sizes for populations of known size. Using a 95% confidence level (Z=1.96), a proportion estimate (p=0.5) for maximum variance, and a margin of error of 5%, the initial sample size was 384. Adjusting for the finite population of 159 healthcare providers at NNPTH, the required sample size was approximately 112. Accounting for potential non-response, an additional 10% was added, bringing the final target sample to 125 participants. The finalized sample included 7 physicians, 91 nurses, and 14 allied health professionals, after excluding those involved in the pilot phase.

Data Collection Tools and Methods

The data collection instrument was an adapted questionnaire originally developed by Lalit Krishna and Jason Tay (2021), tailored with permission for the neuropsychiatric setting. Modifications included removing two patient condition categories (cancer and organ failure) and adding nine others (frequent in the context), as well as expanding the list of challenges faced by healthcare providers. The questionnaire was restructured to align with the study's objectives of capturing perceptions about need for palliative care at NNPTH. A pilot test with 13 participants (10% of the total sample) confirmed the tool's reliability with a Cronbach's alpha of 0.789. Completion time was approximately five minutes. Data were gathered using a self-administered online questionnaire via Google Forms, ensuring participant anonymity and confidentiality by omitting collection of identifiable information.

Data Collection Process

Prior to data collection, the questionnaire and consent form were created and reviewed by the supervisory team. Written informed consent was obtained from all participants after explaining the study purpose and procedures. The survey link was distributed via email and WhatsApp, with weekly reminders sent to encourage completion. Data were downloaded securely in CSV format, cleaned, and prepared for analysis.

Data Management

The collected data underwent systematic processing including error checking, removal of duplicates, and handling of missing values. Variables were coded and appropriately labeled before being imported into SPSS software for analysis.

Data Analysis

SPSS version 25 was used to analyze the data. Statistical significance was set at $p < 0.05$. The questionnaire responses were categorized into five main sections for analysis: demographic information (percentages), perceived need for palliative care (Likert scale mean, standard deviation, percentages), understanding of palliative care (Likert scale descriptive stats), attitudes toward integration of palliative care (descriptive analysis), and perceived barriers (frequency and percentage distributions).

Study Limitations

Challenges during data collection included healthcare providers' busy schedules in emergency and continuous care settings, which sometimes delayed questionnaire completion despite the flexibility offered by the online format. Follow-up visits helped improve response rates. Additionally, the questionnaire, though adapted and piloted, had not previously been used in neuropsychiatric environments. Vocabulary and phrasing were adjusted to fit the local context.

Ethical Considerations

Ethical clearance was granted by the University of Rwanda Institutional Review Board (reference CMHS/IRB/568/2024). Approval to conduct the study was also obtained from the NNPTH ethics committee.

Informed written consent was secured from all participants, who were assured of confidentiality, voluntary participation, and the freedom to withdraw at any time without any penalty or loss of benefits.

Results

Demographic Characteristics of Participants

Table 1 shows the demographic profile of the participants. The majority (57.1%) were aged 30 to 49 years, with more males (54.5%) than females (45.5%). Most were married (59.8%). Nurses constituted the largest professional group (81.2%), followed by allied health professionals (12.5%) and physicians (6.2%). Educationally, 58% held diplomas, 37.5% had bachelor's degrees, and 4.5% possessed master’s degrees or higher. Nearly half of the participants (42%) had between 1 and 5 years of work experience.

Table 1: **Demographic Characteristics of Participants (N = 112)**

Characteristic	Category	Frequency	Percentage (%)
Age	19–29 years	33	29.5
	30–49 years	64	57.1
	≥ 50 years	15	13.4
Gender	Male	61	54.5
	Female	51	45.5
Marital Status	Single	41	36.6
	Married	67	59.8
	Widow	1	0.9
	Religious	3	2.7
Profession	Nurses	91	81.2
	Allied Health	14	12.5
	Physicians	7	6.2
Educational Level	Diploma (A1)	65	58.0

	Bachelor (A0)	42	37.5
	Masters and above	5	4.5
Work Experience	1–5 years	47	42.0
	6–10 years	19	17.0
	11–15 years	25	22.3
	≥16 years	21	18.8

Perceived Need for Palliative Care

Table 2 displays how often healthcare providers engage in conversations about palliative care with terminally ill patients. Nurses and allied health professionals reported some instances of never initiating such discussions (13.2% and 7.1%, respectively), whereas physicians always engaged in these conversations at higher rates. A majority across professions reported often discussing palliative care.

Table 2: **Frequency of Conversations about Palliative Care with Terminally Ill Patients**

Frequency	Nurses (n=91)	Allied Health (n=14)	Physicians (n=7)
Never	12 (13.2%)	1 (7.1%)	0
Occasionally	31 (34.1%)	2 (14.3%)	2 (28.6%)
Often	39 (42.9%)	9 (64.3%)	4 (57.1%)
Always	9 (9.9%)	2 (14.3%)	1 (14.3%)

Regarding agreement with the statement "I have conversations about palliative care with terminally ill patients," physicians (85.7%) and allied health professionals (78.6%) expressed higher agreement compared to nurses (51.6%). Table 3 presents the perceived need for palliative care among various patient groups, rated on a Likert scale (1–4). Physicians consistently rated the need higher (means around 3.14) than allied health professionals (~3.07) and nurses (~2.80).

Table 3: **Perceived Need for Palliative Care Among Different Patient Groups (Mean Scores)**

Patient Group	Nurses Mean (SD)	Allied Health Mean (SD)	Physicians Mean (SD)
Alzheimer/Dementia	2.80 (0.42)	3.14 (0.36)	3.14 (0.38)
Parkinsonism	2.80 (0.42)	3.07 (0.26)	3.14 (0.38)
Amyotrophic Lateral Sclerosis (ALS)	2.79 (0.43)	3.14 (0.36)	3.28 (0.49)
Advanced Stroke	2.80 (0.42)	3.07 (0.26)	3.14 (0.38)
Neurodegenerative Diseases	2.80 (0.42)	3.07 (0.26)	3.14 (0.38)
Multiple Sclerosis	2.81 (0.44)	3.07 (0.26)	3.14 (0.38)
Neurodevelopmental & Neurogenetic Disorders	2.80 (0.42)	3.07 (0.26)	3.28 (0.49)
Severe Bipolar Disorders	2.80 (0.42)	3.07 (0.26)	3.14 (0.38)
Functional Impairment (Depression & Anxiety)	2.80 (0.42)	3.07 (0.26)	3.28 (0.49)
Elderly Patients	2.81 (0.44)	3.14 (0.36)	3.28 (0.49)
Severe and Persistent Mental Illness	3.01 (0.40)	2.92 (0.26)	2.71 (0.49)

4.3 Knowledge and Clinical Exposure

Table 4 shows that most healthcare providers learned about palliative care primarily in their formal education, with a smaller proportion gaining knowledge during hospital practice. The majority identified hospice as a facility for symptom relief and quality of life improvement. However, some participants also viewed hospice as “a place where all hope is lost,” reflecting potential misconceptions.

Table 4: **Sources of Palliative Care Knowledge and Perceptions about Hospice**

Variable	Nurses (n=91)	Allied Health (n=14)	Physicians (n=7)

Learned about palliative care at school	78 (85.7%)	8 (57.1%)	5 (71.4%)
Learned about palliative care at hospital	13 (14.3%)	6 (42.9%)	2 (28.6%)
Hospice as place for symptom palliation and quality of life	79 (86.8%)	14 (100%)	7 (100%)
Hospice as place for pain medication control	89 (97.8%)	14 (100%)	7 (100%)
Hospice as place for elderly patients	26 (28.6%)	2 (14.3%)	1 (14.3%)
Hospice as place where all hope is lost	65 (71.4%)	14 (100%)	7 (100%)
Hospice as place for cancer patients	82 (90.1%)	14 (100%)	7 (100%)

Table 5 reports healthcare providers' understanding of palliative care terminology and their confidence explaining it. Physicians showed the highest confidence levels, while nurses and allied health professionals had moderate confidence.

Table 5: **Understanding and Confidence in Palliative Care (Mean Scores)**

Item	Nurses Mean (SD)	Allied Health Mean (SD)	Physicians Mean (SD)
Confusion about palliative care terminology	3.08 (0.46)	3.14 (0.66)	3.14 (0.70)
Confidence explaining palliative care role	2.60 (0.60)	3.07 (0.26)	3.28 (0.48)

Attitudes Toward Palliative Care

Table 6 displays the perceived importance of palliative care and referral patterns. Physicians rated palliative care as very important in managing neuropsychiatric disorders, with nurses and allied health professionals rating it slightly lower. All groups emphasized the significance of symptom control, psychological and spiritual support, and discharge planning in referrals. There was strong agreement across all professions that palliative care is underutilized, that nurses should be more involved in end-of-life care discussions, and that additional palliative care training is necessary.

Table 6
Attitudes Toward Palliative Care and Referral Patterns (Mean Scores)

Item	Nurses Mean (SD)	Allied Health Mean (SD)	Physicians Mean (SD)
Importance of palliative care in neuropsychiatric management	2.98 (0.83)	2.92 (0.48)	3.57 (0.54)
Physical symptom control as referral factor	3.00 (0.55)	3.21 (0.42)	3.57 (0.53)
Psychological/emotional support as referral factor	2.81 (0.70)	3.35 (0.50)	3.57 (0.53)
Spiritual support as referral factor	2.78 (0.70)	3.35 (0.50)	3.57 (0.53)
Referral during discharge planning	3.01 (0.62)	3.28 (0.61)	3.43 (0.78)
Agreement: palliative care services underutilized	3.34 (0.76)	3.71 (0.47)	3.57 (0.78)
Nurses should be more involved in end-of-life care conversations	3.35 (0.64)	3.43 (0.75)	3.57 (0.53)
More palliative care training needed	3.56 (0.50)	3.85 (0.36)	3.57 (0.53)
Public knowledge about palliative care is insufficient	2.80 (0.80)	2.85 (0.95)	2.42 (0.78)

Table 7 summarizes healthcare providers' views on critical times for palliative care referral. Physicians and allied health professionals largely agreed on all critical time points (around 79–86%), while nurses showed slightly lower agreement rates (~49–52%).

Table 7: **Perceptions of Critical Timing for Palliative Care Referral**

Timing for Referral	Nurses Yes (%)	Allied Health Yes (%)	Physicians Yes (%)
At diagnosis of life-limiting illness	45 (49.5%)	11 (78.6%)	6 (85.7%)

When symptoms worsen or condition deteriorates	47 (51.6%)	11 (78.6%)	6 (85.7%)
When illness becomes clearly terminal	46 (50.5%)	11 (78.6%)	6 (85.7%)
When patient or family is emotionally distressed	46 (50.5%)	11 (78.6%)	6 (85.7%)

Perceived Challenges to Palliative Care Provision

Table 8 details barriers perceived by healthcare providers. The majority actively initiated conversations with patients and families. However, awareness of existing palliative care services within the hospital was low (14–22%). The main challenges identified included unclear palliative care definitions, difficulty predicting disease progression, patient fears, financial constraints, lack of institutional policies, inadequate infrastructure, and insufficient trained staff. These challenges were nearly universally reported by physicians.

Table 8

Perceived Challenges in Providing Palliative Care

Challenge	Nurses Yes (%)	Allied Health Yes (%)	Physicians Yes (%)
Initiate conversation with patient/family	77 (84.6%)	11 (78.6%)	6 (85.7%)
Refer to teammate	12 (13.2%)	2 (14.3%)	1 (14.3%)
Do not introduce palliative care	2 (2.2%)	0	0
Delegate others to speak	0	1 (7.1%)	0
Aware of palliative care services in hospital	20 (22.0%)	3 (21.4%)	1 (14.3%)
Lack clarity about palliative care	90 (98.9%)	14 (100%)	7 (100%)
Difficulty predicting disease progression	87 (95.6%)	14 (100%)	7 (100%)
Patients' fear of abandonment	89 (97.8%)	14 (100%)	7 (100%)
Financial concerns	89 (97.8%)	13 (92.9%)	7 (100%)

Lack of institutional policies	89 (97.8%)	14 (100%)	7 (100%)
Lack of infrastructure or equipment	90 (98.9%)	13 (92.9%)	7 (100%)
Lack of trained staff	89 (97.8%)	14 (100%)	7 (100%)

Relationship Between Demographics and Perceived Palliative Care Need

Table 9 explores the relationship between demographic variables and perceived need for palliative care. Most participants perceived a moderate to high need for palliative care services. Statistically significant associations were found for age ($p < .001$) and work experience ($p < .001$), indicating that older and more experienced healthcare providers tended to perceive a greater need. No significant differences were observed for gender, marital status, profession, or educational level.

Association Between Demographics and Perceived Need for Palliative Care

Variable	Category	Low Need n (%)	Moderate Need n (%)	High Need n (%)	p-value
Age	≥ 50 years	0 (0.0%)	1 (6.7%)	14 (93.3%)	.001
	30–49 years	1 (1.6%)	34 (53.1%)	29 (45.3%)	
	19–29 years	2 (6.1%)	26 (78.8%)	5 (15.2%)	
Gender	Female	2 (3.9%)	27 (52.9%)	22 (43.1%)	.82
	Male	1 (1.6%)	34 (55.7%)	26 (42.6%)	
Marital Status	Religious	0 (0.0%)	1 (33.3%)	2 (66.7%)	.07
	Widow	0 (0.0%)	0 (0.0%)	1 (100%)	
	Married	3 (4.5%)	31 (46.3%)	33 (49.3%)	
	Single	0 (0.0%)	29 (70.7%)	12 (29.3%)	
Profession	Physicians	0 (0.0%)	3 (42.9%)	4 (57.1%)	.66
	Allied Health	0 (0.0%)	6 (42.9%)	8 (57.1%)	
	Nurses	3 (3.3%)	52 (57.1%)	36 (39.6%)	
Education	Masters and above	0 (0.0%)	2 (40.0%)	3 (60.0%)	.28
	Bachelor	0 (0.0%)	20 (47.6%)	22 (52.4%)	
	Diploma	3 (4.6%)	42 (64.6%)	20 (30.8%)	
Work Experience	≥ 16 years	0 (0.0%)	6 (28.6%)	15 (71.4%)	.001
	11–15 years	0 (0.0%)	11 (44.0%)	14 (56.0%)	
	6–10 years	2 (10.5%)	12 (63.2%)	5 (26.3%)	
	1–5 years	1 (2.1%)	32 (68.1%)	14 (29.8%)	

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Discussion

This study examined how healthcare professionals at Ndera Neuropsychiatric Teaching Hospital perceive the necessity of palliative care for patients with neuropsychiatric conditions. The results revealed diverse views on the need for such care, alongside several obstacles faced during its implementation. These challenges mirror not only the global difficulties encountered in palliative care integration but also specific barriers unique to Rwanda and the Sub-Saharan African context (Moreland et al., 2018; WHO, 2020; Knaul et al., 2018). The participant group was mainly composed of 91 nurses, 14 allied health workers, and 7 physicians. Most participants were middle-aged, with over half between 30 and 49 years old. The majority were male, and a significant portion were married. A large share held Diploma-level qualifications, and many had limited work experience of one to five years. These demographic details are consistent with previous findings by Tay et al. (2019), who also reported a predominance of nursing staff in hospital-based research, underscoring nurses' central role in healthcare provision.

The participants generally recognized palliative care as a vital part of managing multiple neuropsychiatric diseases. Scores reflecting perceived need for palliative care varied between 2.79 and 3.28 across several conditions, including Alzheimer's disease, amyotrophic lateral sclerosis, advanced stroke, neurodevelopmental and neurodegenerative disorders, multiple sclerosis, and severe mental health disorders affecting functionality. This perception aligns with studies such as Stoll et al. (2017), which showed that over 80% of surveyed individuals agreed on the appropriateness of palliative care for severe mental illnesses. Likewise, Gloeckler and Trachsel (2016) observed high recognition of palliative care necessity among nurses caring for bipolar disorder patients. Willert et al. (2019) also identified substantial palliative care needs among patients with neurodegenerative and neoplastic conditions, noting a variety of referral patterns. Globally, the requirement for palliative care is increasing in low- and middle-income countries, driven by rising non-communicable diseases like stroke, cancer, and dementia (Knaul et al., 2018). The current findings reinforce this trend, showing that healthcare workers at NNPTH are aware of the importance of palliative care for both neurological and psychiatric patient populations. However, many healthcare workers expressed discomfort initiating palliative care discussions, with 13.19% of nurses and 7.14% of allied health professionals indicating a lack of confidence in this area. Despite these difficulties, the majority indicated a readiness to participate in conversations about palliative care, highlighting a potential area for capacity building. These results correspond with Walsh et al. (2015), who reported that work pressures and the absence of clear institutional protocols can inhibit such communication. Christine et al. (2016)

also identified factors like inadequate knowledge, challenges in forecasting disease outcomes, financial constraints, religious considerations, and the complex nature of neuropsychiatric conditions as barriers to effective dialogue. Similar issues were observed at NNPTH, where insufficient knowledge and lack of formal policies hinder comprehensive palliative care delivery.

When it comes to understanding palliative care concepts and communication, healthcare providers were generally confident, but nurses reported lower self-assurance compared to other professional groups. This aligns with findings from Kim et al. (2017), who attributed such differences to variations in educational attainment. In this study, many nurses held diploma qualifications, which may partly explain their lower confidence despite some academic exposure. A notable confusion existed around differentiating palliative care from hospice care, with many associating hospices primarily with end-stage hopelessness or pain control. Hawkins-Taylor et al. (2018) found that many healthcare staff conflate these terms, and Tay et al. (2019) documented that cultural interpretations contribute to such misunderstandings. The World Health Organization (2018) stresses that these misconceptions delay timely palliative care. Moreland et al. (2018) also linked limited training and stigma to misunderstandings in Rwanda. These findings reflect the local situation at NNPTH, where inadequate exposure and education likely perpetuate confusion and stigma about palliative care. Attitudes towards palliative care were mostly positive, although nurses showed relatively lower scores, particularly regarding spiritual support. Allied health professionals and physicians tended to hold more favorable views. This is consistent with Tay et al. (2019), who found broad recognition of palliative care's benefits among healthcare providers, and Vishnevetsky et al. (2016), who reported provider acknowledgment of its importance in neurological care. Interestingly, only half of the nurses correctly identified the appropriate timing for referral, a trend also noted in other studies demonstrating less favorable nursing attitudes (Smith & Jones, 2017; Lee et al., 2018). Participants emphasized nurses' key role in starting palliative care conversations and the critical need for enhanced training, echoing Xu et al. (2015), who highlighted nurses' multifaceted responsibilities in improving patient quality of life. Locally, Karikwera (2019) revealed knowledge and attitude gaps among nurses at Kigali's teaching hospital, recommending targeted education. Overall, these findings suggest that at NNPTH, policy and training deficiencies contribute to challenges in palliative care provision.

Communication challenges were evident both among healthcare staff and in interactions with patients and families. Awareness of palliative care services was low, with only about one-fifth of nurses and allied health workers knowing about existing programs at NNPTH. This poor internal communication reflects the absence of clear governance and protocols. Wallerstedt et al. (2017) emphasize communication as essential for smooth palliative care delivery, and Di et al. (2018) noted similar barriers affecting team collaboration. Communication with patients was often indirect or delegated, with some providers avoiding direct engagement. Agom et al. (2019) found that many nurses withhold end-of-life information from patients, a phenomenon confirmed in Rwanda by Moreland et al. (2018). At NNPTH, these issues are compounded by lack of formal programs, workload pressures, and insufficient knowledge. Knowledge gaps represent a major obstacle. Nearly all healthcare providers lacked the ability to accurately prognosticate or anticipate positive outcomes of palliative care. This finding is consistent with Laabar et al. (2016), Park et al. (2017), and Kafadar et al. (2019), who all identified inadequate knowledge as a key barrier. Osman et al. (2015) similarly reported poor palliative care familiarity among Egyptian providers. Despite Rwanda's national goals for comprehensive training by 2020 (Rwanda Ministry of Health, 2016), these deficits persist at NNPTH, likely due to lack of structured programs.

Financial limitations were widely cited as critical barriers. Nearly all participants noted funding shortages and inadequate resources as major impediments, echoing Hojjat et al. (2017). At NNPTH, policies, patient costs, location, and unclear insurance roles further complicate funding. Patient-related issues, such as fear of abandonment, also emerged as barriers, aligning with Gilbert and Lillekroken (2016) and other studies highlighting stigma and social isolation's role in decision-making (Jones et al., 2018; Smith et al., 2017; Agom et al., 2019). Institutional factors such as absent policies, lack of guidelines, and inadequate infrastructure were significant barriers, consistent with Kafadar et al. (2019) and WHO's framework emphasizing policy, education, medication, and infrastructure as core to palliative care (WHO, 2018). Krakauer et al. (2017) also identified policy and training as crucial for integration. At NNPTH, these challenges reflect missing feasibility assessments, policy development, and training initiatives. Lastly, a strong association was found between age, experience, and perceived palliative care need, with older and more experienced providers showing greater awareness, consistent with Araújo et al. (2018). Clinical exposure and accrued expertise at NNPTH likely enhance this understanding. Study limitations include uneven sample sizes and diverse educational backgrounds, which may limit statistical robustness and generalizability.

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Conflict of Interest Disclosure

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