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Awareness, Practices and Challenges of Myanmar Health Professionals in Spiritual Care for Advanced Cancer

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ABSTRACT

Background: Spiritual care is increasingly recognized as an essential component of holistic healthcare, particularly for patients with serious illnesses like cancer. Healthcare providers must be equipped with appropriate knowledge and skills to address these spiritual needs effectively. This study aimed to assess the awareness, practices, and challenges faced by health professionals in Myanmar in providing spiritual care to cancer patients.
Methods: This multicenter cross-sectional descriptive study was conducted from January to May 2022 with 120 participants from various healthcare settings in Myanmar. A structured survey questionnaire was used to collect data on participants' awareness, practices, and challenges related to spiritual care.
Results: Most participants were moderately religious (78%) and believed their faith influenced their care (54%). While 86% had provided spiritual care to at least one cancer patient, 77.5% lacked specific training in this area. Major barriers to providing spiritual care included time constraints (95%), patient-doctor/nurse power imbalances (93%), and inadequate training (95%). Despite these challenges, the majority expressed a willingness to practice spiritual care for holistic healing.
Conclusion: This study highlighted Myanmar health professionals' recognition and strong motivation to integrate spiritual care into cancer treatment, often rooted in own religious beliefs. However, consistent implementation was hindered by limited training, institutional support, and role clarity. Addressing structural barriers such as staffing constraints and time pressures through strategies like telemedicine and efficient scheduling, alongside targeted education and policy development, is crucial. These efforts could foster a more holistic, culturally sensitive care model that honors patients' spiritual needs and emotional well-being.

Keywords*:* Spiritual care; Advanced cancer; Health Professionals; Awareness; Challenges

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INTRODUCTION

Facing a chronic illness, such as cancer, can profoundly impact one's well-being and sense of vulnerability. In the cancer care continuum, spirituality is acknowledged as a vital element in coping with this multidimensional challenge. World Health Organization (WHO), the National Consensus Project on Quality Palliative Care, and the Joint Commission have all identified Spiritual Care at the End of Life as a core domain (1).

"Spirituality", viewed as a lifelong developmental task, provides meaning, hope, insight, and a sense of purpose, particularly during terminal illness. Higher spirituality, stemming from internal practices, is associated with reduced depression (2,3). "Religiosity" represents the external expression of spirituality within a religious denomination, affirming the importance of religion and spirituality among the general population [3,4]. The neglect of spiritual needs can lead to poorer health outcomes and quality of life, prompting recommendations to address these needs in clinical settings (3–5).

Although spiritual care has traditionally been associated with chaplains and religious leaders, its integration into clinical practice by healthcare providers—especially in palliative and oncology settings—is increasingly acknowledged. Doctors and nurses are now seen as essential contributors to a patient's spiritual well-being. Many patients wish their clinicians were attuned to their spiritual beliefs. It was highlighted in the OASIS study. This study demonstrated that healthcare professionals—particularly oncologists—can serve as effective proxies for understanding and delivering spiritual care. It showed that with even minimal training and a structured framework, clinicians are able to engage in spiritual conversations that patients find both meaningful and beneficial[5]

In well-developed healthcare systems, various training programs have been introduced to help doctors, nurses, social workers, and other professionals incorporate spiritual care into patient management across institutions (6). Despite increasing awareness of its value, practitioners in lower-resource settings encounter significant barriers to offering spiritual support. Best practices remain uncertain, though commonly used strategies include exploring patients' spiritual histories, encouraging faith-based coping, and facilitating open dialogue (5). Additional challenges—such as limited formal education, lack of organizational backing, communication hurdles, inadequate privacy, and the emotional demands of end-of-life care—further complicate delivery (7,8). While extensive research has addressed these concerns in high-income countries, far less is understood about how healthcare providers in low-resource, culturally diverse contexts like Myanmar interpret, apply, and navigate the nuances of spiritual care.

In Myanmar, the only Outpatient Department (OPD) for Palliative Care was established in 2015 at Yangon General Hospital. This department adopts a holistic approach that includes psychosocial and spiritual care. Oncology services are provided in a few tertiary public hospitals, such as Yangon General Hospital, some private hospitals, and the Hospice run by the U Hla Tun Cancer Foundation (9). However, there is a significant imbalance between the number of healthcare providers and the increasing number of cancer patients. A study conducted at Yangon General Hospital between 2016 and 2017 revealed that the quality of life and care for patients with advanced cancer was inferior. This highlights the urgent need for the development of palliative care services at both the hospital and community levels in Myanmar (10).

Despite the OPD's commitment to holistic care, spiritual support from health professionals remains limited. Religious leaders often provide faith-based guidance tailored to the patient's background, but the role of medical professionals in delivering spiritual care is still underdefined. Current data on how healthcare providers perceive and implement spiritual care within palliative settings in Myanmar is scarce (11). This study therefore seeks to explore their awareness, and challenges in delivering spiritual support to patients with advanced cancer—with the broader aim of integrating spiritual care into oncology services in a culturally meaningful way.

METHODS

This hospital-based, multi-centered, cross-sectional descriptive study was conducted in Yangon General Hospital, U Hla Tun Hospice, and Shwe La Min Hospital between January 2022 and May 2022. Physicians, nurses, and nurse aids who met the inclusion criteria from these areas were invited to participate in the study. The inclusion criteria were healthcare providers involved in cancer care, and of all ages and genders. Participants who were on leave on the day of data collection and who did not give informed consent were excluded.

Prior to the main data collection, a pilot study was carried out with 10 healthcare professionals (including physicians, nurses, and nurse aides) to evaluate the clarity, relevance, and cultural appropriateness of the questionnaire items. To test reliability, the questionnaire was administered to the same participants at two time points, spaced two weeks apart, and test-retest reliability was calculated, yielding a correlation coefficient of r = 0.82, indicating good stability over time. Based on participant feedback, minor revisions were made to improve the clarity and flow of select items—particularly those addressing spiritual care practices. The findings from the pilot were used solely for instrument refinement and were not included in the final analysis to maintain the integrity of the main study.

In parallel, content validity was assessed by an expert panel composed of a senior oncologist, a statistician, a palliative care specialist, and a professor of Burmese Language, all with clinical and/or academic experience in Myanmar. The questionnaire was evaluated for conceptual alignment with the study objectives, completeness of content areas, and linguistic appropriateness. Following their recommendations and participant feedback, minor modifications were implemented—primarily involving the clarification of three items concerning the frequency of spiritual care practices and perceived barriers.

These pre-tested, self-administered questionnaires were subsequently used for data collection.

Initially, the Principal Investigator and co-investigators explained the procedure and aim of the survey to the participants, along with outlining their benefits and rights. Written informed consent was obtained thereafter.

The questionaries contained four parts:

1. Data on demographic and academic information, such as age, gender, ethnicity, religion, field of oncology, marital status, and years of practice, were collected.
2. Intrinsic religiosity and influence on medical care.
    - To understand the role of religion in their life and its impact on their healthcare decisions, participants were asked: "*How religious do you think you are?* "With options ranging from "Not at all religious" to "Very Religious" and "*How much do you agree your religious beliefs influence your medical care?*" with options ranging from "Totally disagree" to "Totally agree".
3. Perceptions and practices about spiritual care.
    - The participants were asked to rate their responses on a scale of seven points, ranging from "Never" to "Always" to answer the questions about *"How often do you desire to offer any type of spiritual care.."* and *"How often do you offer any type of spiritual care during the course of your relationship with advanced, incurable cancer patients?"*
    - Experience of spiritual are training was asked as "Yes" or "No"
    - Practitioners were also asked a "Yes "or "No" question about their desire for further training in providing spiritual care to their patients for healing purpose.
4. Barriers to spiritual care
    - Eleven items for assessing barriers to spiritual care were developed by the above-mentioned expert panel.
    - These items were then piloted among health practitioners in the field of oncology.
    - Regarding these items, the participants were asked "Here is a list of potential reasons why spiritual care might not be provided, even under ideal circumstances. Could you please rate the significance of each factor in terms of how much it prevents you from offering spiritual care?" The response options ranged from "not significant" to "very significant".
    - In an initial analysis, the ratings for each item were totaled to create a comprehensive spiritual care barrier score (ranging from 11 to 44).
    - This score represented the combined impact of the 11 barriers.

Statistical Analysis

Excel data spreadsheet was used for data entry. For data cleaning, both manual inspection and SPSS software version 16.0 were used to identify frequency distributions, extreme values or outliers, and missing data. Baseline demographics and questionnaire responses were summarized using descriptive statistics, including medians, means, ranges, and percentage distributions.

The study was done following the approval of the Academic Board of Study and Research and the Ethics Committee at the University of Medicine 1, Yangon. (Approval Number: 686, Date of Approval: 30 December 2019)

RESULTS

There were 120 participants in the study, including 61 doctors,44 nurses, and 15 nurse aids. They were 86 from one public hospital (Yangon General Hospital), 20 from one private hospital (Shwe La Min Hospital), and 10 from one NGO charity organization providing end-of-life care to cancer patients (U Hla Tun Hospice). The age range was 19 to 59, with an average age of 33. Among them, 75.6% participants were below 30 years, 38.4% were between 31-40 years, 16.8 % were between 41-50 years, and 13.2% were among 51-60 years. There were 106 females and 14 males in the study population. Most participants (91.7%) were Buddhists, 5% as Christians, 0.8% as Muslims, and 0.8% as Hindus. Two participants (1.7%) indicated they followed both Buddhism and Christianity.

Their collective work experience in patient care ranged from 3 months to 36 years, with an average work experience of 18 years. The majority (78.3%) believed themselves moderately religious (**Table 1**), with 54% considering their religious beliefs influenced their medical care.

Table 1: Participants Responses to the Question "How religious do you think you are?" (N=120)

Question	Frequency (*f*)	Percentage (%)
Not at all religious	1	0.8
Slightly religious	11	9.2
Moderately religious	94	78.3
Very religious	14	11.7
Total	120	100

The frequency with which spiritual care was desired to be used in treatment, and the frequency with which it had actually been used in the treatment of advanced cancer patients, were depicted in **Table 2**. The majority (36.7%) said they "sometimes" provide spiritual care, followed by 26.7% who do so "often." However, 18.4% (combining "never" and "rarely") had very little experience. The desire to provide spiritual care is clustered around "sometimes" (33.3%) and "occasionally" (31.7%), with fewer respondents choosing "never" (1.7%) or "rarely" (10.7%), signaling strong intent even among those with limited past involvement. While only 5% of participants reported "always" providing spiritual care, 91% expressed a desire to do so frequently suggesting a significant aspiration-practice gap.

However, a large portion (77.5%) had not received training in spiritual care, but the majority (91%) expressed a willingness to practice spiritual care for healing purposes. Regarding questionnaires about challenges and barriers in provision of spiritual care to advanced cancer patients, the responses were as follows: Most participants (95%) indicated that Not Enough time was a significant barrier. About 89% of respondents agreed that the unavailability of private spaces for such discussions was a significant challenge. The majority (95%) expressed that not having received sufficient training in spiritual care was a notable barrier. A significant portion (57%) reported feeling personally uncomfortable discussing spiritual matters with patients. 43% said that "Spirituality is not important to them personally" was not a significant barrier (**Table 3**).

Table 2: Frequency Of Desire to Treat with Spiritual Care and Frequency of Having Treated with Spiritual Care for Advanced Cancer Patients (N=120)

Variable	Desire to treat with spiritual care (%)	Treated with spiritual care (%)
Never	1.7	9.2
Rarely	0.0	9.2
Occasionally	1.7	7.5
Sometimes	31.7	36.7
Often	33.3	26.7
Usual	20	5.0
Always	10.8	5.0
Missing data	0.8	0.8

Table 3: Respondents' Grading Upon Some Barriers to Provide Spiritual Care for Advanced Cancer Patients (N=120)

Variables	Not enough time (%)	Lack of private space to discuss these matters with my patients (%)	I have not received adequate training (%)	I am personally uncomfortable discussing spiritual issues (%)	Religion/ spirituality is not important to me personally (%)
Missing data	2.5	1.7	2.6	30	3.4
Not Significant	0.7	8.3	1.7	11.8	43
Moderately Significant	48.3	47.5	40.8	28.4	15
Slightly Significant	23.5	23.5	34.2	24.3	35
Very Significant	25	19.2	20.7	5.5	3.6

Among the participants, 97% consider "Spiritual care is better provided by other healthcare team members" as a significant challenge. Additionally, 59% did not agree that "Cancer patients do not want spiritual care from nurses/doctors " was a significant barrier.

However, 71% expressed concern that patients might feel uncomfortable, and 93% found that the power imbalance between patients and nurses was significant. A significant portion, 65%, felt uncomfortable addressing these issues with patients whose religious or spiritual beliefs differed from their own. Furthermore, 68.3% responded that "I do not believe it is my professional role to engage patients spiritually" was not a significant challenge (**Table 4**).

Table 4: Respondents' Grading Upon Some Other Barriers to Provide Spiritual Care for Advanced Cancer Patients (N=120)

Variables	I believe that spiritual care is better done by others in the health care team (%)	I do not believe cancer patients want spiritual care from (nurse/ doctors) (%)	I am worried that patients will feel un-comfortable (%)	I worry that manpower between patient and doctor or nurse is inappropriate (%)	I feel un-comfortable engaging these issues with patients whose religious/ spirituality differs from my own (%)	I do not believe it is my professional role to engage patient spirituality (%)
Missing data	3.5	1.8	1.7	3.5	3.2	3.4
Not Significant	38.3	59.3	25.8	3.5	31.7	68.3
Moderately significant	20.8	13.4	25.8	25.7	21.7	9.2
Slightly Significant	30	17.5	31.7	13.2	34.2	13.3
Very Significant	7.5	7.6	15	54.1	9.2	5.8

DISCUSSION

The study was conducted with 120 participants from diverse cancer care settings. Most participants were under 30 years of age and identified as female. They adhered to various religions and faiths, with Buddhism being the majority. Participants occupied varied professional roles and had an average of 18 years of experience in cancer care.

A significant proportion (78.3%) was identified as moderately religious, and more than half (54%) reported that their religious beliefs had influenced their clinical practice. This finding was aligned with regional studies. For instance, research conducted in Pakistan demonstrated that healthcare workers' personal religiosity played a crucial role in shaping openness to spiritual care, although this did not always translate into clinical competence or consistent application (12).

Similarly, a Taiwanese study involving physicians and nurses in a long-standing Buddhist hospice ward revealed that spiritual care was often difficult to define in practical terms, with its delivery being shaped by patients' emotional and physical needs (8).

In terms of providing spiritual care, a significant portion of participants had done so for at least one patient, reflecting a willingness to engage in such care. However, while only 5% reported that spiritual care was "always" provided, 91% expressed a desire to do so more frequently suggesting a considerable awareness-practice gap. This may have reflected the lack of formal training or institutional support, as noted in the findings.

Similar sentiments were observed in Malaysia, where health professionals acknowledged the spiritual dimension of patient care but often relied on personal belief systems rather than formal training to guide their approach (13).

The challenges and barriers identified in this study were consistent with those reported in reference papers (7,8). Lack of time and the unavailability of private spaces—common concerns in busy healthcare environments—were identified as major challenges by more than 90% of participants. Insufficient training and disproportionate manpower were also reported by 95% of participants, emphasizing the need to address these gaps in professional development.

Approximately 43% of respondents did not perceive their personal level of spirituality as a significant barrier to providing spiritual care. This may have been due to their ability to separate personal beliefs from professional duties, or possibly due to a lack of awareness and understanding of spiritual care. This finding underscored the necessity of implementing more structured spiritual training and education programs in local settings.

Many participants voiced concerns about power imbalances and discomfort when addressing spiritual issues with patients of different faiths. Robert Klitzman's 2022 article highlighted that physicians' unfamiliarity with diverse belief systems posed substantial challenges, thus reinforcing the need for cultural competency training, open dialogue, and enhanced interdisciplinary collaboration in delivering spiritual care (10).

The findings of this study were consistent with international literature that underscored common barriers to spiritual care delivery, including limited privacy, time constraints, and a lack of skilled personnel (7,8,12,14). A 2021 Portuguese survey likewise highlighted contextual and assistance-related obstacles—namely inadequate privacy, communication skills, and staff competency (7).

The fact that 57% felt personally uncomfortable discussing spiritual matters indicated emotional or cognitive hesitation perhaps due to lack of training, fear of offending, or uncertainty about what is appropriate to say. Additionally, the finding that 97% of participants agreed that spiritual care was better provided by others reflected a deferral of responsibility—often resulting from unclear role expectations or insufficient preparation. It was likely that participants assumed chaplains, social workers, or designated spiritual care teams were more suitably equipped for this role. These responses were interpreted not as disinterest, but rather as a desire to help, tempered by a lack of confidence, training, or institutional support.

A substantial portion of participants did not consider statements such as "I do not believe cancer patients and families want spiritual care from healthcare personnels" and "spiritual care is better provided by other healthcare team members" to be significant challenges. The majority did not agree that "Cancer patients do not want spiritual care from nurses/doctors" was an obstacle. These responses indicated a shared recognition of the importance of spiritual care for cancer patients and their families, despite low confidence.

Building on this, a 2025 BMC Nursing systematic review of 10 studies across Iran, Taiwan, and Turkey found that structured spiritual care education significantly improved students' self-awareness, attitudes, and clinical skills. These programs effectively bridged the gap between motivation and competence—yet the review also underscored the importance of culturally tailored curricula and called for the development of region-specific assessment tools (15).

Together, these findings reinforced the idea that while internal motivation rooted in personal beliefs was a powerful catalyst, it must be matched with formal training, clear role definitions, and institutional support to ensure consistent, culturally appropriate spiritual care delivery.

CONCLUSION

To be concluded, Myanmar healthcare professionals demonstrated a strong commitment to incorporating spiritual care into clinical practice, often drawing upon their own religious traditions. Despite this motivation, most complained of lack of formal training, institutional support, and clearly defined clinical roles. These challenges echo patterns observed across Asia and underscore the need for targeted education initiatives, supportive policy frameworks, and role development. Advancing these areas is essential to creating a culturally responsive, holistic cancer care model that honors patient dignity and emotional well-being.

LIMITATION AND RECOMMENDATION

This study had several limitations. First, the generalizability of findings is potentially constrained by the use of convenience sampling, which may not fully capture the diversity of perspectives within Myanmar's broader healthcare workforce. Second, although participants were drawn from a range of oncology settings, the responses of physicians, nurses, and nurse aides were not analyzed separately, limiting insights into profession-specific experiences. Third, as a descriptive, cross-sectional design, the study captured a snapshot of current awareness and practices without establishing causal relationships or trends over time. Additionally, potential institutional differences—such as variations in staffing levels, training opportunities, and clinical models between public and private facilities—were not examined in depth and may have influenced participant responses.

Future research should adopt analytical or longitudinal designs to investigate predictors of spiritual care engagement and to assess the impact of targeted training interventions. Disaggregating findings by professional role and institutional context could yield more tailored recommendations. In particular, focused studies on physicians' attitudes and challenges toward spiritual care in Myanmar would offer valuable, nuanced understanding. These enhancements can support the development of evidence-based, culturally sensitive training and policy frameworks for holistic oncology care.

CONFLICT OF INTEREST

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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AUTHOR CONTRIBUTIONS

WWMZ: Conceptualized the study design and led the development of the research protocol, coordinated the data collection and entry with field support from clinical staff at participating hospitals, drafted the manuscript and critically revised.
TMH: Supervised instrument validation and pilot testing, conducted statistical analysis and interpretation
SMA: Coordinated the data collection and entry with field support from clinical staff at participating hospitals, approved the final version for submission.

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