

Barriers and Facilitators to Implementing Home-Based Palliative Care in a Resource-Constrained Setting: A Qualitative Descriptive Study from the West Bank, Palestine

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Research Article

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Abstract

Background

In many low- and middle-income countries (LMICs), palliative care is concentrated in hospitals, which limits access for people affected by cancer, physical frailty, financial constraints, and the cost of travel. These barriers are more acute in the West Bank, where the referral system is fragmented and movement is restricted. Home-based palliative care may be a suitable response, but its barriers, facilitators, and implementation requirements in the West Bank are poorly understood.

Aim

To explore healthcare professionals' perceptions of the barriers, facilitators, and implementation requirements for home-based palliative care for people with cancer in the West Bank, Palestine.

Design:

A qualitative descriptive study using semi-structured interviews and reflexive thematic analysis was conducted. We used the socio-ecological model to interpret factors operating at the individual, interpersonal, organizational, community, and contextual levels.

Setting/participants:

All eligible palliative-care professionals ($n = 7$) were purposively recruited from an oncology and palliative care hospital in East Jerusalem, the only institution providing palliative-care services during the study period. Therefore, sample size was determined by the accessible population rather than by data saturation.

Results

Five themes were identified: accessibility of home-based palliative care services, psychosocial benefits of home visits, multidisciplinary teamwork in palliative care delivery, facilitators to implementing home-based palliative care services, and barriers to implementing home-based palliative care services. Participants described potential benefits for people affected by frailty, transportation difficulties, and restricted movement. At the same time, they identified workforce shortages, limited resources, travel barriers, and the misconception that palliative care means giving up treatment.

Conclusions

Introducing home-based palliative care requires trained multidisciplinary teams, clear referral pathways, hospital–home coordination, family engagement, community awareness, reliable transportation and medication systems, and policy support. Future service development should also incorporate the perspectives of patients and family caregivers.

What is already known about the topic?

- Palliative care services in Palestine remain concentrated in hospitals, and transportation, cost, referral, and movement barriers can restrict access.
- Home-based palliative care can support access, continuity, and family involvement, but its implementation requirements in the West Bank are underexplored.

What this paper adds

- Healthcare professionals viewed home-based palliative care as a practical response to frailty, transportation difficulties, and movement restrictions.
- Implementation requires coordinated action across the workforce, referral, transportation, medication, organizational, community, and policy levels.

Implications for practice, theory, or policy

- A context-sensitive service model should define eligibility, team roles, hospital-home coordination, transportation, medication access, family engagement, and community education.

Introduction

Palliative care aims to improve the quality of life of patients and their families who experience problems associated with life-threatening illness. It seeks to prevent and relieve suffering by addressing physical, psychological, and spiritual concerns (World Health Organization [WHO], 2020). Although palliative care services tend to be limited across many low- and middle-income countries (LMICs), including those in the Eastern Mediterranean Region (EMR), available services are often concentrated in hospitals and poorly integrated with primary care and community- and home-based services. Therefore, organized palliative care can be difficult to access in many resource-constrained settings (Fadhil et al., 2017; WHO, 2025). The implementation of HBPC in Palestine may be influenced by broader health-system constraints, including workforce shortages, limited funding, fragmented services, inadequate policy support, and limited access to essential medicines (Abu-Odah et al., 2022). As the global need for palliative care grows, substantial inequities in access persist, particularly in LMICs, where services and essential pain-relief interventions remain unavailable to many people experiencing serious health-related suffering (Abu-Odah et al., 2020; Knaul et al., 2018).

Cancer represents an important and increasing health burden in the West Bank, and substantial cancer-related mortality has been reported among the Palestinian population (Abu-Rmeileh et al., 2016).

Palliative care in the Palestinian context has been limited, and specialized services are relatively underdeveloped (Shawawra & Khleif, 2011). People with advanced cancer may require pain and symptom management, psychosocial support, and family-centered care. However, services tend to be concentrated in hospitals, while costs, transportation barriers, fragmented referral pathways, and movement restrictions can impede access in the West Bank (Mitwalli et al., 2023; Nasr et al., 2021; United Nations Office for the Coordination of Humanitarian Affairs [OCHA], 2023).

Home-based palliative care can enable patients to receive end-of-life care in a familiar environment while supporting continuity of care, family involvement, and preservation of dignity and autonomy. Evidence from an umbrella review indicates that home is frequently preferred as a place of end-of-life care and death; however, achieving this preference requires accessible, well-coordinated home-based palliative care and adequate support for family caregivers (Pinto et al., 2024). Home-based palliative care (HBPC) brings assessment, symptom management, and family support closer to where patients live. International evidence suggests that it can improve access and continuity, support care at home, and reduce avoidable hospital use when clinically appropriate (Feliciano & Reis-Pina, 2024; Gomes et al., 2013; Gonzalez-Jaramillo et al., 2021). These potential benefits may be particularly relevant in the West Bank, where travel and mobility barriers affect both patients and healthcare professionals.

The implementation of HBPC in the West Bank remains underexplored. Some organizations provide home visits, but there is no standardized program with clearly defined eligibility criteria, referral pathways, service availability, and hospital-home coordination. Qualitative evidence from Gaza has identified related barriers and facilitators, but evidence specific to the West Bank has been limited (Abusenjar et al., 2026). Healthcare professionals are important informants because they are directly involved in care delivery, coordination, symptom management, and multidisciplinary support.

This study sought to address the limited evidence base on the implementation of HBPC for people with cancer in the West Bank. It aimed to explore healthcare professionals' perceptions of barriers, facilitators, and implementation requirements. The research question was: What factors may hinder or support the implementation of HBPC for people with cancer in the West Bank?

Methods

Design and framework

A qualitative descriptive design was used to present a practice-based account of healthcare providers' perceptions of implementing HBPC in the West Bank. The study was guided by a naturalistic paradigm, and participants' perceptions were interpreted in relation to the practice environment in which HBPC would be implemented (Creswell & Poth, 2018). The study was conducted in accordance with the principles of the Declaration of Helsinki and applicable institutional and national ethical requirements.

The socio-ecological model was used as a sensitizing theoretical framework to consider interacting factors at the individual, interpersonal, organizational, community, and contextual or policy levels

(Bronfenbrenner, 1979; McLeroy et al., 1988). The framework guided the development of the interview guide and the interpretation of implementation-related factors.

Research team

The first author, a registered nurse and a student in the Master of Oncology and Palliative Nursing (MOPN) program, served as the primary researcher and was responsible for the design, data collection, analysis, and interpretation of the study findings. During the study, he worked as a palliative care nurse at Augusta Victoria Hospital (AVH) and had approximately six years of clinical experience, including five years in oncology and palliative care. The researcher was previously acquainted with some participants and was introduced to them as the researcher conducting the study for his master's thesis.

The second author is associate professor who was the thesis supervision offered methodological and academic supervision throughout the research process.

Setting and participants

The study was conducted at AVH in East Jerusalem, a cancer hospital serving patients from East Jerusalem, the West Bank and Gaza Strip. AVH was selected because of its involvement in oncology, palliative care, and home visits. Other institutions providing HBPC in the West Bank were not included. Al-Sadeel Society was excluded, as it is dependent mostly on volunteers, while Bethlehem Care and Hospice Trust elected not to participate.

Participants included palliative care professionals, some of whom had direct experience providing HBPC through home visits. Their responses were interpreted according to their level of direct experience with HBPC.

The sample consisted of seven healthcare professionals from nursing, medicine, pharmacy, nutrition, physiotherapy, and psychology. The suitability of the sample size was considered in the context of the specificity of the research question and target population, the range of disciplines represented, and the richness of the interviews conducted in a single institution. Data saturation was not used as the primary criterion for determining sample size. The study population comprised a small, defined group of healthcare professionals actively involved in palliative care at the study site. At the time of recruitment, palliative care services were concentrated in a single institution, and no additional eligible professionals working specifically in palliative care were identified at other institutions. As such, we used purposive/total population sampling to recruit all eligible participants from the accessible population. Therefore, the final sample reflected the available pool of palliative care professionals rather than a predetermined saturation threshold.

Potentially eligible healthcare professionals were identified through personal contacts and unit lists at AVH. Unit managers helped confirm eligibility according to the inclusion criteria. Eight healthcare

professionals met the eligibility criteria, and all were contacted and invited to participate. Seven agreed to participate and completed face-to-face interviews; one declined because of a busy schedule. All invitees responded to the invitation, and no participants withdrew after providing consent.

The inclusion criteria were at least six months of experience in oncology or palliative care; active involvement in patient care, including care management, symptom control, and psychosocial support, among other things; and the ability to provide informed consent. Purposive sampling was used to achieve maximum variation in professional experience.

Of the seven participants, only three had prior direct experience with palliative care home visits. P1 had approximately two years of experience conducting home visits, whereas P4 had approximately one year of such experience. P5, a physician and the head of the palliative care unit, was also actively involved in home visits. He had initiated the home-visit service and was primarily responsible for its implementation. The other four participants (P2, P3, P6, and P7) were experienced in palliative care within their respective professions but had never conducted home visits. Participants’ direct experience with home-based palliative care visits is summarized in Table 1.

Table 1 Participants’ Direct Experience With Home-Based Palliative Care Visits	
Participant	Direct home-visit experience
P1	Yes – approximately 2 years
P2	No
P3	No
P4	Yes – approximately 1 year
P5	Yes – direct experience; initiator/founder and supervisory role
P6	No
P7	No

In qualitative research, sample size is determined by the depth and relevance of the data rather than by numerical considerations alone. Therefore, the multidisciplinary composition of the sample was an important consideration. The demographic and professional characteristics of the participants are presented in Table 2.

Data collection

Data were collected from February to March 2026 through semi-structured interviews. The open-ended interview guide was informed by the socio-ecological model, literature on palliative care in low- and middle-income and resource-constrained settings, and approaches to assessing palliative care

development (Abu-Odah et al., 2020; Bronfenbrenner, 1979; WHO, 2021). The interviews addressed the availability, accessibility, sustainability, and quality of HBPC services, as well as barriers, facilitators, and requirements for implementation. The semi-structured interview guide was developed specifically for this study and had not been previously published. An English-language version of the study-specific interview guide is provided as Supplementary File 1.

The interview guide was pilot-tested with one potential participant from the same clinical setting, who was subsequently included in the final sample. Some wording minor changes were made after the pilot test, but the substance of the interview guide was still the same (van Teijlingen & Hundley, 2001). Therefore, the pilot interview data were included in the final analysis.

Face-to-face interviews were conducted in a private office at AVH to protect participants' privacy. No other individuals were present during the interviews. The interviews were conducted in Arabic, lasted 30–60 minutes, and were audio-recorded after participants provided consent

The audio recordings were transcribed using automated transcription and translation software recommended by the second author. The first author independently listened to each recording while reviewing the corresponding transcript and corrected any identified transcription errors. Arabic-language interviews were then translated into English using the same software. To enhance translation accuracy, the first author reviewed the English translations against the original Arabic recordings and transcripts with assistance from an English-language teacher. The second author subsequently conducted an additional review of the translated transcripts. The transcripts were returned to participants for review and verification. No corrections or additional comments were received.

Data analysis and trustworthiness

The first author conducted reflexive thematic analysis following Braun and Clarke's (2006, 2019, 2021) six iterative phases: familiarization with the data, initial coding, theme construction, theme review and development, theme definition and naming, and report writing. He listened to the audio recordings, read the transcripts multiple times, made notes of his initial observations, generated initial codes, constructed potential themes, and refined the themes based on the coded data and the full data set. Illustrative quotations were selected to represent the themes. NVivo 14 was used to organize the data (Lumivero, 2023).

An inductive approach was used for the analysis. The socio-ecological model was used as an interpretive framework for examining the themes at the individual, interpersonal, organizational, community, and policy levels; it was not used as a preset codebook. The second author reviewed the developing analysis and critically examined the interpretations.

Methodological transparency was supported by an audit trail documenting decisions made during data collection and analysis, a reflexive journal recording assumptions and interpretations, and peer

debriefing with the second author. These strategies were used to support credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985).

Ethical considerations

Ethical approval

was obtained before data collection from the Institutional Review Board of Bethlehem University, the AVH Ethics Committee, and the Palestinian Ministry of Health Research Committee. Each committee reviewed and approved the study protocol before data collection began.

After ethical approval was obtained, participants were invited to take part in the study and provided with written and verbal information about the study aim, voluntary participation, confidentiality, audio recording, and their right to withdraw without penalty. Written informed consent was obtained before participation. Participant codes were used in place of names in transcripts and reports. Audio recordings, transcripts, consent forms, and other study documents were stored in password-protected files accessible only to the researcher.

Results

Five themes were identified: accessibility of home-based palliative care services, psychosocial benefits of home visits, multidisciplinary teamwork in palliative care delivery, facilitators to implementing home-based palliative care services, and barriers to implementing home-based palliative care services. Across these themes, participants considered HBPC both an important service and a challenging model to implement. The relationships between the themes and sub-themes are illustrated in Fig. 1.

Table 2
Participant characteristics

Participant	Age	Gender	Profession	Years of Healthcare Experience	Years of Palliative Care Experience
P1	30	Male	Nurse/Palliative Care Coordinator	6.5	1.5
P2	31	Female	Clinical Pharmacist	7	5
P3	32	Female	Clinical Nutritionist	9	4
P4	34	Male	Nurse/Head Nurse	13	3
P5	44	Male	Physician/Head of palliative care unit	13	10
P6	52	Male	Physiotherapist	21	7
P7	34	Male	Clinical Psychologist	12	1.5

Theme 1: Accessibility of home-based palliative care

Accessibility was identified as a key factor affecting the implementation of HBPC. Participants indicated that many patients had difficulty accessing hospitals because they were physically frail, immobile, or depended on family members for transportation. Therefore, providing care at home could reduce the need for frequent travel to hospitals.

The issue of accessibility was also related to the specific context of the West Bank. Patients may face difficulties accessing services because of economic constraints, long distances, transportation difficulties, and movement restrictions. In this context, accessibility refers not only to the availability of services but also to patients' ability to obtain and benefit from them.

Home palliative care makes it easier for patients who cannot reach the hospital because of transportation difficulties or physical limitations. (P3)

Some patients are confined to bed and are unable to travel from their residences to hospitals. (P4)

Sometimes, patients end up missing their scheduled appointments since transportation can be an issue. (P1)

A lot of patients suffer from physical weakness and exhaustion. (P6)

These accounts indicate that participants found HBPC to be a practical means of addressing physical, geographic, and transportation barriers to care. In this context, accessibility was understood as a practical concern rather than an issue of clinical services alone.

Theme 2: Psychosocial benefits of home visits

Participants noted the psychological and social benefits of home visits. Providing palliative care at home was seen as increasing patients' and families' emotional comfort and sense of security. The home environment was also considered important for preserving patients' dignity and reducing stress.

Participants identified home visits as one way to reduce loneliness and depression among patients who were unable to leave their homes. They also noted that home visits could facilitate better communication between healthcare professionals and family caregivers.

When patients know that someone will visit them at home, they feel reassured and supported. (P3)

Patients feel emotionally safe when surrounded by their family members at home. (P7)

Patients were perceived to feel less anxious when receiving care at home rather than in the hospital. (P5)

Home visits enable family members to be actively engaged in decision making regarding the patient's health. (P1)

This theme indicates that participants associated HBPC with greater patient comfort, family involvement, emotional support, and overall well-being. These benefits are particularly important for patients with advanced illness and their families, as their needs extend beyond symptom control to emotional support and guidance.

Theme 3: Multidisciplinary teamwork in palliative care delivery

Participants stressed the importance of multidisciplinary teamwork in HBPC. The needs of patients receiving palliative care were described as diverse and dynamic; they required input from doctors, nurses, physiotherapists, psychologists, nutritionists, pharmacists, and other professionals. Each discipline was considered to make a valuable contribution to HBPC.

Participants also emphasized the importance of communication between the hospital-based healthcare team and professionals providing HBPC. Effective communication was considered necessary so that patients would know whom to contact when their condition changed or problems arose.

Each professional plays a complementary role in delivering care to a patient. (P6)

Intercommunication among the members of the healthcare team is critical for continuity of care. (P1)

Besides receiving medical care, patients in palliative care require emotional and psychological support. (P7)

Each member of the team brings something unique depending on the needs of the patient. (P3)

These accounts show that participants considered multidisciplinary teamwork important for ensuring the safety and comprehensiveness of HBPC. A single discipline cannot address the full range of patient needs, particularly when medical, psychological, nutritional, mobility, and family needs coexist.

Theme 4: Facilitators to implementing home-based palliative care services

Participants identified several factors that could facilitate the implementation of HBPC, particularly training and professional expertise. They emphasized the importance of communication skills, symptom-management skills, and the ability to provide care safely in the home environment. Institutional support was also considered important; participants noted the need for adequate resources, coordination, and organized programs to support home visits.

Training is required to enhance the capabilities of the team prior to providing services within the home. (P2)

The family feels that they are not alone when there is follow-up from the healthcare team. (P3)

We require administrative support from the hospital to ensure regular home visits. (P6)

Families tend to be more open towards home-based care if they trust the health workers. (P1)

These facilitators operated at multiple levels. Training enhanced individual professional readiness, while institutional support strengthened organizational readiness through staffing, logistics, referral systems, documentation, and transportation. At the community level, trust enhanced social readiness by increasing acceptance of HBPC and addressing misconceptions.

Theme 5: Barriers to implementing home-based palliative care services

Although participants recognized the importance of HBPC, they also identified several challenges to its implementation. Common barriers included workforce shortages, limited resources, transportation difficulties, movement restrictions, and misconceptions about palliative care. Participants viewed these barriers as interrelated.

There are not enough healthcare workers to carry out routine home visits for all those requiring it. (P4)

At times, healthcare providers find it difficult to access certain places due to the presence of checkpoints and difficulties with travel. (P6)

Some patient families consider PC as giving up treatment. (P7)

There are families who do not have good knowledge about palliative care. (P2)

These accounts indicate that successful implementation depends on more than clinicians' preparedness alone. An HBPC model requires adequate staffing, reliable transportation, the ability of healthcare professionals to reach patients in their homes, well-defined institutional systems, sufficient resources, and greater public awareness of palliative care. Misconceptions about palliative care are particularly important because they may affect families' acceptance of HBPC. The relationship between the identified themes, socio-ecological model levels, and their implementation implications is summarized in Table 3.

Table 3
Themes, socio-ecological model levels, and implementation implications

Theme	Main barriers/facilitators	Socio-ecological model level(s)	Implementation implications
Accessibility of home-based palliative care	Mobility limitations, transportation difficulty, checkpoints, financial burden	Individual, organizational, policy/contextual	HBPC may reduce the burden of repeated hospital visits and improve access for frail patients.
Psychosocial benefits of home visits	Emotional reassurance, family involvement, dignity, reduced isolation	Interpersonal, community	Home visits may support patients and families beyond symptom control.
Multidisciplinary teamwork in palliative care delivery	Team-based care, complementary professional roles, hospital-home coordination	Organizational, interpersonal	Safe HBPC requires communication, role clarity, and shared care planning.
Facilitators to implementing home-based palliative care services	Training, institutional support, community trust	Individual, organizational, community	Implementation requires professional preparation, resources, coordination, and public acceptance.
Barriers to implementing home-based palliative care services	Workforce shortages, travel restrictions, limited resources, misconceptions about palliative care	Organizational, community, policy/contextual	Service planning must address workforce capacity, transportation, resources, public awareness, and policy support.

Discussion

This study examined healthcare professionals' perceptions of the barriers and facilitators to implementing HBPC for people with cancer in the West Bank. The findings suggest that HBPC is not simply a change in the location; rather, it is a multilevel approach where individual, family/community, organizational, transportation, referral-system, and contextual factors play a role.

Accessibility was one of the main issues identified. Participants considered HBPC especially important for patients who have difficulty reaching hospitals because of physical weakness, reduced mobility, transportation problems, financial constraints, or movement restrictions. Regional evidence similarly suggests that the development of palliative care in the EMR is hindered by poor policy integration, inadequate professional training, low public awareness, lack of cooperation, and limited access to essential pain medications (Fadhil et al., 2017). In the West Bank, distance, checkpoints, and movement restrictions can affect access for both patients and healthcare professionals (OCHA, 2023).

Participants also described psychological and social benefits of home visits. Receiving care at home was perceived to provide reassurance and support through the presence of family members and healthcare professionals. This is consistent with the concept of palliative care, as it includes not only symptom relief but also psychological, social, and spiritual components (WHO, 2020). At the same time, home visits by healthcare professionals may also reassure families that patients continue to receive support after hospital discharge. Thus, these visits may strengthen trust and communication, which is consistent with evidence that HBPC can support continuity, comfort, family participation, and reduced hospitalizations (Feliciano & Reis-Pina, 2024; Gonzalez-Jaramillo et al., 2021).

Participants also emphasized the importance of multidisciplinary collaboration. Patients receiving palliative care may have medical, psychological, nutritional, mobility-related, medication-related, and family needs that cannot be addressed by a single profession. This finding is consistent with international guidance that palliative care should respond to the needs of patients and their families through interdisciplinary care (WHO, 2020).

The facilitators to implementing HBPC highlighted by the respondents included professional training, institutional support, and community acceptance. Professional training is important because healthcare professionals require skills to assess symptoms, interact with patients, provide psychosocial support, and make informed decisions in the home environment. This finding is consistent with evidence from the West Bank showing gaps in palliative care knowledge among nurses and physicians and the association between previous palliative care training and better knowledge (Remawi et al., 2025; Toqan et al., 2023). Institutional support is also necessary because HBPC depends on adequate staffing, transportation, medications, documentation, and coordination. Community acceptance is important because families may be more willing to use HBPC when they trust healthcare professionals and understand that palliative care is intended to improve quality of life.

The main barriers to HBPC implementation were structural and contextual. Participants identified workforce shortages, transportation difficulties, checkpoints, limited resources, and misconceptions about palliative care. These barriers may also interact. Workforce shortages can limit the number of home visits, movement restrictions can make it difficult to reach patients, and misconceptions may reduce family acceptance even when services are available. This finding is consistent with studies showing that palliative care implementation is influenced by infrastructure, policy, medication availability, and contextual factors (Knaul et al., 2018; WHO, 2020). The sociopolitical context of the West Bank may also intensify these barriers because movement restrictions can limit access to patients' homes and healthcare facilities (OCHA, 2023).

This study adds qualitative evidence on the implementation of HBPC in the West Bank. The findings indicate that barriers and facilitators to HBPC occur not only at the level of healthcare professionals but also at the organizational, community, and policy levels. Therefore, implementing HBPC requires a multi-level strategy.

Limitations

This study has some limitations. First, the sample was small and concentrated within a single institution. Because dedicated palliative care services were available primarily at one institution during the study period, professionals from multiple institutions could not be recruited. As data saturation could not be established across a broader range of palliative care settings, the transferability of the findings to other institutional or geographic contexts may be limited. In other words, the findings reflect the views of this sample rather than those of all healthcare professionals providing palliative care in the West Bank. Second, the study included only healthcare professionals and did not include patients or caregivers. Patients and caregivers could provide further insight into their experiences of receiving care at home. Third, other HBPC services in the West Bank were not included. Finally, the sociopolitical situation in the West Bank may have influenced both participants' views and the provision of HBPC. However, this context is also integral to the study because of its direct relevance to the implementation of HBPC.

Implications for practice, policy, and research

The findings have several implications for practice and policy. Health institutions should strengthen training, referral processes, documentation, interdisciplinary care, and follow-up systems. A clear framework is also needed to expand workforce capacity and support medication supply, transportation services, communication, and coordination between hospital- and community-based care. Policymakers should also look into an integrated HBPC approach that will determine referral criteria, team members' duties, documentation requirements, follow-up frequency, medication supply, and coordination with primary and oncology care services.

Future research should include the perspectives of patients and caregivers, whose experiences are crucial for better understanding the challenges of home-based care. Quantitative studies could assess service demand, patient outcomes, hospitalizations, and resource needs. Mixed-methods research could also support the development and evaluation of HBPC models.

Conclusion

This descriptive qualitative study examined the barriers and facilitators associated with HBPC for people with cancer in the West Bank. Five themes were identified: accessibility of HBPC services, psychosocial benefits of home visits, multidisciplinary teamwork in palliative care delivery, facilitators to implementing HBPC services, and barriers to implementing HBPC services. The participants described HBPC as a means of addressing the problems of accessing hospitals.

Implementation of HBPC should not rely solely on the efforts of individual professionals. It requires trained multidisciplinary teams, organizational support, effective referral pathways, transportation, community cooperation, family involvement, medication availability, and supportive policies. Progress across these areas could help establish a more patient-centered palliative care system in the West Bank.

Declarations

Ethical approval: Approval was obtained from the Institutional Review Board of Bethlehem University, the Augusta Victoria Hospital Ethics Committee, and the Palestinian Ministry of Health Research Committee. The study was conducted in accordance with the principles of the Declaration of Helsinki and applicable institutional and national ethical requirements. Written informed consent was obtained from all participants before data collection.

Consent for publication: Not applicable.

Availability of data and materials: The qualitative data are not publicly available because of confidentiality and the small number of participants.

Competing interests: The authors declare no competing interests.

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Authors' contributions: Amin Dahdulan conceptualized the study, developed the proposal, collected the data, transcribed and analyzed the interviews, interpreted the findings, and drafted the manuscript. Hanan Hazboun supervised the study, provided methodological and academic guidance, reviewed the analysis and interpretation of the findings, and critically revised the manuscript. Both authors read and approved the final manuscript.

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Figures

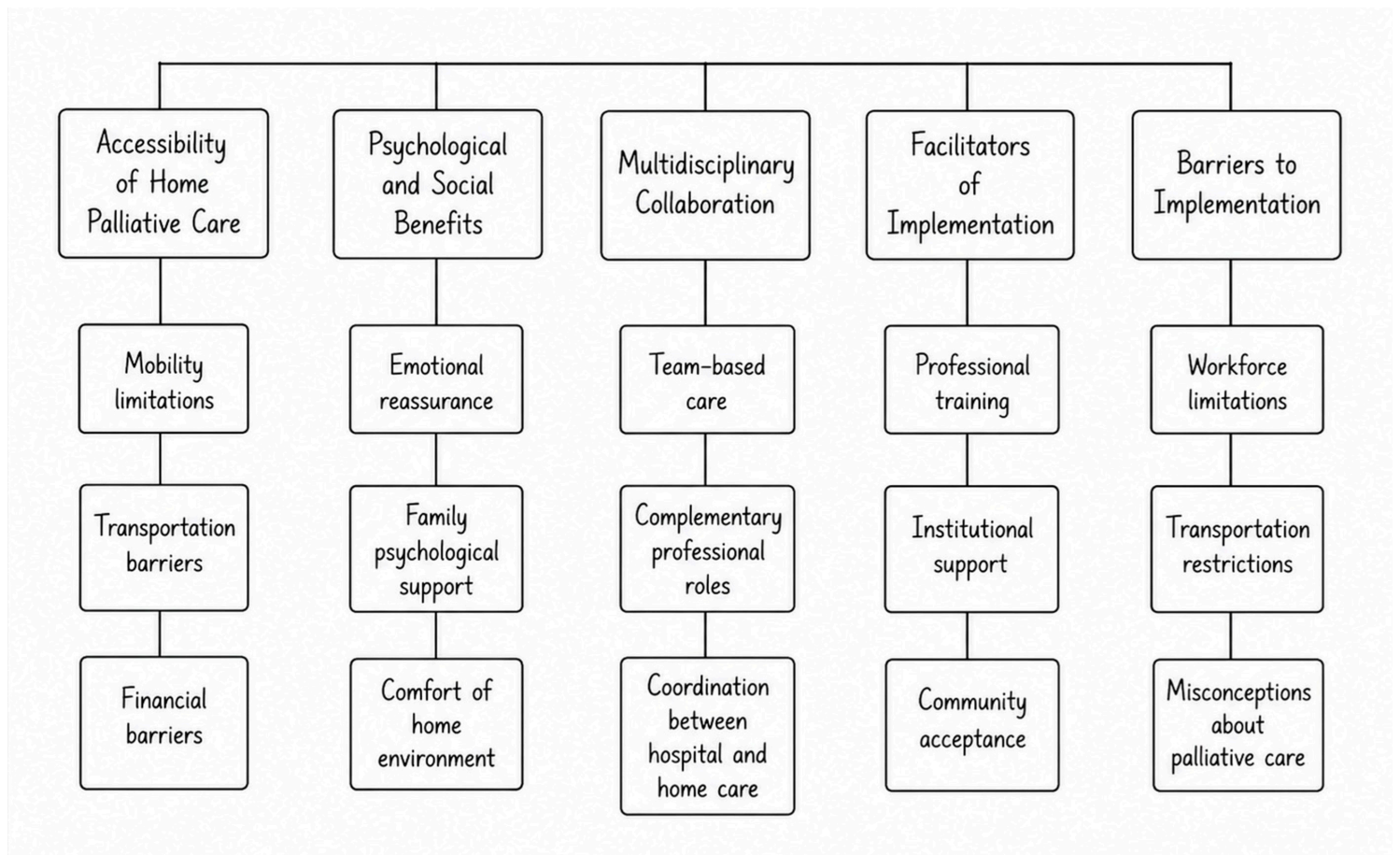


Figure 1

Thematic map of themes and sub-themes on home-based palliative care implementation.

Supplementary Files

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