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KNOWLEDGE, PERCEPTION AND PRACTICES TOWARDS PALLIATIVE CARE AMONG CLINICAL OFFICERS IN MOI TEACHING AND REFERAL HOSPITAL UASIN GISHU COUNTY, KENYA

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RESEARCH PROJECT REPORT SUBMITTED TO THE MOI TEACHING AND REFFERAL HOSPITAL COLLEGE OF HEALTH SCIENCE IN PARTIAL FULFILLMENT FOR THE REQUIREMENTS FOR THE AWARD OF HIGHER DIPLOMA IN CLINICAL MEDICINE (PALLIATIVE AND HOSPICE CARE)

JULY 2022

DECLARATION AND APPROVAL

I Mirieri Isaac Nyabayo hereby declare that this research project is my own work and has not been presented to any other institution for any award. All sources of information have been acknowledged by means of references and citations

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DEDICATION

This research project is dedicated to my family for their support and commitment. You are my best source of energy; you have been my building block all the way. May God Bless You.

ACKNOWLEDGEMENTS

Firstly, would like to express my thanks to God for His love, grace and mercy upon my life and work.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
C.O	clinical officer
HIV	Human Immunodeficiency Virus
MTRH	Moi Teaching and Referral Hospital
PCKT	Palliative Care Knowledge Test
PC	Palliative Care
WHO	World Health Organization
HIV	Human Immunodeficiency Virus

OPERATIONAL DEFINITION OF TERMS

Health workers:	Referring the trained registered health care providers such as Doctors, clinical officers, Nurses, Laboratory personnel/technicians
HIV:	The human immune-deficiency virus – the virus which causes AIDS.
Knowledge:	Is a familiarity, awareness and understanding someone or something as facts, information, descriptions and skills which is acquired through experience and education by perceiving, discovery or learning.
Palliative care:	Is a philosophy of care that provides a combination of disease modifying and supportive, compassionate therapies intended to alleviate pain and other symptoms while addressing the emotional, social, cultural, and spiritual needs of patients and families who are experiencing life threatening progressive illness.
Perception:	An evaluative judgment by health workers towards a palliative care behavior that result in perception of favor or disfavor that put an individual on risk to adopt or reject health related behavior.
Practice:	Actual performance of a specific task in relation to the standard conventional guidelines to provide palliative care to a terminally ill patient.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABSTRACT

Background: To provide quality care at the end of life or for chronically sick patients, clinical officers must have good knowledge, perception, and practices about palliative care. In Moi teaching and referral hospital PC is new and very little is known about the type of services offered and the readiness of clinical officers to provide PC.

Objectives: The objectives of this study was to determine the knowledge, perception and practices towards palliative care among clinical officers in Moi Teaching and Referral Hospital, with more focus on the knowledge, perception and practices on clinical officers at departmental levels.

Methodology: The study was conducted at MTRH, Uasin Gishu County Kenya Located at Eldoret. Descriptive cross-sectional study design was used**.** A total of110 clinical officers, using solving formula. All clinical officers at MTRH with a population of an approximate of 151 clinical officers. Semi-structured questionnaires was used to collect data with instructions to tick where appropriate. Part A socio-demographic factors about palliative care, Part B knowledge about palliative care. Part C perceptions about palliative care. Part D practices about palliative care**.** Data cleaning was done to remove erroneous questionnaires, coding of variables was done, and data analyzed using statistical package for social sciences (SPSS) for windows Version 20.0 Armonk, NY: IBM corp. Data has been presented using descriptive and inferential statistics**.** Informed consent obtained from the respondents**.** Participation was voluntarily and no incentive given**.** Approval to conduct the research was sought from MTRH and IREC.

Findings:85.5% of the participants in the survey were clinical officers at MTRH, 14.5% were occupying other positions in the hospital like administration. However, 55% of them have been in the clinical department more than 4 years period, 18% of the participants have been in the clinical department for 2-4 years,27% of the participants have been in the clinical department for 1-2 yrs. The survey had 110 participants whereby 47 of them were males and the rest 63 were females. 56.4% of the participants were at the age of 30-40 years while 29.1% of them were below 30 years ,9.0% of them were 40-50years and the rest 5.5% are more than 50 years of age.

Conclusions: This study came to the conclusion that clinical officers lack knowledge and practices of palliative care, particularly the element related to standard medical procedure, and that this knowledge gap prevents them from practicing palliative care to patients. Ages, educational background, year of experience were all significant indicators of knowledge of palliative care.

Recommendation: Palliative care programs should be created to address clinical officers' knowledge level, practices by implementing on job training and mentorship, and educational needs in order to promote high-quality palliative care for patients and their families. This study offers pertinent data that can be used to create palliative care teaching programs for Clinical Officers who treat patients with terminal illness. Palliative care should also be specialized in accordance with the peculiarities of the disease and coordinated professional specialties.

CHAPTER ONE: INTRODUCTION

1.0 Background of the study

Death is an inevitable phenomenon that affects every human being. Nurses are present at both the beginning and the end of life and play a key role in caring for dying patients. That role is seen as one of the most stressful facets of nursing (Hopkinson, Hallett, and Luker, 2005).

Palliative care (PC) is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness through the prevention and relief of suffering by means of early identification, impeccable assessment and treatment of pain and other problems like physical, psychosocial and spiritual" (WHO, 2006). Palliative care is traditionally viewed as being the intense care of a patient who is close to death. In recent years, the scope of palliative care has expanded to include patients who may live for many years with end stage organ failure or cancer. Some chronically ill patients die from the side effect of treatment (Sanderson and Tieman, 2010).

Palliative patients have to be hospitalized, because the problems cannot be handled in the home situation or because sufficient family care is lacking. More than half of the home patients moves in the last months for dying still to another setting because of acute medical problems, lack of professional home care or overload of the informal care (Visser, 2006).

According to Harriet (2013), Palliative care is the level of palliative care which should be provided by all healthcare professionals, in primary or secondary care, within their duties to patients with life-limiting disease. Palliative care is a philosophy of care that provides a combination of disease modifying and supportive, compassionate therapies intended to alleviate pain and other symptoms while addressing the emotional, social, cultural, and spiritual needs of patients and families who are experiencing life threatening progressive illness (Anila, 2013).

Globally, Stjernsward (2007), reported that35 million people experience pain and suffering caused by old age or by life-limiting conditions such as cancer, AIDS, and other chronic diseases. In developing countries account for two-thirds of the global burden of 35 million and a high proportion of patients in these areas are in the advanced stages of illness, with little chance of being cured (Stjernsward, 2007).

The World Health Organization report revealed that care should be provided from the moment a life-threatening illness is diagnosed and be adapted to the increasing needs of patients and their families during the progression of a disease, through and to the terminal phase and ultimately death (WHO, 2007).

People live longer and longer and the number of people reaching a very high age is increasing. The increased medical-technological developments and the emphasis on safety aspects in e.g. traffic play an important part in this. Moreover, the acute death from heart diseases and CVD has decreased. This means that the causes of death shift from acute to chronic (Mackenbach& Van der Maas, 2004). With the increasing age people more and more often suffer from chronic diseases, that can have a prolonged course after a possibly acute beginning. Globally the top five of these diseases is made up of heart disease, Cerebro- vascular disease, chronic respiratory disease, respiratory infections and lung cancer (Council of Europe, 2003; Davies & Higginson, 2004)

Palliative to care improves the quality of life of individuals with life- limiting conditions and illness and their families. It focuses on the prevention and relief of suffering by means of early identification, assessment and treatment of pain, and by addressing physical, psychosocial and spiritual needs (WHO 2020).

As the world population ages and the prevalence of cancer and other non-communicable diseases continues to rise in low- and middle-income countries, the global, regional, and national needs for palliative care are increasing. It is estimated that about 40 million people around the world need palliative care services each year. 78% of these people live in low- and middle-income countries, with almost half of them living in Africa (WHO 2020).

In Africa, health systems remain overburdened with an increasing disease burden, great geographical distances, and late presentation of disease, limited financial resources, and a lack of trained health care professionals, inadequate access to essential medicines, and palliative care services at home and in the hospital.

Anila (2013), study conducted in SreeGokulam Nursing College, Venjaramoodu showed that majority (69%) had moderate knowledge and (79.5%) moderate attitude regarding palliative care. In Africa, the Cape Town Declaration years back in 2002 in South Africa declared that pain relief is a human right and outlined key strategies to address suffering related to HIV/AIDS, cancer, and other life-limiting illnesses (Harriet, 2013).

Much of the palliative care services in Kenya has been provided by Non-Governmental Organizations (NGOs).In 2005, a team of palliative care providers from 7 hospices joined hands to register the Kenya Hospices and Palliative Care Association (KEHPCA) as an NGO mandated to coordinate palliative care services in the country. By 2007, an active secretariat was in place whose role was to advocate for availability of palliative care services.

Palliative care service provision was through mission hospitals, hospices and private facilities in 18 sites. Through partnership with the Ministry of health, it was agreed that the services need to be integrated into government health facilities. This also included integrating palliative care in undergraduate training curriculum in nursing and medical schools. Currently palliative care has been integrated in 78 health facilities in 42 out of the 47 counties.

The Kenya Health Facility Assessment conducted in 2018 revealed that mean availability of palliative care services in Kenya was low with only 3% of health facilities offering the services. It also showed that the mean availability of tracer items for palliative care like morphine was only 5% among facilities offering palliative services. Additionally, of the facilities that reported they offer palliative care services, only 7% had all the tracer items. Persons living with palliative care needs currently access palliative care services from hospices, government facilities, faith-based facilities and through community organizations.

According to Kenya Palliative Care Policy 2021-2030 (2021), palliative healthcare burden in Kenya is about 137,700 patients given that an additional two family or voluntary caregivers per patient may also need support, it is therefore likely that the total number of people requiring help is nearer 413,000 with about 90% of patients in Kenya who need palliative care do not access such services A global body of scientific knowledge on palliative care interventions could be used to improve the quality of life, the process of dying, and the death of sufferers, and their affected families (Stjernsward, 2007).

According to a report by Kenya Hospices Palliative Care Association (KEHPCA, 2021) Kenya is already over-stressed health infrastructure, palliative care services have not been adequately scaled up, 30% suffer a loss of income, 5% need counseling support, and 7% require other support. Clinical officers find it difficult and emotionally heavy to deliver palliative care to patients and often do not feel competent enough (White et al., 2004). The success of nurses and clinical officers in palliative care relies on their relationship with each patient and it is related to her/ his interest and willingness to care for people at the end of life (Olthuis,Dekkers, Leget, et al., 2006). Clinical officers working on the day shift, clinical officers having 17–21 years of experience reported more favorable attitudes toward caring for dying patients than younger clinical officers, clinical officers on afternoon and night shifts, and clinical officers with less experience (Roman, Sorribes, &Ezquerro, 2001). Clinical officers as well as other healthcare workers often feel not well-prepared for their task in palliative care and are much in need of more expertise in the field of pain and symptom management, communication and dealing with ethical dilemmas.

1.1 Statement of the Problem

Globally, Palliative care is time-intensive and holistic care requires considerable investment in provider-patient relationships (Merriman, 2010). According to Merriman (2010), about 35 million people experience pain and suffering caused by old age or by life-limiting conditions such as cancer, AIDS, and other chronic diseases. In Palestine, one study revealed that 45.8% of nurses had poor knowledge and 37.5% had poor attitude (Ahmad *et al*., 2015).

Based on its extensive work in African region, Palliative care is rarely accessible in rural Sub-Saharan Africa. In Malawi, providers registered 112 patients with chronic illness receiving palliative care services of which 22(20%) were home visits, 43(68%) patients had document pain at base line of WHO, 23(53%) were treated with morphine and majority 35(56%) had less than or equal follow up. (Herce*et al*., 2014).

In East Africa, recently formed Kenya Hospice and Palliative Care Association (KHPCA) that along with Nairobi Hospice continue to advocate for palliative care with the health care system and improve access to pain medications in Kenya (Margaret, 2008). The HAU has estimated that the optimum quality care ratio of health professionals (including doctors, clinical officers, nurses and dispensers) to patients is 1:30 (Merriman, 2010).

To provide quality care at the end of life or for chronically sick patients, health care professionals must have good knowledge, perception and practices about palliative care. East African nations have huge disease burdens, both communicable and non-communicable diseases. HIV and cancer are one of the major causes of mortality in Kenya and put huge demands on the health care system and on the country's economy. All these conditions will require palliative care services as the disease burden increases. Unfortunately, for many African countries, accessing palliative care services, including access to pain relief, remains very limited resulting in serious suffering for patients and their families. lack of policies for strengthening and expanding human resources, including training of existing health professionals. While several challenges ranging from insufficient funding to weak policies have been attributed to poor development of palliative care implementation and research studies in sub-Saharan Africa, countries like India with similar challenges and higher population density have been able to make major breakthrough in the field of palliative care. Majority of the successes in India have been attributed to capacity building of the health care workers and policy makers in the aspect of palliative care. These innovations provide a source of learning to improve palliative care in sub-Saharan Africa. (2) (ajisegir, abubakar, gobir, balogm, & sabitu, 2019). Palliative care is still not optimal in MTRH. The study seeks to establish the relationship between knowledge, perceptions and practices among health care workers and palliative care at the MTRH in Uasin Gishu County, Kenya.

1.2 Purpose of the Study

This study seeks to examine the knowledge, perception and practice of clinical officers about Palliative care at MTRH, Uasin Gishu County, Kenya.

1.3 Study Objectives

1.3.1 General Objective

To determine the knowledge, perception and practice towards palliative care among clinical officers in Moi Teaching and Referral Hospital Uasin Gishu County, Kenya

1.3.2 Specific Objectives

i. To determine socio-demographic factors among clinical officers in Moi teaching and referral hospital
ii. To assess knowledge towards palliative care among clinical officers in Moi Teaching and Referral Hospital
iii. To assess perceptions towards palliative care among clinical officers in MTRH
iv. To assess practices towards palliative care among clinical officers in MTRH.

1.4 Research Questions

The study will be guided by the following research questions:

i. What are the socio-demographic factors of clinical officers in MTRH?
ii. What is the knowledge of clinical officers towards palliative care in MTRH?
iii. What is the perception towards palliative care among clinical officers in MTRH?
iv. How is the practice among clinical officers towards palliative care in MTRH?

1.5 Justification of the Study

The concept of palliative care is not new, most physicians have traditionally concentrated on trying to cure patients and even treatments for the alleviation of symptoms were viewed as hazardous and seen as inviting addiction and other unwanted side effects (Walsh, Gombeski and Goldstein, 2011). Efforts should therefore be made to improve perceptions of palliative care and to highlight the range of potential benefits offered by a holistic form of treatment that helps to restore quality of life.

Medical knowledge is dynamic in that it changes with evolution of new technologies and advances in biomedical science that is why it is very crucial to examine the knowledge, attitude and practice of health workers about Palliative care at MTRH. The results from this study will help health profession planning to understand the level of knowledge, attitude and practices of health workers in giving palliative care to terminally ill. It will help to identify and prioritize training needs in the study area.

1.6Significance of the study

The study will determine knowledge, perception and practices towards palliative care among clinical officers at Moi teaching and referral Hospital. It will be important for Program implementers/departmental heads to gain knowledge on how to successfully develop strategies to promote palliative care services at MTRH. Findings from this study will assist the clinical officers to improve service provision to patients within MTRH. It will also provide information to policy makers and top-level management on feasibility of the implementation of palliative care policies at MTRH. And finally, the findings will be used to make recommendations that could be utilized to improve palliative care programs at MTRH and the entire country at large.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter provides an outline of the literature reviewed for the purpose of deriving the propositions against which a palliative approach to care improves the quality of life of individuals with life- limiting conditions and illness and their families. It focuses on the prevention and relief of suffering by means of early identification, assessment and treatment of pain, and by addressing physical, psychosocial and spiritual need. The study will analyze empirical, conceptual and theoretical framework and establish gaps to inform the current study.

2.2 Socio-demographic Factors and Palliative Care

The aim of this study is to examine whether a set of sociodemographic factors is associated with palliative care knowledge and beliefs: gender, age, education, race/ethnicity, and personal and familial history of palliative.

Belachewetal, (2012) used cross sectional community-based study and a modified WHO EPI cluster sampling method for sample selection to investigate the determinants of palliative care. The results showed that whereas the patient's area of residence and sociodemographic characteristics were not significantly associated with the kind palliative care received, proximity to a health facility; care follow-up and caregiver's knowledge about the palliative care were significant determinants of palliative care access and provision.

Place of residence is also an underlying determinant to palliative care. This perspective is supported by Henry et al. (2011) who showed that patients in urban areas had consistently higher and better care rates than their rural counterparts. This is attributed to the fact that palliative care services are more accessible in urban areas due to higher availability of health facilities.

Distance to a health facility according to Ibnouf, A. et al., (2017) determines palliative care outcomes. He undertook a cross sectional study in Khartoum State, Sudan and revealed that patients who walked less than 30 minutes to health centers were 3.4 times more likely to have had the right care than were those who walked 30 minutes longer. Hence walking time to the nearest Health Centre had a strong influence on the correct care status of the patient.

Caregiver level of education is also a contributory determinant of care outcomes. Lisa et al., (2014) used primary data to investigate full and timely health care coverage and associated factors in children aged 12-23 months in Gem, Siaya County Kenya. Simple random method was used for sample selection. Multivariate logistic regression was applied and results showed that children of mothers with lower maternal education or children in households with the spouse absent were less likely to be fully vaccinated. The study also found evidence of distance decay effect, where vaccination decreased with increasing distance from the vaccination clinic considering the study was conducted in a rural setting.

Unlike racial disparities, however, prior studies reported mixed results for gender disparity in palliative care knowledge. Some found that men were less likely to be aware of palliative care (Koffman et al., 2007; Boakye et al., 2019) or less knowledgeable Shalev et al., 2018) than women, while others reported the opposite results (Barwise et al., 2019) or no significant difference (Taber et al., 2019). These studies did not provide a clear explanation as to why such mixed results may exist and anticipated further studies to examine gender as a determinant of disparity in palliative care knowledge.

These studies did not provide a clear explanation as to why such mixed results may exist and anticipated further studies to examine gender as a determinant of disparity in palliative care knowledge. Still, studies that found women to be more knowledgeable than men about palliative care offered a possible explanation in that women usually seek more health information (Koffman et al., 2007; Boakye et al., 2019) or take on caregiving roles more often than men do, therefore being more likely to hear or learn about different types of health care options such as palliative care.

As indicated in other studies patients and relatives with limited education background often only have limited access to these special services. Racial and ethnic disparities in the utilization of healthcare services in general and in palliative care in particular are well-documented. Some may find accessing quality care and funding for hospice, palliative care or other EOL services a challenging process that may be evoked by unfamiliarity with laws and regulations of the host country.

2.3 Knowledge of health workers about Palliative care

The knowledge and perception of doctors, pharmacists, nurses, clinical officers, and other healthcare workers toward palliative care and end of life matters have been explored in studies from Pakistan, Lebanon, India, and Turkey.

Palliative care according to the World Health Organization (WHO 2020) is the active total care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms, and of psychological, social, and spiritual problems is paramount. The goal of palliative care is achievement of best quality of life for patients and their families. Palliative care is required for a wide range of diseases. The majority of adults in need of palliative care have chronic diseases such as cardiovascular diseases (38.5%), cancer (34%), chronic respiratory diseases (10.3%), AIDS (5.7%) and diabetes (4.6%). Many other conditions may require palliative care, including kidney failure, chronic liver disease, multiple sclerosis, Parkinson's disease, rheumatoid arthritis, neurological disease, dementia, congenital anomalies and drug-resistant tuberculosis (WHO 2018).

To provide quality care at the end of life or for chronically ill patients, health workers must have good knowledge about palliative care (Begum and Khanam, 2015). Merriam Webster defines Knowledge as information, understanding, or skill that you get from experience or education.

According to Prem and colleagues used the instrument to compare differences in knowledge between genders and among work settings (e.g. Intensive care units, out patients' unit, medical and surgical floors and others) findings showed that the overall score of PCKT was 35.86% (Prem *et al.,* 2012). Budkaew and Chumworathayi (2013), findings revealed that insufficient knowledge regarding truth telling, pain control and management with morphine, emergency management in terminal cancer care and treatment of fluid intake in terminal stages.

Similarly, in a study conducted to examine oncology and intensive care nurses' knowledge about palliative care in South East Iran, results revealed that 20% of the staff nurses had adequate knowledge while majority 69% were having moderate knowledge and 11% were having poor knowledge (Anila and Haseena, 2015).

In a study done by Ahmad and the colleague found out that 20.8% of the respondents had good knowledge towards PC and 59.4% had training of PC (Ahmad *et al*., 2015). The scholars reported that the provision of quality PC services requires however the education and training of health workers such as nurses in this field needs to become an integral part of all nursing school curricula as well as continuing nursing and medical education program offerings (Ahmad *et al*., 2015).

In a study done by Abudari*et al.* (2014), scores indicate a knowledge deficit regarding palliative care among health workers and long-term effect associated to the use of morphine in management of severe pain. Furthermore, the nurses' palliative care training and years of nursing experience significantly affected the scores.

According to Gopal and Archana (2016), reported that knowledge regarding services offered and time to intervene (early/late) was very much inadequate in general population than in health care providers. They found that only 9% of general population and 38% of health care providers were opting to start palliative care early (immediately after the diagnosis of terminally ill disease is made), whereas the majority of the population in both the groups did not know about early intervention (Gopal and Archana, 2016).

A study carried out among 83 third Year Diploma Nursing students by using cluster sampling method from selected Nursing schools of Udupi district to assess the knowledge and attitude of nursing students towards PC showed that only 43.4% of them were aware of the term PC and it was during their training period (Karkada, Nayak, and Malathi, 2011).

In Kenya the population is estimated to be 43 million. The leading causes of death are infectious disease, cardiovascular disease, and cancer. It is estimated that the annual incidence of cancer is about 37,000 new cases with an annual mortality of 28,000 cases. The leading cancers in women are breast and cervical and in men, prostate and esophageal. Seventy to 80% of patients are diagnosed in late stages because of lack of awareness, inadequate diagnostic and treatment facilities, high cost, and high poverty index.

2.3 Perception of health workers about Palliative care

Perception is a paramount feature in utilizing the facilities provided by health care providers to help the sufferers by providing them physical and emotional support (Gopal and Archana, 2016). A study conducted in SreeGokulam Medical College and Research Foundation, Venjaramoodu revealed that among 200 subjects' majority (79.5%) have moderate attitude, (17.5%) had adequate attitude and only (3%) had poor attitude regarding palliative care (Anila and Haseena, 2013).

According to Gopal and Archana (2016), palliative care services is an exclusive form of holistic treatment which interconnects both sufferers and their families with doctors at hospitals, home based care (maintaining a standard of care at the place of stay for a bedridden patient, through family/community empowerment, and/or home visits by trained teams; usually inclusive of a nurse) as well as the community irrespective of age/religious differences/social status.

A study done in Lebanon showed that perception of Registered Nurses (RN) and Medical Doctors (MD) towards PC, nurses were twice as likely as physicians to disagree to give the right of “Do not resuscitate” to terminally ill patients (17.8% verses (vs) 8.6%) whereas MDs were twice as likely as RNs to disagree with giving hope to terminally ill patients against all odds (7.5% vs. 3.6%). The majority (94% to 99%) believes terminally ill patients and their families should be informed of the diagnosis and prognosis (Huijer and Dimassi, 2007).

Though most of RNs and MDs agreed that having the same religious back- ground as the patients enhances the caring process, the percent among RNs (67.3%) was significantly higher than among MDs (59.6%) (Huijer and Dimassi, 2007). The preferred place of death was reported by both RNs and MDs to be the home of the patient (91.7% and 91.0%). It is interesting to note that 40% of RNs and MDs did not consider the hospital as a right place to die and 66.9% of RNS and 60.2% of MDs did not consider hospice as a good place to die (Huijer and Dimassi, 2007).

A study done in Palestine, assessment of the nurses’ attitude of palliative care result showed that the most respondents' attitudes levels towards palliative care were moderate attitude 54 (56.2%), 36 (37.5%) poor attitude, and 6 (6.2%) good attitude level (Ayed, 2015). More than half of the nurses were more likely to disagree of Palliative care is given only for dying patient (63.5%), as well as they also disagree if the nurse should withdraw from his/her involvement with the patient (56.7%) and Nurses’ attitudes toward Family should maintain as normal an environment as possible for their dying member agrees 34.4% whereas the attitudes toward the family should be involved in the physical care of the dying person were 44.8% agree and 8.3% disagree (Ayed, 2015).

Similarly,Kassa*et al*. (2014), cross sectional study in Addis Ababa, Ethiopia to assess the knowledge and attitude of 341 nurse’s results showed that 259 (76%) nurses had a favorable attitude towards palliative care. Furthermore, over half of the nurses 174 (51%) agreed that family should be concerned about helping their dying member; likewise, nearly half of the respondents 170 (49.9) agreed that patients and family should be in charge of making decisions about patients' care (Kassa*et al*., 2014).

2.4 The practice of health workers about Palliative care

Palliative care services should be provided from the time of diagnosis of life-threatening illness, adapting to the increasing needs of cancer patients and their families as the disease progresses into the terminal phase (Gopal and Archana, 2016). In a study to construct a detailed account of the role of district nurse in providing palliative care in primary home setting in Manchester, England, results showed that district nurses have key skills in providing physical care and in coordinating with the work of others but struggled more with psychological aspects of care (Catherine, 2010).

Meanwhile in Thailand, a study to describe the nursing interventions that nurses in Thailand identify as most important in promoting dignified death, results revealed that the most important nursing intervention to promote dignified dying ranked average importance rating were maintaining dignity and privacy, establish trust, manage pain, establish rapport, and manage dyspnea (Adith*et al*., 2013).

According to Begum and Khanam (2015), reported that the levels of practice of staff nurses on palliative care in selected hospitals of Guwahati city, maximum 48% practiced adequately whereas 43% practiced moderately adequate and only 9% practiced inadequately. Another studies done by revealed that demonstration of certain benefits such as limited need for daily physical examination and assessment, screening for a need for a clinical visit or admission, communication assistance to patients who cannot speak or hear and increased satisfaction by the patient and the caregivers (Dhiliwal&Salins, 2015; De Jongh *et al*., 2012).

Palliative care aims to affirm life while regarding dying as a normal process, to provide support to enable patients to live as actively as possible until death and to offer support to the family during the patient's illness and in their bereavement. Though palliative care has been somewhat established in many developed countries of the world, it is an emerging medical specialty in many developing ones with establishment of palliative care centers in India, Saudi Arabia, and Lebanon. In Nigeria, palliative care is still in its early stage of development with the establishment of the first palliative care Centre in the oldest teaching and tertiary hospital in 2003. The frequency of chronic no communicable diseases as major cause of morbidity and mortality in developing countries has also emphasized the need for professionals in the healthcare sector to acquire knowledge and develop skills in palliative care.

2.5 Conceptual Framework

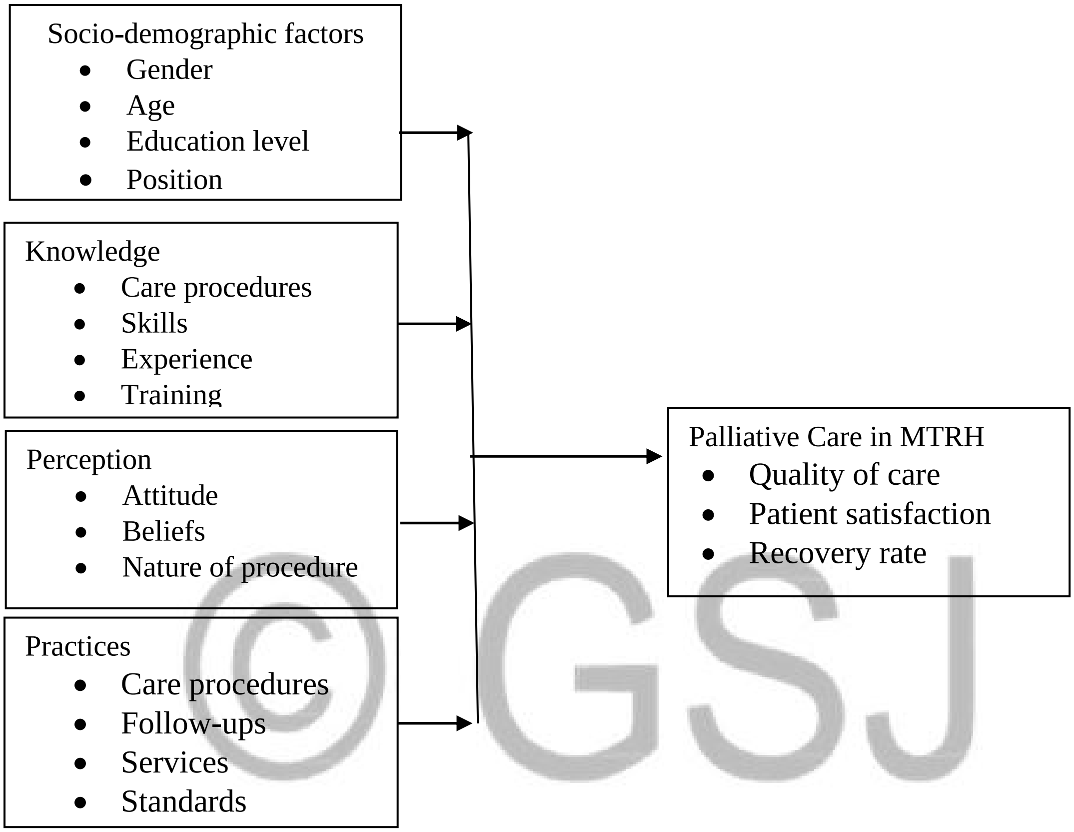

Figure 2.1: Conceptual Framework

2.6 Theoretical Framework

The study will be anchored on the Humanistic Nursing Theory (HNT). Although the original theory is considerably older, modern humanistic Nursing Theory has continued to develop over the course of thirteen years across three independent studies authored by O'Connor (1992), Kleiman, (2001) and McCamant (2006). HNT examines in, "the phenomenon of nursing as it is experienced in the everyday world" (Paterson &Zderad, 1976). HNT follows a step-by-step approach which reads, *"nurse-patient relationship is characterized by interaction designed to promote well-being and existential growth in the context of the lived world. The nurse cares for the patient by presence or being with the patient, and other nursing actions or activities" (Wu, Volker, 2011).*

HNT examines the relationship of the nurse to the patient and the importance that both are unique individuals but are working towards the same end goal. The relationship between the patient and the nurse and the ability to be open and interact are crucial in providing effective humanistic nursing. Every relationship is different and nurses and patients may differ in opinion on a wide variety of topics ranging from values to expectations.

An additional characteristic of HNT is the idea of the nurse fulfilling a role of availability. In HNT, it is important for the nurse to be a dependable presence for the patient. This not only provides the patient with a pillar on which to lean on, but it also encourages positive interactions between the patient and nurse.

Recently, the World Health Organization has voiced an opinion that, “expert, palliative and end-of-life care are a top priority for global health care” (Wu, Volker, 2011). According to the researchers of this study, the specialties required of both hospice and palliative care lend themselves well towards adapting a humanistic and holistic model (Wu, Volker, 2011). This study examines the philosophical viewpoints and approach of Humanistic Nursing Theory (HNT) within the realms of hospice and palliative care.

As opposed to direct medical intervention, hospice and palliative care focus on the comfort of the patient while providing compassionate attentiveness. Within the interdisciplinary hospice team, nurses and clinical officers play a vital role as they are charged with providing care on a regular basis and interact with patients and families regularly. The researchers state in their study that, “hospice and palliative care nursing embraces a humanistic caring and holistic approach to patient care.” The research being discussed explores the usefulness of HNT to hospice and palliative care in the field of clinical medicine (We, Volker, 2011).

CHAPTER THREE: MATERIALS AND METHOD

3.1 Introduction

This chapter presents a description of the sources of data, sample selection, data quality and the analytical tool used in this study so as to yield the necessary conclusions of knowledge, perception and practices among clinical officers towards palliative care at Moi Teaching and Referral Hospital.

3.2 Research design

Cross-sectional descriptive study in which qualitative methods was used to collect relevant data. Data collection took one month after getting approval from IREC. The research process involved two main components. The first component was secondary data collection which was done through a review of the existing theoretical and empirical literature, and the second component was primary data collection which was done through use of semi-structured questions.

3.3 Study population

The study population comprised of 151 clinical officers working at the Moi Teaching and Referral Hospital. The unit of analysis was the individual clinical officers providing palliative care to patients in the health facility covered by the study.

3.4 Study Site

The study was conducted at Moi Teaching and Referral Hospital, Uasin Gishu County Kenya located at Eldoret, former Rift Valley Province, Kenya which lies at Latitude: 0.5175727 and Longitude: 35.2713933 above sea levels. MTRH is a level 6 hospital that is one of the largest referrals and teaching health facility in the Rift Valley and Western Region. The hospital provides training to Moi University, Eldoret and Kenya Medical Training College medical trainees. It has a bed capacity of 2000 and provides various forms of care. It serves an estimated patient population of 24 million with a catchment area covering the lake region block. As a teaching and referral hospital, MTRH receives palliative patients from hospitals across this catchment area.

3.5 Study Variables

The study was anchored on two variables which include dependent and independent variables. The independent variables include: knowledge, perception and practices among clinical officers while the dependent variable is palliative care at MTRH.

3.6 Selection Criteria

3.6.1 Inclusive Criteria

- All clinical officers working at MTRH at the time of the recruitment.
- All clinical officers willing to consent for the study at MTRH

3.6.2 Exclusive Criteria

- Clinical officers who will decline to consent for the study
- Clinical officers who will be on leave at the time of recruitment

3.7 Sample Size Determination

Because the target population is known, the study will adopt the Slovin formula;

$n = N / (1 + Ne^2)$ where:
n = Number of samples,
N = Total population and
e = Error /confidence level (95%)

Therefore;
n=151/1+150*0.05^2
=151/1+150*0.0025
=151/1+1.375
=151/1.375
=109.81

The study sample will therefore be 110 clinical officers offering palliative care to patients at MTRH within the study period.

3.7.1Sampling Frame

The list of all clinical officers from each department at Moi Teaching and Referral Hospital from Monday to Friday at that particular month will be drawn. The sampling frame will assist so that every clinical officer identified would have an equal opportunity for selection as a subject.

3.8 Data Collection Tool

Semi-structured questionnaires were used to collect data with instructions to tick where appropriate. Part A socio-demographic background of the clinical officers, Part B covers knowledge about palliative care, Part C perceptions about palliative care while Part D practices about palliative care.

3.8.1 Pretesting

Pretest for the questionnaire was carried out among clinical officers at MTRH oncology department. This ensured the content of the questionnaire was appropriate to the respondent understanding. 5% of the questionnaires was used for pretesting.

3.8.2 Reliability and Validity

An expert opinion was sought from the Supervisor before developing the final questionnaire. Feedback from the pretesting was used to improve the questionnaire.

3.8.3 Data Collection Method

Semi structured questionnaires was used to collect data from the respondents. The questionnaire contains open and closed ended question. The language used in structuring the questions in the questionnaires was simple, consistent and easy to understand. I administered the questionnaires personally to help the participants answer them correctly and reduce non respondent.

3.9 Data Analysis

Data cleaning was done to remove erroneous questionnaires, coding of variables was done and data was analyzed using statistical package for social sciences (SPSS) for windows Version 20.0 Armonk, NY: IBM corp. The study was both descriptive and inferential statistics to analyze and present data findings. The analyzed data has presented in form of frequencies, percentages, charts, tables and graphs.

3.10 Ethical Consideration

Informed consent was obtained from the respondents who are clinical officers. Participation was voluntary and no incentive was given. Confidentiality was observed by coding the questionnaire in numerical form and no names will be used. Approval to conduct the research was given from MTRH college of health sciences. Further permission was given from MTRH top management.

CHAPTER FOUR: RESULTS

4.1 Social demographic factors

The tables below show that 85.5% of the participants in the survey were clinical officers at MTRH, 14.5% were occupying other positions in the hospital like administration. However, 55% of them have been in the clinical department more than 4 years period, 18% of the participants have been in the clinical department for 2-4 years,27% of the participants have been in the clinical department for 1-2 yrs.

The survey had 110 participants whereby 47 of them were males and the rest 63 were females as shown in the table below. 56.4% of the participants were at the age of 30-40 years while 29.1% of them were below 30 years ,9.0% of them were 40-50years and the rest 5.5% are more than 50 years of age.

Most of the participants (86.4%) had diplomas as their highest level as a clinical officer and the rest 13.6% had a degree as their highest level of clinical officer. 68 out of 110 participants had done clinical officer as their qualification while 4 of them had C.O oncology 7 C.O orthopaedics,6 C.O ENT,8 C.O peadiatrics,3 C.O EYE,2 C.O SKIN,12 C.O anesthesia's the area of specialization.

In the tables below, 29.1% of the participants agreed that counselling of the patient is the standard medical procedure for palliative care while 28.2% of the participants said that there is no standard medical procedure and they don't know the standard medical procedure for palliative care respectively. 14.5% of them said that seeking convent with the patient is the standard medical procedure for palliative care.

Table 4.1: Sociodemographic factors

CHARACTERISTICS	FREQUENCY(n)110	VALID PERCENTAGE (%)
POSITION		
C.O	94	85.5
others(specify)	16	14.5
GENDER		
Male	47	42.7
Female	63	57.3
AGE		
LESS 30yrs	32	29.1
30-40yrs	62	56.4
40-50yrs	10	9.0
Above 50yrs	6	5.5
Level of training		
Diploma	95	86.4
Degree	15	13.6
Qualification		
Clinical officer	68	62
C.O ORTHO	7	6
C.O ENT	6	5
C.O PAED	8	7
C.O ANAEST	12	11
C.O EYE	3	3
C.O ONCOLOGY	4	4
C.O SKIN	2	2
Period(yrs.) clinical department		
Less 1yr	0	0
1-2yrs	30	27
2-4yrs	20	18
Above 4yrs	60	55

Table 4.2: What is the standard procedure for palliative care?

Characteristics	**Frequency(n)110**	**Valid percentage**
Counselling of the patient	32	29.1
Seeking consent	16	43.6
None	31	28.2
Don’t know	31	28.2

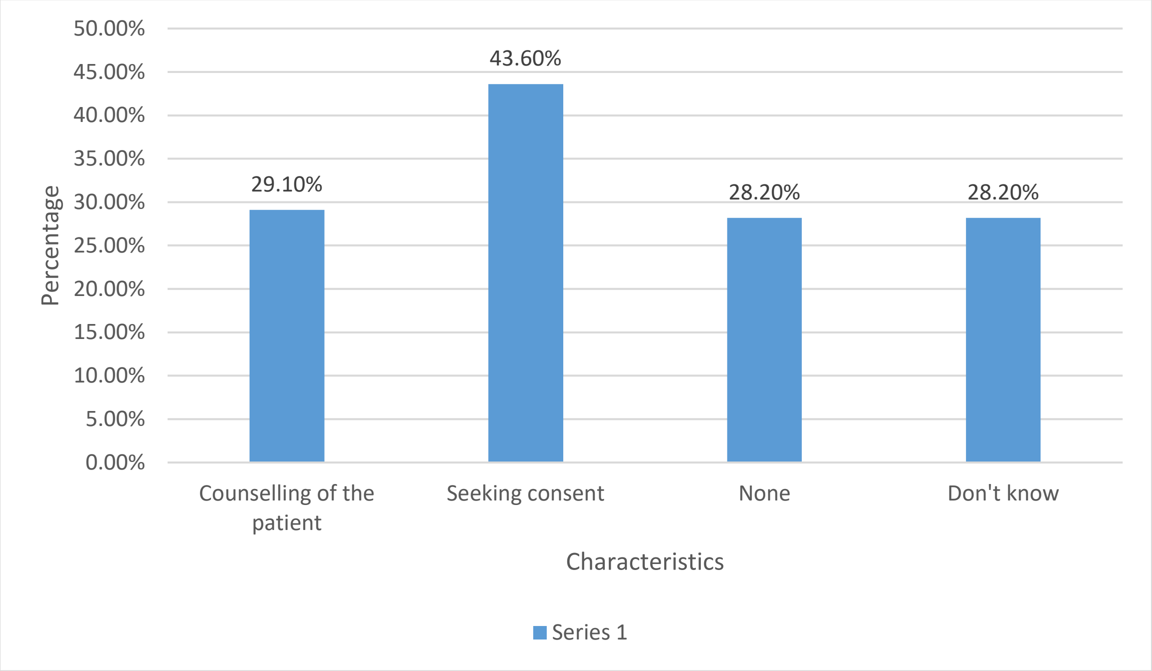

Figure 4.1: Shows what is the standard procedure for palliative care?

In providing palliative care to the patients, some factors hinder the ability to provide the care needed. 42.7% of the participants agreed that lack of training mostly affect the ability to provide professional palliative care. 14.5% of the participants agreed that patients who are not willing to take up the care and unavailability of medical equipment affects the ability to provide professional palliative care respectively. 13.6% of the participants said that insufficient information to the patient can affect one’s ability to provide professional palliative care

Table 4.3: What are some of the factors that affect your ability to provide professional palliative care?

	Frequency	**Percentage**
Lack of training	47	42.7
Patients not willing to take up the care	16	14.5
Unavailability of medical equipment	16	14.5
Insufficient information to the patient	15	13.6
Nothing	16	14.5
Total	**110**	**100**

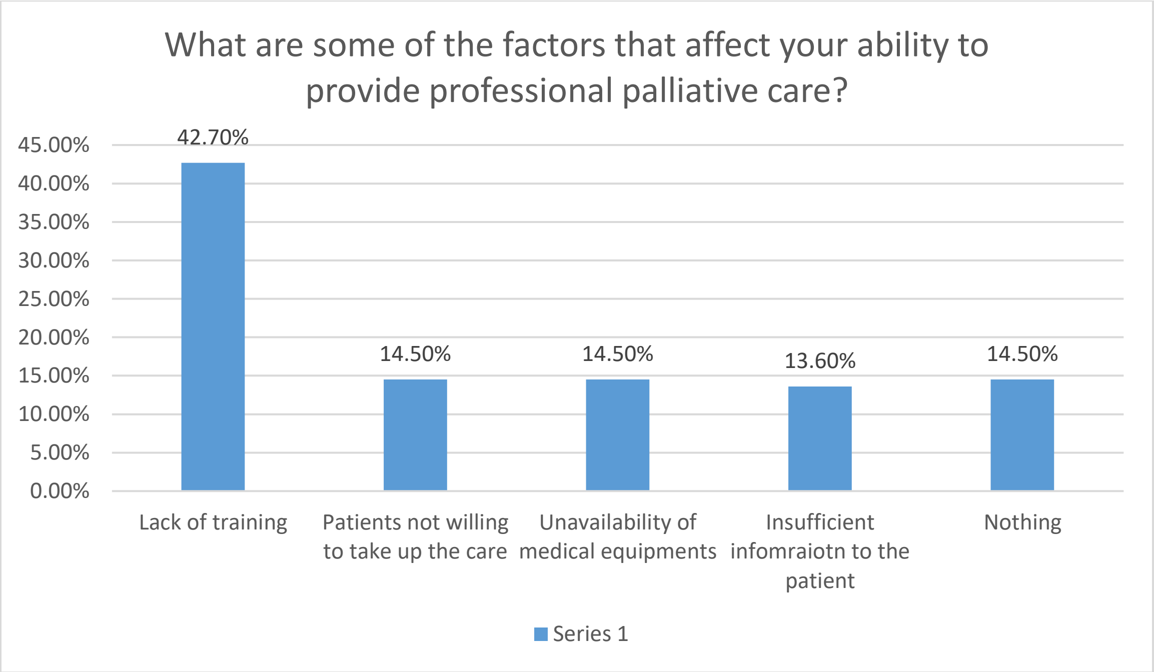

Figure 4.2: Shows what are some of the factors that affect your ability to provide professional palliative care?

4.2 Knowledge on palliative care

85.5% of the participants agreed that they have sufficient knowledge and skills in palliative care while 14.5% said that they have no sufficient knowledge and skills on palliative care. Also, all the participants agreed that palliative care needs sufficient knowledge to administer as shown in the tables above.

Characteristics	Frequency	Percentage
Disagree	16	14.5%
Moderately agree	46	41.8%
Agree	32	29.1%
Strongly agree	16	14.5%
Total	**110**	**100.0%**

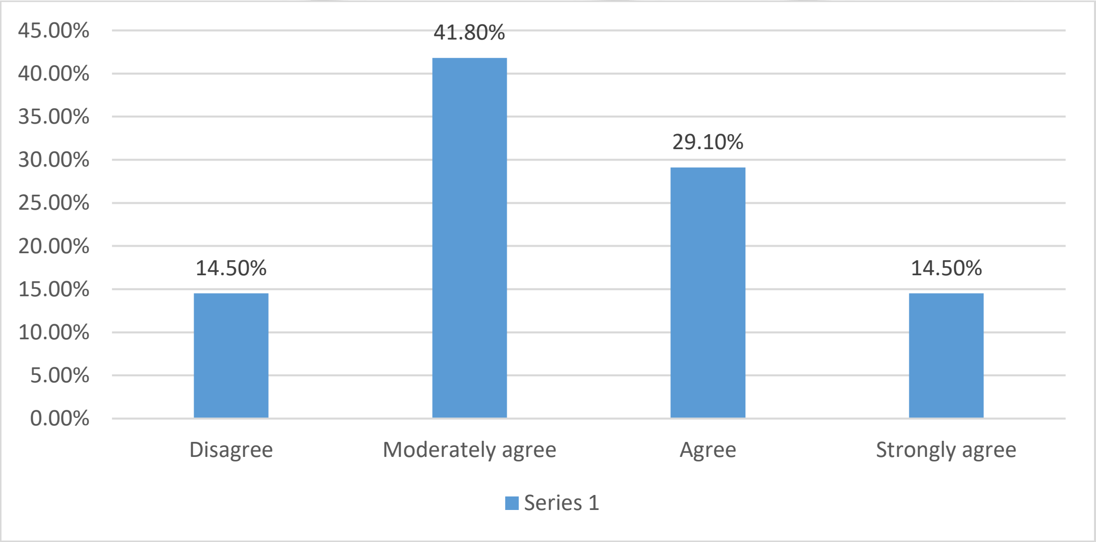

Figure 4.3: Shows sufficient knowledge and skills in palliative care

Table 4.5: Palliative care needs sufficient knowledge to administer

Characteristics	Frequency	Percentage
Agree	15	13.6%
Strongly agree	95	86.4%
Total	**110**	**100.0%**

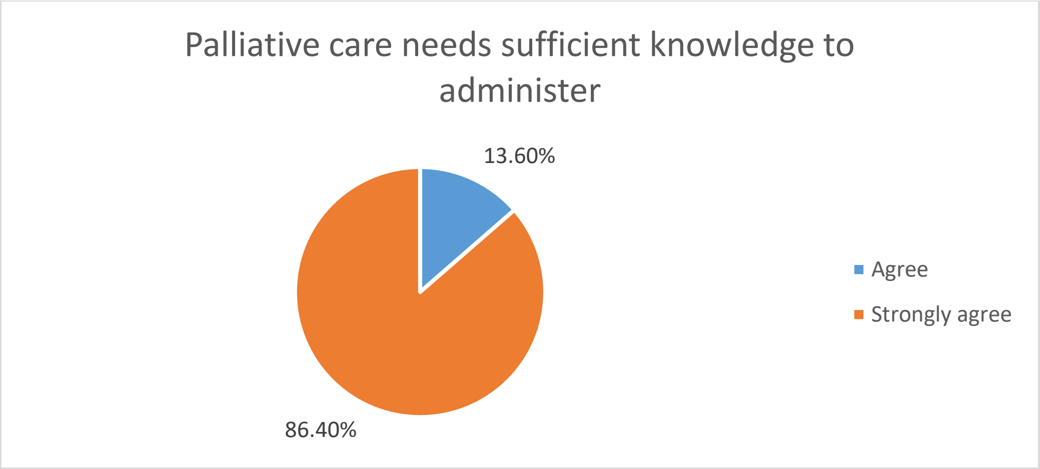

Figure 4.4: Shows palliative care needs sufficient knowledge to administer

Table 4.6: I have advanced my training on palliative care

	Frequency	**Percentage**
Strongly disagree	16	14.5%
Disagree	31	28.2%
Moderately agree	32	29.1%
Agree	31	28.2%
Total	**110**	**100.0%**

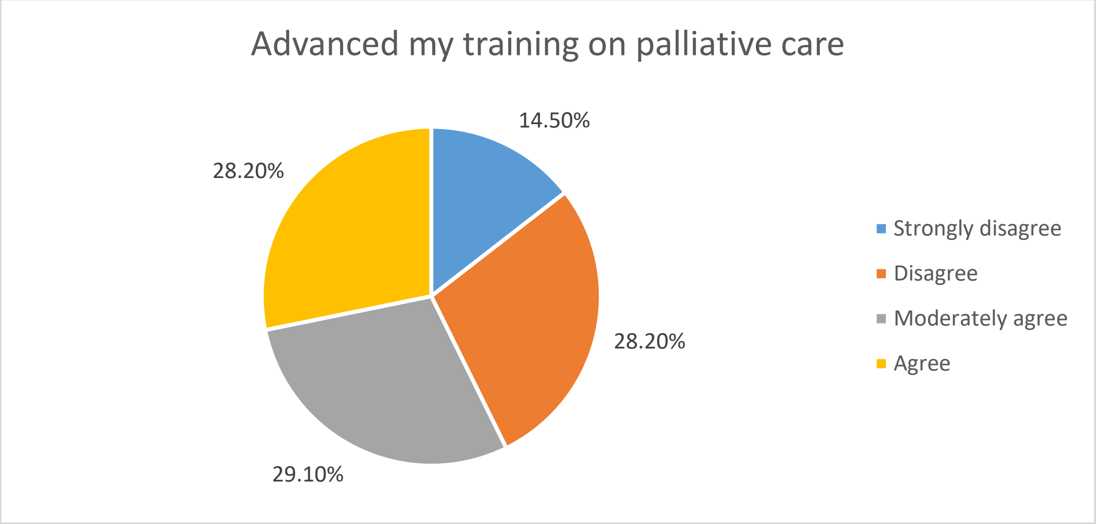

Figure 4.5: Shows I have advanced my training on palliative care

As shown in the tables above, 57% participants have advanced their training on palliative care while the rest 42.7% of the participants said that they haven't advanced their knowledge on palliative care.

Table 4.7: Provision of palliative care

Characteristics	**Frequency**	**Percentage**
Moderately agree	16	14.5%
Agree	32	29.1%
Strongly agree	62	56.4%
Total	**110**	**100.0%**

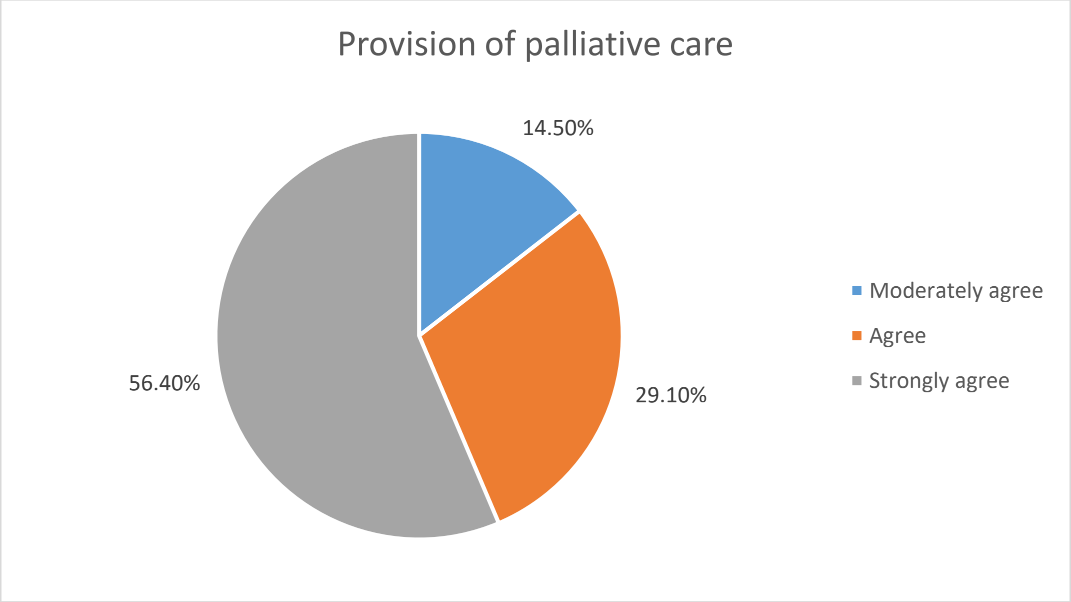

Figure 4.6: Shows provision of palliative care

Table 4.8: I need to learn more on palliative care

Characteristics	**Frequency**	**Percentage**
Moderately agree	16	14.5%
Strongly agree	94	85.5%
Total	**110**	**110**

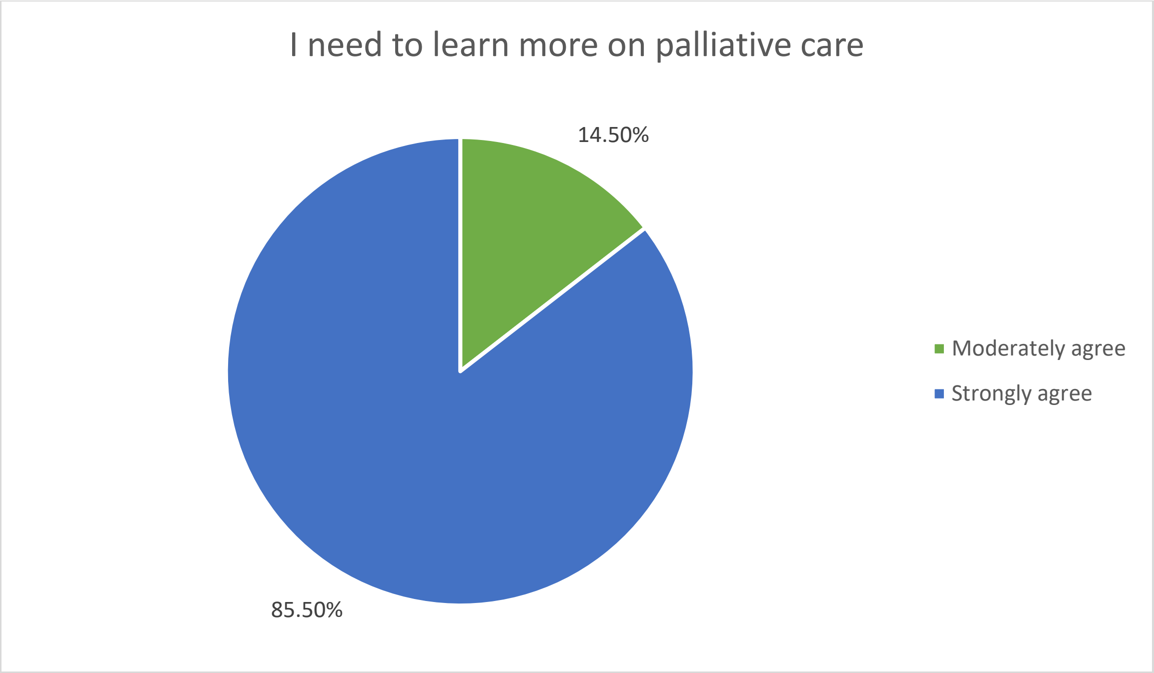

Figure 4.7: Shows I need to learn more on palliative care

In provision of palliative care to the patients at MTRH, all the participants agreed that they learn from each other. Also, all the participants agreed that they need to learn more on palliative care as shown in the tables above.

4.3 Perception on palliative care

According to the table results above, 86.4% of the participants strongly disagreed that they don't like providing palliative care while the rest 13.6% agreed that they don't like providing palliative care. 57.3% disagreed that palliative care is tiresome procedure to administer while 42.7% agreed that palliative care is tiresome procedure to administer.

Table 4.9: I don't like providing palliative care

Characteristics	**Frequency**	**Percentage**
Strongly disagree	95	86.4%
Strongly agree	15	13.6%
Total	**110**	**100.0%**

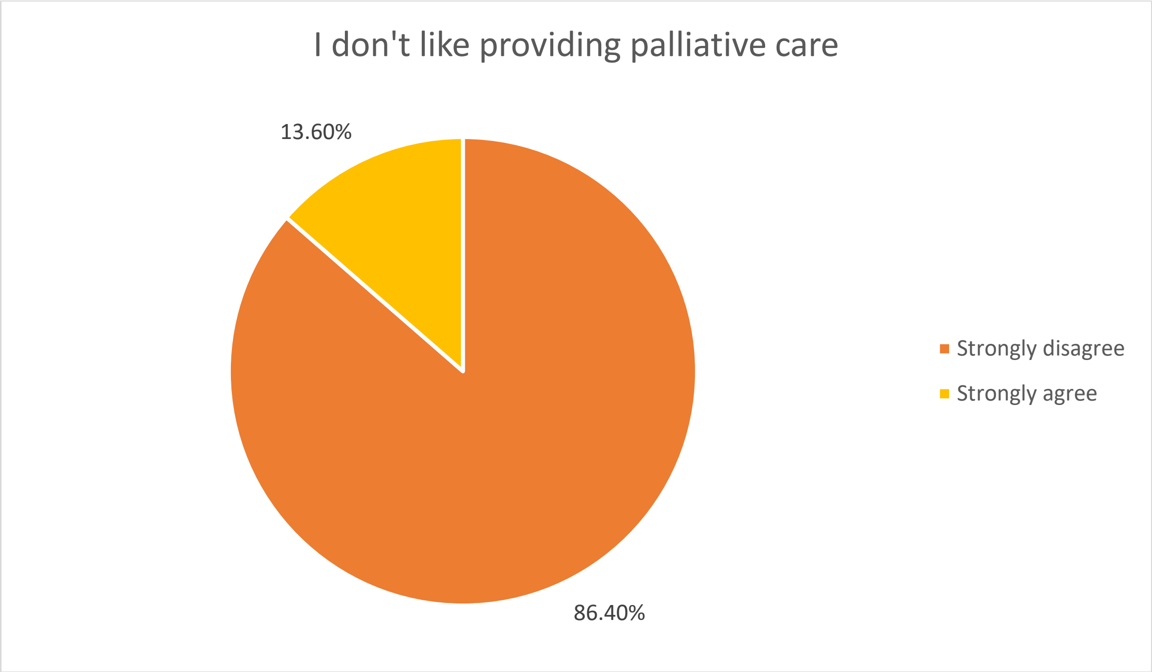

Figure 4.8: Shows I don't like providing palliative care

Table 4.10: Palliative care is a tiresome procedure to administer

Characteristics	Frequency	Percentage
Strongly disagree	16	14.5%
Disagree	47	42.7%
Agree	31	28.2%
Strongly agree	16	14.5%
Total	**110**	**100.0%**

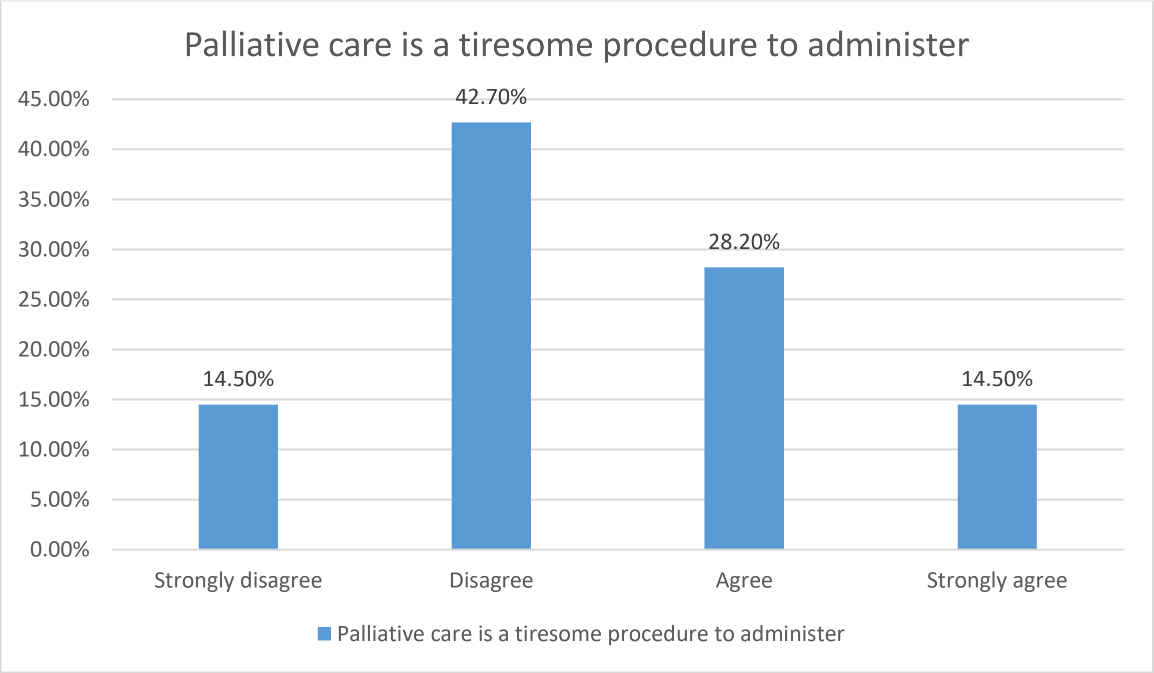

Figure 4.9: Shows palliative care is a tiresome procedure to administer

Table 4.11: You need to widely learn on palliative care to administer it

Characteristics	**Frequency**	**Percentage**
Strongly disagree	31	28.2%
Disagree	15	13.6%
Moderately agree	16	14.5%
Agree	16	14.5%
Strongly agree	32	29.1%
Total	**110**	**100.0%**

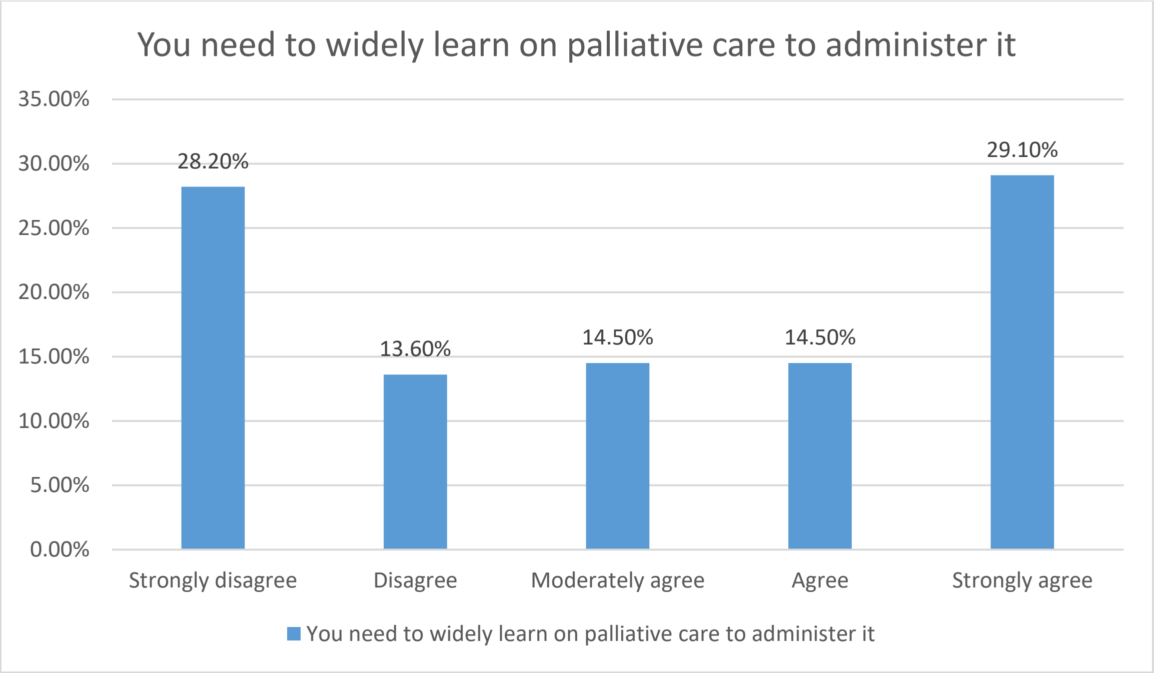

Figure 4.10: Shows need to widely learn on palliative care to administer it

To administer palliative care, 58.1% of the participants agreed that you need to learn more and widely do research on the palliative care while 41.9% of the participants disagreed that you need to learn more and widely do research on the palliative care as shown in the tables above.

Table 4.12: Our patients do not appreciate our commitments

Characteristics	**Frequency**	**Percentage**
Strongly disagree	62	56.4%
Disagree	16	14.5%
Moderately agree	32	29.1%
Total	**110**	**100.0%**

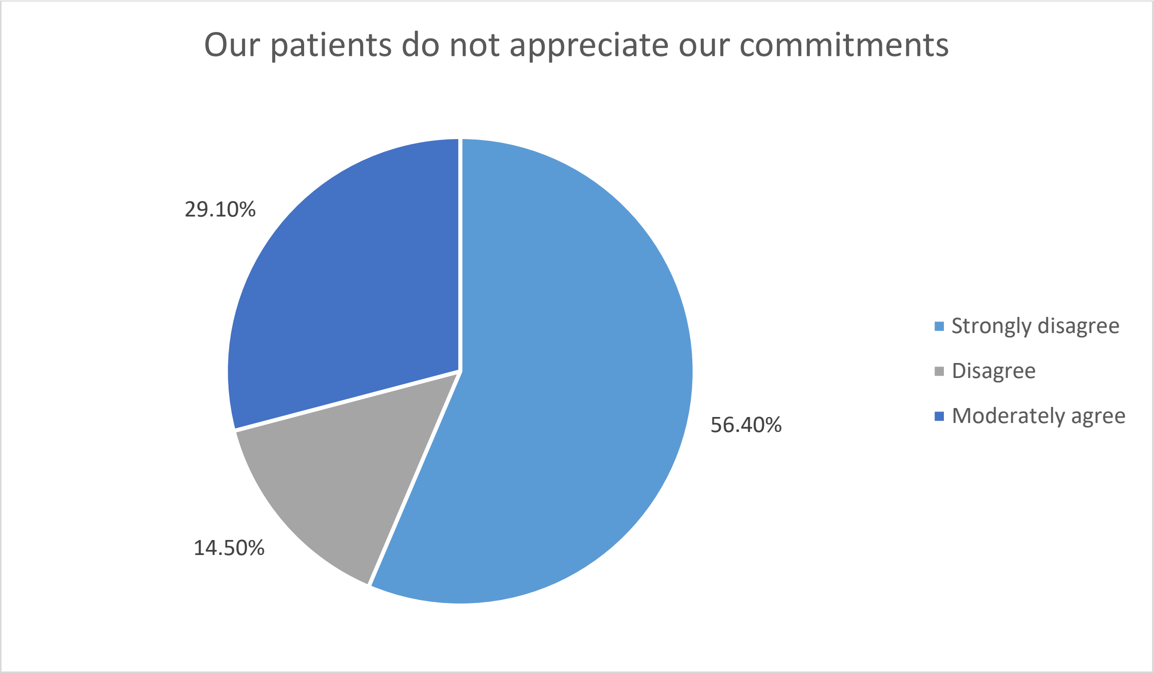

Figure 4.11: Shows our patient do not appreciate our commitments

Table 4.13: Not well appreciated in providing palliative care by our employer

Characteristic	**Frequency**	**Percentage**
Strongly disagree	64	58.2%
Disagree	31	28.2%
Moderately agree	15	13.6%
Total	**110**	**100.0%**

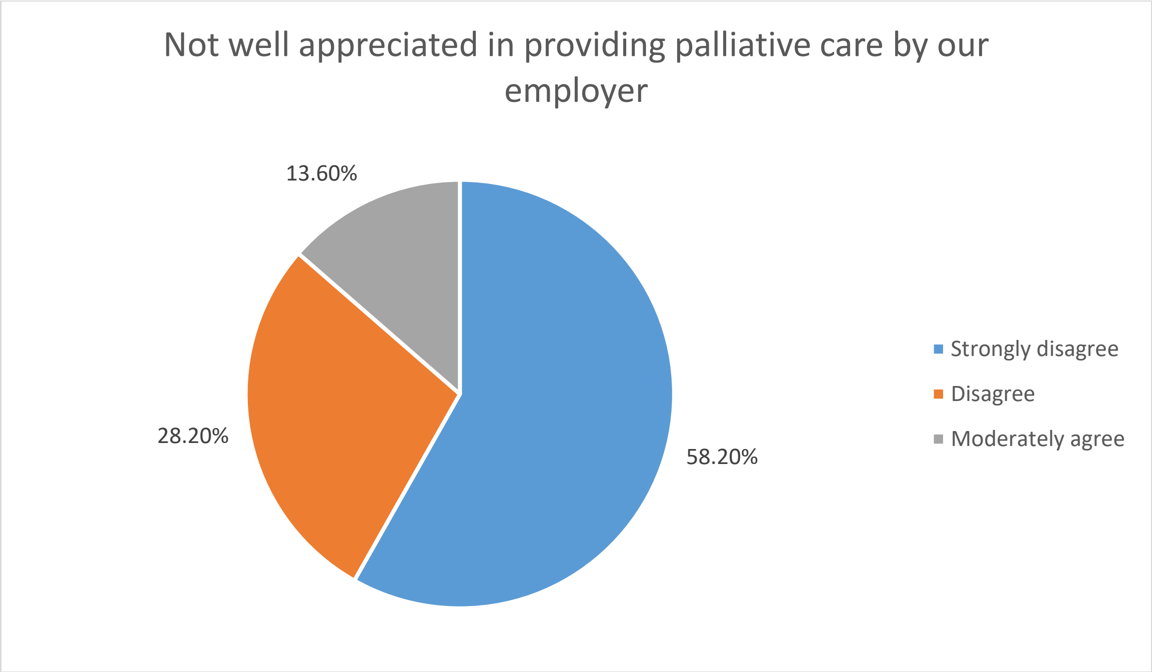

Figure 4.12: Shows not well appreciated in providing palliative care by our employer

70.9% of the participants disagreed that their patients don't appreciate their commitments towards administering palliative care while the rest of the participants agreed that their patients don't appreciate their commitments towards administering palliative care. Also, 86.4% of the participants disagreed that they are not well appreciated in providing palliative care by their employer while 13.6% of them agreed that they are not well appreciated in providing palliative care by their employer as demonstrated in the tables above.

Table 4.14: I don't like the long procedure involved in providing palliative care

Characteristics	**Frequency**	**Percentage**
Strongly disagree	47	42.7%
Disagree	32	29.1%
Moderately agree	16	14.5%
Strongly agree	15	13.6%
Total	**110**	**100.0%**

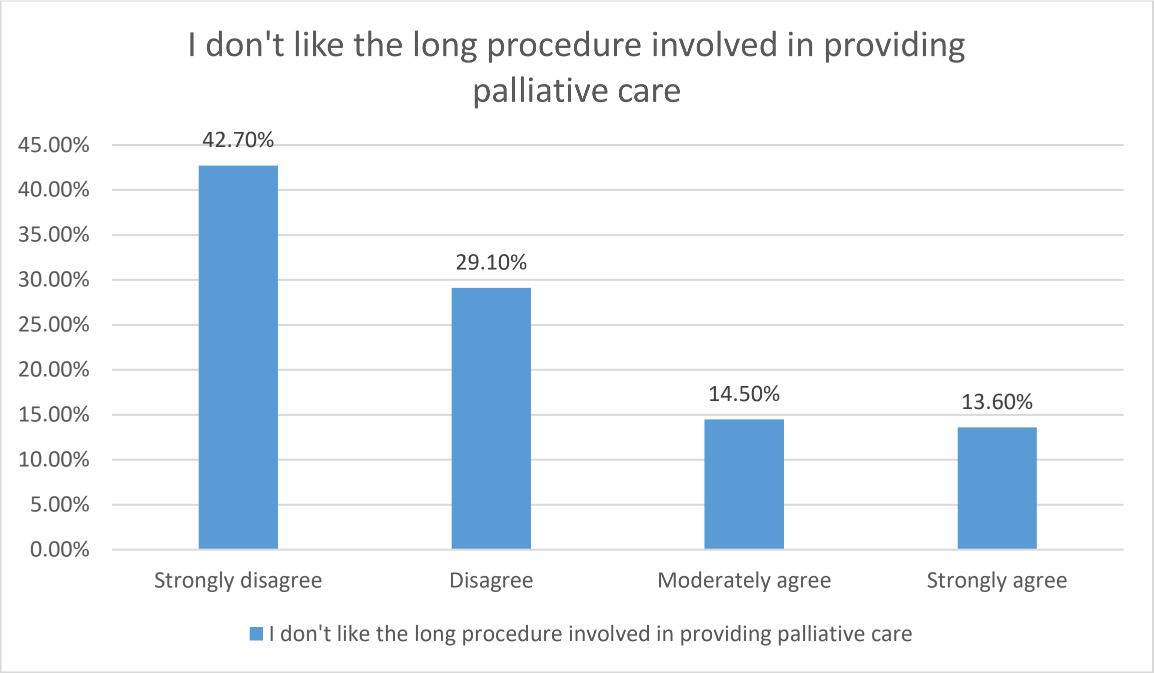

Figure 4.13: Shows I don’t like the long procedure involved in providing palliative care

71.8% of the participants disagreed that they don’t like the long procedure involved in providing palliative care while the rest 28.1% of them agreed that they don’t like the long procedure involved in providing palliative care.

4.4 Practices among clinical officers

Table 4.15: I always provide palliative care in surgical wards

Characteristics	**Frequency**	**Percentage**
Strongly disagree	32	29.1%
Disagree	46	41.8%
Moderately agree	16	14.5%
Strongly agree	16	14.5%
Total	**110**	**100.0%**

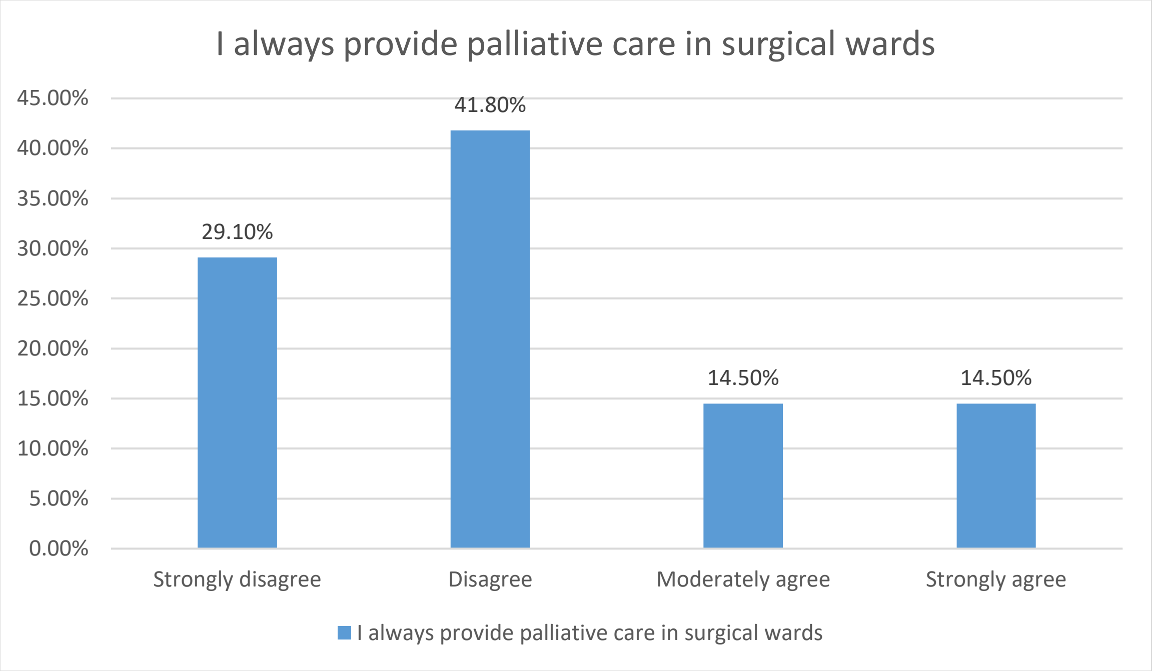

Figure 4.14: Shows provision of palliative care in surgical wards

In the tables above, 70.9% of the participants disagreed that they provide palliative care in surgical wards while the remaining 29.1 of them agreed that they provide palliative care in surgical wards.

Table 4.16: We always observe hygiene

Characteristics	**Frequency**	**Percentage**
Strongly disagree	16	14.5%
Disagree	16	14.5%
Agree	15	13.6%
Strongly agree	63	57.3%
Total	**110**	**100.0%**

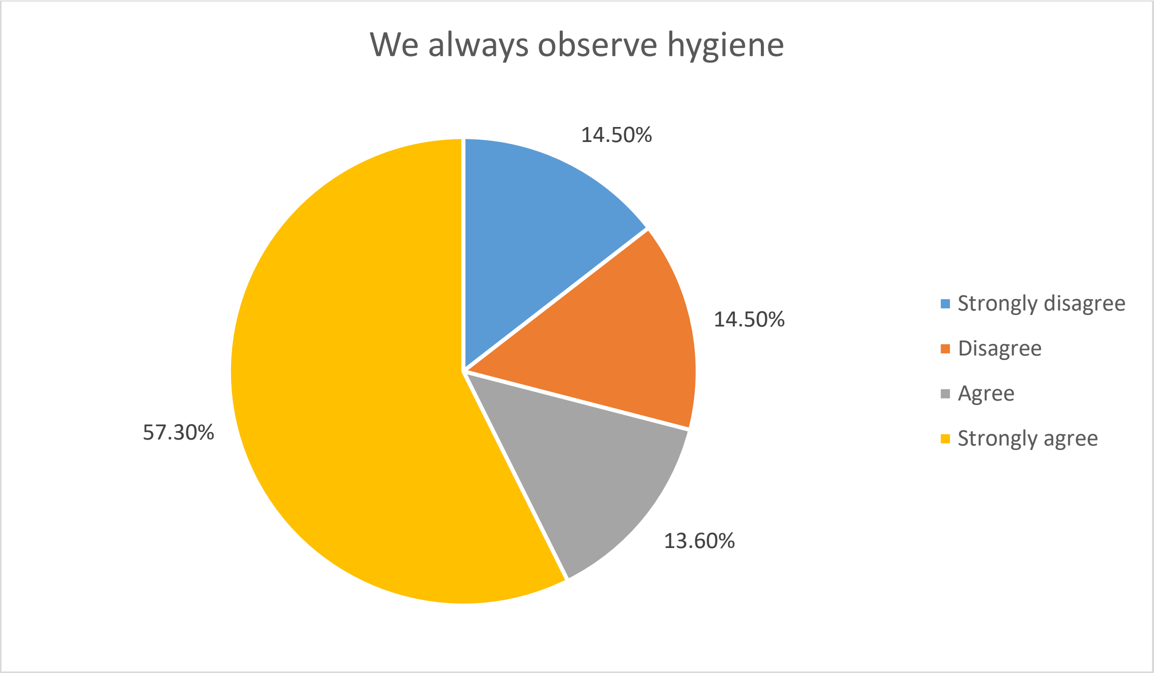

Figure 4.15: Shows we always observe hygiene

Table 4.17: I always dress my patients well before discharge

Characteristic	**Frequency**	**Percentage**
Strongly disagree	15	13.6%
Disagree	48	43.6%
Agree	15	13.6%
Strongly agree	32	29.1%
Total	**110**	**100.0%**

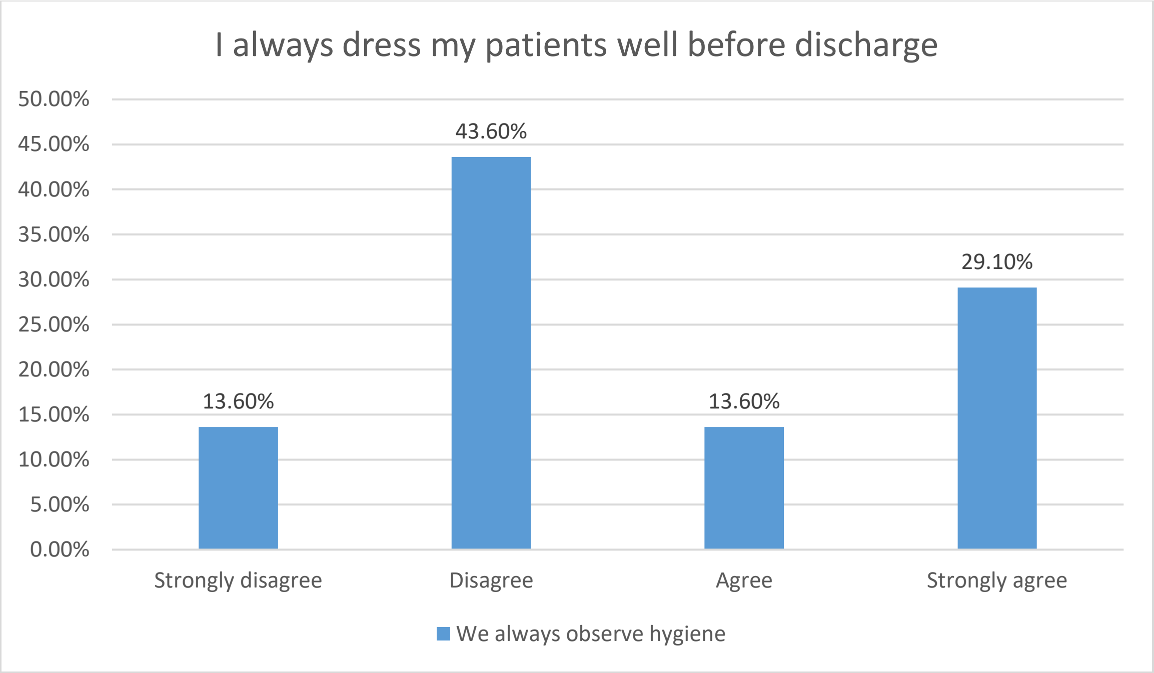

Figure 4.16: Shows always dress my patients well before discharge

Most of the participants agreed that they always observe hygiene when administering palliative care among the patients. Also, 57.3% disagreed that they always dress their patients well before discharge while the rest 42.7% agreed that they always dress their patients well before discharge.

Table 4.18: We conduct follow-ups to patients after discharge

Characteristics	**Frequency**	**Percentage**
Moderately agree	15	13.6%
Agree	16	14.5%
Strongly agree	79	71.8%
Total	**110**	**100.0%**

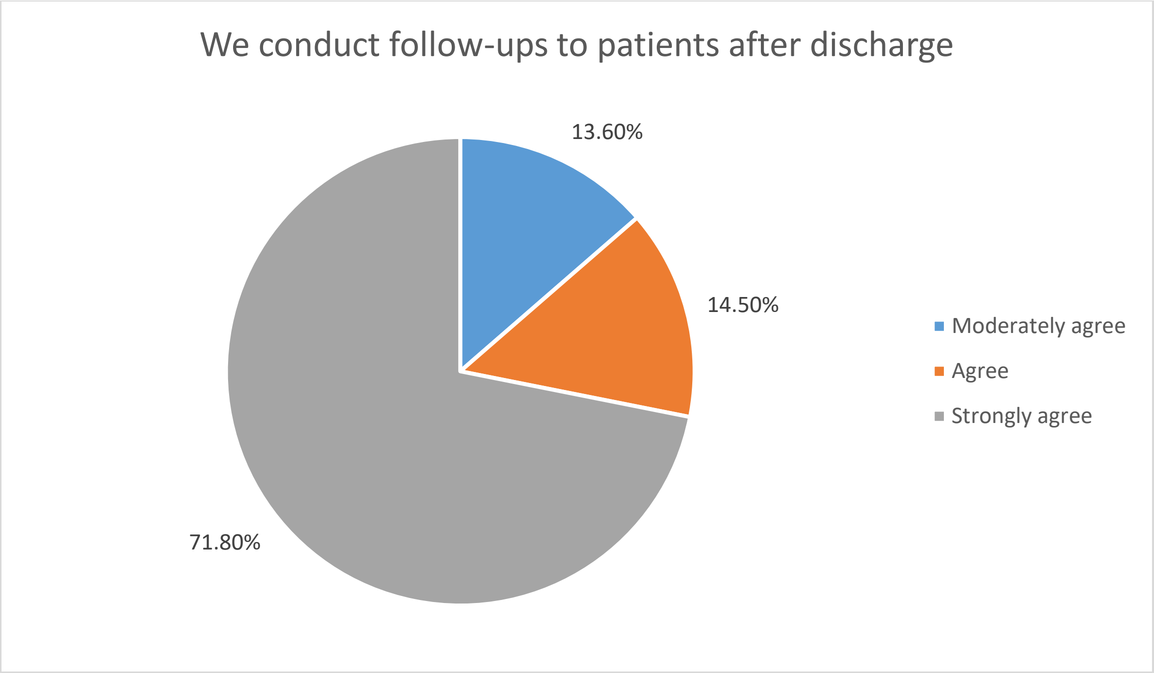

Figure 4.17: Shows follow-ups to patients after discharge

Table 4.19: We provide both in-patient and out-patient services

Characteristics	**Frequency**	**Percentage**
Strongly disagree	15	13.6%
Agree	15	13.6%
Strongly agree	80	72.7%
Total	**110**	**100.0%**

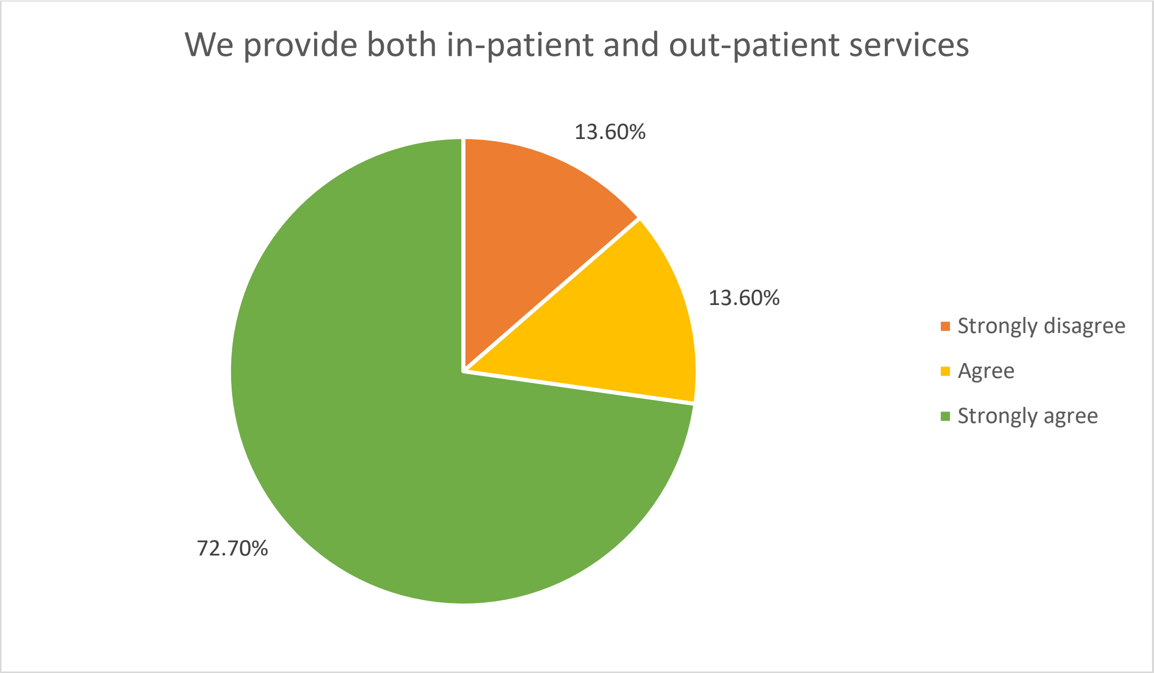

Figure 4.18: Shows both inpatient and outpatient services

All the participants agreed that they conduct a follow up to patients after discharge. Also, 86.3% of the participants agreed that they provide both in-patient and out-patient services while the rest disagreed on that statement.

Table 4.20: We observe medical standards when providing palliative care

Characteristic	Frequency	Percentage
Moderately agree	15	13.6%
Agree	15	13.6%
Strongly agree	80	72.7%
Total	**110**	**100.0%**

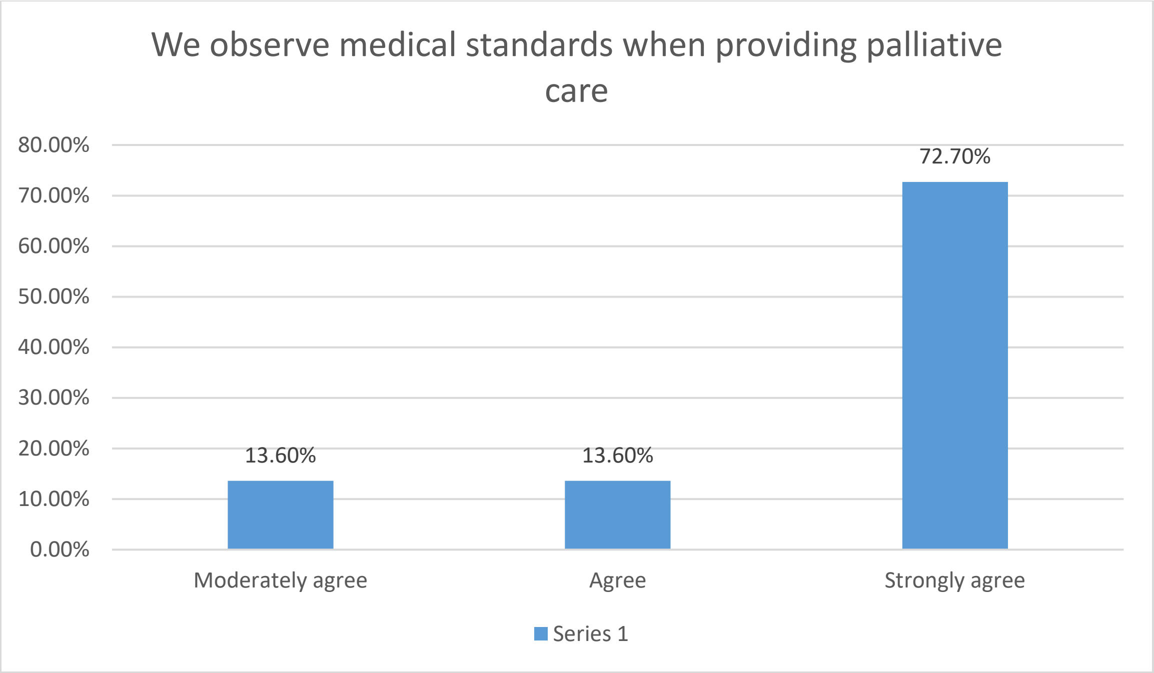

Figure 4.19: Shows medical standards when providing palliative care

All the participants agreed that they observe medical standards when providing palliative care.

CHAPTER FIVE: DISCUSSION

5.1 Demographic Characteristics

85.5% of the participants in the survey were general clinical officers at MTRH, 14.5% were occupying other positions in the hospital like administration. However, 58.2% of them have been in the clinical department in 2-4 years' period, 41.8% of the participants have been in the clinical department for over four years. Most of the participants (86.4%) had diplomas as their highest level as a clinical officer and the rest 13.6% had a degree as their highest level of clinical officer. 68 out of 110 participants had done clinical officer as their qualification while 4 of them had C.O oncology 7 C.O orthopaedics,6 C.O ENT,8 C.O peadiatrics,3 C.O EYE,2 C.O SKIN,12 C.O anesthesia's the area of specialization.

29.1% of the participants agreed that counselling of the patient is the standard medical procedure for palliative care while 28.2% of the participants said that there is do standard medical procedure and the don't know the standard medical procedure for palliative care respectively. 14.5% of them said that seeking convent with the patient is the standard medical procedure for palliative care. The survey had 110 participants whereby 47 of them were males and the rest 63 were females, this agrees with prior studies reported for gender disparity in palliative care knowledge. Some found that men were less likely to be aware of palliative care (Koffman et al., 2007; Boakye et al., 2019) or less knowledgeable Shalev et al., 2018) than women, anticipate further studies to examine gender as a determinant of disparity in palliative care knowledge.

5.2 Knowledge on palliative care

All healthcare institutions should work to make palliative care delivery a priority part of the healthcare system. Despite the fact that palliative care has many advantages, many people with chronic, life-threatening illnesses do not receive it. The main obstacles to applying palliative care are health professionals' overestimations of patients' prognoses and their lack of expertise in the field. 85.5 percent of the participants indicated they felt they had the necessary knowledge and skills to provide palliative care, whereas 14.5% claimed they lacked those skills. Additionally, everyone present agreed that palliative care requires adequate knowledge to provide as stated by (Begum and Khanam, 2015),to provide quality care at the end of life or for chronically ill patients, health workers must have good knowledge about palliative care.57% participants have advanced their training on palliative care while the rest 42.7% of the participants said that they haven't advanced their knowledge on palliative care, this indicates a great percentage of clinical officers have not advanced their knowledge(42.7%) this correlates with studies done by Ahmad and the colleague found out that 20.8% of the respondents had good knowledge towards PC and 59.4% had training of PC (Ahmad *et al*., 2015). The scholars reported that the provision of quality PC services requires however the education and training of health workers such as nurses in this field needs to become an integral part of all nursing school curricula as well as continuing nursing and medical education program offerings (Ahmad *et al*., 2015).

Therefore, lack of advanced knowledge in palliative care hinders the goal of palliative care which is achievement of best quality of life for patients and their families.

5.3 Perception on Palliative care

While 41.9 percent of participants disagreed that you should learn more and conduct more research on the palliative care, 58.1 percent of people agreed that you should do both in order to administer palliative care. 86.4 percent of participants strongly disagreed with the statement that they dislike giving palliative care, and the remaining 13.6 percent agreed. 42.7 percent of respondents agreed with the statement that providing palliative care is a time-consuming task, while 57.3 percent disagreed, this correlates with a study done in Lebanon showed that perception of Registered Nurses (RN) and Medical Doctors (MD) towards PC, nurses were twice as likely as physicians to disagree to give the right of "Do not resuscitate" to terminally ill patients (17.8% verses (vs) 8.6%) whereas MDs were twice as likely as RNs to disagree with giving hope to terminally ill patients against all odds (7.5% vs. 3.6%). Therefore Perception is a paramount feature in utilizing the facilities provided by health care providers to help the sufferers by providing them physical and emotional support (Gopal and Archana, 2016).

5.4Practices among clinical officers

29.1 percent of the participants agreed that they provide palliative care on surgical wards, compared to 70.9 percent of the people who disagreed this contradicts a study by Begum and Khanam (2015), which reported that reported that the levels of practice of staff nurses on palliative care in selected hospitals of Guwahati city, maximum 48% practiced adequately whereas 43% practiced moderately adequate and only 9% practiced inadequately. The majority of participants concurred that they always practice hygiene when providing patients with palliative care.

Additionally, 42.7 percent of respondents agreed that they always dress their patients well before discharge, compared to 57.3 percent who disagreed.

CHAPTER SIX: SUMMARY, CONCLUSION AND RECOMMENDATION

6.1 Summary

This study came to the conclusion that clinical officers lack knowledge and practices of palliative care, particularly the element related to standard medical procedure, and that this knowledge gap prevents them from practicing palliative care to patients. Ages, educational background, year of experience were all significant indicators of knowledge of palliative care.

Some participants indicated positive perception towards palliative care, 58.1 percent of people agreed that you should do both (learn more and conduct more research on the palliative care in order to administer palliative care.

6.2 Conclusion and Recommendation

Recommendations based on the findings are made to help implement the palliative care Programs at MTRH.

Palliative care programs should be created to address clinical officers' knowledge level, practices by implementing on job training and mentorship, and educational needs in order to promote high-quality palliative care for patients and their families. This study offers pertinent data that can be used to create palliative care teaching programs for clinical officers who treat patients with terminal illness. Palliative care should also be specialized in accordance with the peculiarities of the disease and coordinated professional specialties. Future research should study the experiences of various healthcare professionals and non-cancer patients receiving palliative care in order to create efficient training programs for palliative care specialists working with non-cancer patients. Health care policy makers should strengthen and expand training of existing health professionals, embedding palliative care into the core curricula of all new health professionals. Providing palliative care should be considered an ethical duty for health professionals. Having knowledge and good practices about palliative care will bridge the gap of people in need of palliative care, WHO 2020, each year, an estimated 40 million people are in need of palliative care; 78% of them people live in low- and middle-income countries where Kenya is included.

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APPENDICES

APPENDIX I: INFORMED CONSENT

KNOWLEDGE, PERCEPTION, PRACTICES TOWARDS PALLIATIVE CARE AMONG CLINICAL OFFICERS IN MOI TEACHING AND REFERAL HOSPITAL UASIN GISHU COUNTY, KENYA

Thank you for accepting to participate in this study. The study aims to determine knowledge, perception and practices towards palliative care among clinical officers in MTRH. Your participation is voluntary and should you choose not to participate, you will not be discriminated against in any way. The information given will be treated with at most confidentiality and the information obtained will be analyzed and the result obtained may help fill the gaps in management and provision of palliative care at Moi Teaching and Referral Hospital.

If you consent to participate in the study kindly sign below

Participant signature……………………date …………

Witnessed by ……………………….......date…….

(Researcher, Isaac Nyabayo)

APPENDIX II: RESEARCH QUESTIONNAIRE

KNOWLEDGE, PERCEPTION, PRACTICES TOWARDS PALLIATIVECARE AMONG CLINICAL OFFICERS MTRH

CODE---

DATE---

My name is Mirieri Isaac Nyabayo, student number CMS/PALHC/10/003/2021 pursuing Higher Diploma Clinical Medicine in Palliative and Hospice Care. As part of my academic requirements I am carrying out a study on "Knowledge, Perception and Practices on Palliative Care among Clinical Officers at MTRH". Please assist in filling this questionnaire to enable me complete writing this project. Thank you.

Please answer all Questions by inserting a TICK where appropriate or alternatively please write in the space provided.

Section 1: Socio-Demographic Factors

1. Position

C.O Admin ☐ C.O ☐ ☐

Other (specify)……………………………………………………………………….

1. Period in years in the clinical department?
   Less than 1 year ☐
   1-2 years ☐
   2-4 years ☐
   Above 4 years ☐
2. Your Gender: Male ☐ Female ☐
3. Your age brackets
   Below 30 years ☐ 30-40 years ☐ 40-50 years ☐ More than 50 years ☐
4. What is your level of training as a clinical officer?
   Diploma ☐
   ☐

Degree ☐

Post-graduate ☐

5. What is your qualification? (can tick more than one)

Clinical officer ☐

C.O Orth ☐

C.O ENT ☐

C.O PAED ☐

C.O ANAEST ☐

C.O EYE CLINIC ☐

C.O ONCOLOGY ☐

C.O SKIN ☐

6. What is the standard medical procedure for Palliative Care? (please describe)

………………………………………………………………………………………………

………………………………………………………………………………………………

………………………………………………………………………………………………

7. What are some of the factors that affect your ability to provide professional Palliative care?

………………………………………………………………………………………………

………………………………………………………………………………………………

………………………………………………………………………………………………

Section 2: Knowledge on Palliative Care

8. Please rate how the following factors related to your Knowledge on Palliative Care on a scale of 1-5 where 1 (strongly disagree), 2 (disagree), 3 (moderately agree), 4 (agree), 5 (strongly agree).

Indicator	**1**	**2**	**3**	**4**	**5**
I have sufficient knowledge and skills on palliative care					
Palliative care needs sufficient knowledge to administer					
I have advanced my training on palliative care					
We learn from each other on provision of palliative care					
I need to learn more on palliative care					

Section 3: Perception on Palliative Care

9. Please rate how the following perception factors affect palliative care administration on a scale of 1-5 where 1 (strongly disagree), 2 (disagree), 3 (moderately agree), 4 (agree), 5 (strongly agree).

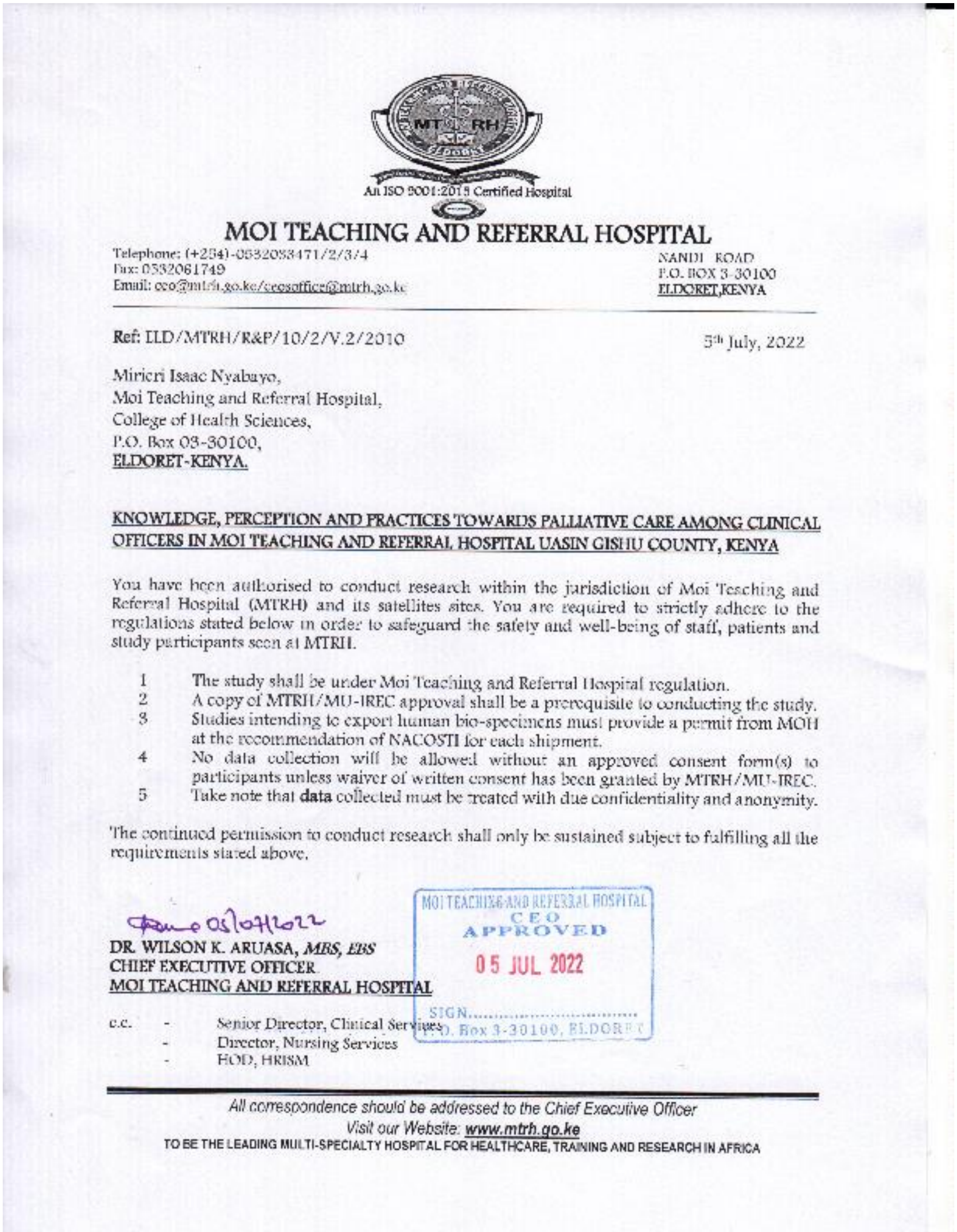
Indicator	**1**	**2**	**3**	**4**	**5**
I don’t like providing palliative care					
Palliative care is a tiresome procedure to administer					
You need to widely learn on palliative care to administer it					
Our patients do not appreciate our commitment					
We are not well appreciated in providing palliative care by our employer					
I don’t like the long procedure involved in providing palliative care					

Section 4: Practices among clinical officers

10. Please rate how the following practices affect palliative care administration on a scale of 1-5 where 1 (strongly disagree), 2 (disagree), 3 (moderately agree), 4 (agree), 5 (strongly agree).

Indicator	**1**	**2**	**3**	**4**	**5**
I always provide palliative care in surgical wards					
We always observe hygiene					
I always dress my patients well before discharge					
We conduct follow-ups to patients after discharge					
We provide both in-patient and out-patient services					
We observe medical standards when providing palliative care					

APPENDIX III: MTRH APPROVAL



An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

Telephone: (+254)-0532033471/2/3/4
Fax: 0532061749
Email: ceo@mtrh.go.ke/ceosoffice@mtrh.go.ke

NANDI ROAD
P.O. BOX 3-30100
ELDORET,KENYA

Ref: ELD/MTRH/R&P/10/2/V.2/2010

5th July, 2022

Miricri Isaac Nyabayo,
Moi Teaching and Referral Hospital,
College of Health Sciences,
P.O. Box 03-30100,
ELDORET-KENYA.

KNOWLEDGE, PERCEPTION AND PRACTICES TOWARDS PALLIATIVE CARE AMONG CLINICAL OFFICERS IN MOI TEACHING AND REFERRAL HOSPITAL UASIN GISHU COUNTY, KENYA

You have been authorised to conduct research within the jurisdiction of Moi Teaching and Referral Hospital (MTRH) and its satellites sites. You are required to strictly adhere to the regulations stated below in order to safeguard the safety and well-being of staff, patients and study participants seen at MTRH.

1 The study shall be under Moi Teaching and Referral Hospital regulation.
2 A copy of MTRH/MU-IREC approval shall be a prerequisite to conducting the study.
3 Studies intending to export human bio-specimens must provide a permit from MOH at the recommendation of NACOSTI for each shipment.
4 No data collection will be allowed without an approved consent form(s) to participants unless waiver of written consent has been granted by MTRH/MU-IREC.
5 Take note that **data** collected must be treated with due confidentiality and anonymity.

The continued permission to conduct research shall only be sustained subject to fulfilling all the requirements stated above.

05/07/2022

DR. WILSON K. ARUASA, *MBS, EBS*
CHIEF EXECUTIVE OFFICER
MOI TEACHING AND REFERRAL HOSPITAL

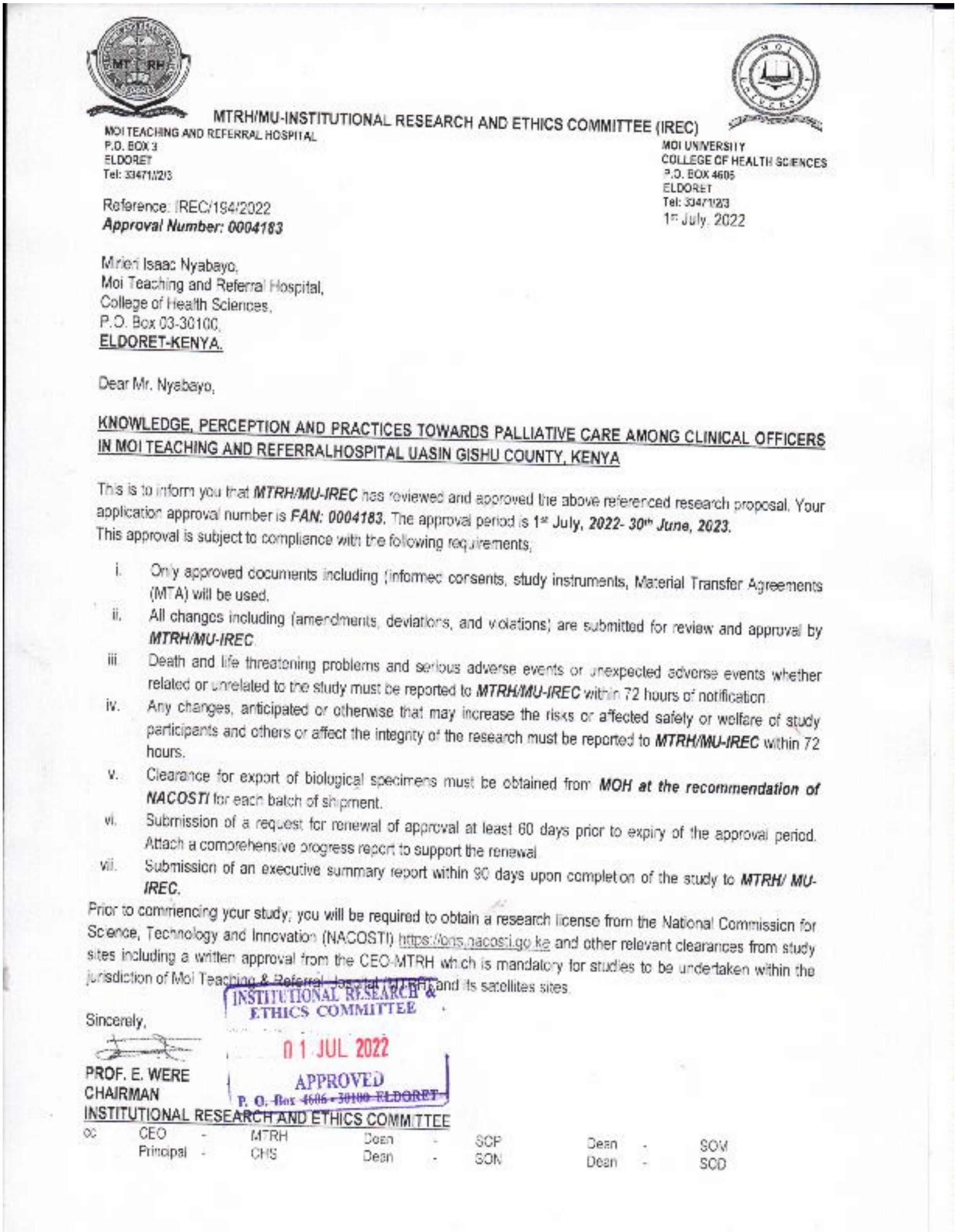
MOI TEACHING AND REFERRAL HOSPITAL
CEO
APPROVED
05 JUL 2022
SIGN..............................
P.O. Box 3-30100, ELDORET

c.c. - Senior Director, Clinical Services
- Director, Nursing Services
- HOD, HRISM

All correspondence should be addressed to the Chief Executive Officer
Visit our Website: www.mtrh.go.ke
TO BE THE LEADING MULTI-SPECIALTY HOSPITAL FOR HEALTHCARE, TRAINING AND RESEARCH IN AFRICA

59

APPENDIX IV: IREC APPROVAL



MTRH/MU-INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE (IREC)

MOI TEACHING AND REFERRAL HOSPITAL
P.O. BOX 3
ELDORET
Tel: 33471/2/3

MOI UNIVERSITY
COLLEGE OF HEALTH SCIENCES
P.O. BOX 4606
ELDORET
Tel: 33471/2/3

1st July, 2022

Reference: IREC/194/2022
Approval Number: 0004183

Mirieri Isaac Nyabayo,
Moi Teaching and Referral Hospital,
College of Health Sciences,
P.O. Box 03-30100,
ELDORET-KENYA.

Dear Mr. Nyabayo,

KNOWLEDGE, PERCEPTION AND PRACTICES TOWARDS PALLIATIVE CARE AMONG CLINICAL OFFICERS IN MOI TEACHING AND REFERRALHOSPITAL UASIN GISHU COUNTY, KENYA

This is to inform you that ***MTRH/MU-IREC*** has reviewed and approved the above referenced research proposal. Your application approval number is ***FAN: 0004183.*** The approval period is 1st ***July, 2022- 30th June, 2023.*** This approval is subject to compliance with the following requirements;

i. Only approved documents including (informed consents, study instruments, Material Transfer Agreements (MTA) will be used.
ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by ***MTRH/MU-IREC.***
iii. Death and life threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to ***MTRH/MU-IREC*** within 72 hours of notification.
iv. Any changes, anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to ***MTRH/MU-IREC*** within 72 hours.
v. Clearance for export of biological specimens must be obtained from ***MOH at the recommendation of NACOSTI*** for each batch of shipment.
vi. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal.
vii. Submission of an executive summary report within 90 days upon completion of the study to ***MTRH/ MU-IREC.***

Prior to commencing your study, you will be required to obtain a research license from the National Commission for Science, Technology and Innovation (NACOSTI) https://oris.nacosti.go.ke and other relevant clearances from study sites including a written approval from the CEO-MTRH which is mandatory for studies to be undertaken within the jurisdiction of Moi Teaching & Referral Hospital (MTRH) and its satellites sites.

INSTITUTIONAL RESEARCH &
ETHICS COMMITTEE
01 JUL 2022
APPROVED
P. O. Box 4606 - 30100 ELDORET

Sincerely,

PROF. E. WERE
CHAIRMAN
INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE

cc CEO - MTRH Dean - SOP Dean - SOM
Principal - CHS Dean - SON Dean - SOD