

Moving from unmet need to culturally responsive psychosocial, palliative, and end-of-life care in Africa: a reflection on the 2025 GIPPEC symposium

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Abstract

The Psychosocial, Palliative, and End-of-Life Care in Africa Symposium (PPEoLC) was held virtually on February 18–19, 2025, and convened clinicians, researchers, policymakers and other healthcare professionals from Africa and internationally to examine current challenges and future directions in PPEoLC across African contexts. This symposium highlighted that the central challenge is not only limited access to palliative care services, which has been well documented, but also the insufficient integration of psychosocial, spiritual, family and community dimensions into serious illness care.

Key learnings were identified through a review of symposium presentations, session recordings and transcripts, audience questions, moderated discussions, collaborative working-session content and an anonymous post-symposium survey ($n = 12$).

Across sessions, six interconnected priorities emerged: strengthening community and family support structures; integrating cultural and spiritual dimensions of care; developing culturally relevant assessment and outcome measures; strengthening health systems and access to care; evaluating digital health and technological innovations; and building

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workforce capacity. These priorities reflected the interconnected structural, cultural, relational, and health-system factors that shape care delivery across African contexts. The symposium generated a conference-derived framework with implications for clinical practice, policy, education and research. The findings support a shift from documenting unmet need towards developing, implementing and evaluating locally responsive models of care that reflect what matters to patients, families and communities across Africa.

Keywords [MeSH compliant]: *palliative care, supportive care, psychosocial care, cancer, bereavement, grief, dementia, advance care planning, health systems, dementia, global health, Africa*

Background

Individuals with advanced disease and their families around the world face complex challenges at the end of life (EoL). As populations age and the burden of non-communicable diseases increases, there is a pressing need for integrated models of care that address the physical, psychological, social and spiritual dimensions of suffering in advanced disease [1]. However, access to high-quality psychosocial, palliative, and end-of-life care (PPEoLC) remains limited, particularly in low- and middle-income countries (LMICs).

The World Health Organization (WHO) estimates that nearly 57 million people worldwide require palliative care (PC), with the vast majority residing in LMICs [2]. In Africa alone, approximately 10 million individuals need such services, although only a small proportion of those in need receive them [3]. According to the 2019 WHO Global Survey, 68% of countries reported some level of funding for PC, but only 40% indicated that services reached even half of those in need [4,5]. Across Africa, these gaps are compounded by shortages of trained providers and essential medications for symptom management. In some regions, there are fewer than 3 physicians and 40 nurses per 100,000 inhabitants [6], while even countries with more developed healthcare infrastructures continue to experience significant disparities between patient needs and provider availability. For example, South Africa has only one specialist PC nurse for every 39,400 cancer patients [3,6]. Access to psychosocial care in Africa is similarly limited, with shortages of trained mental health professionals, inadequate integration of psychosocial support within PC services and limited availability of culturally appropriate interventions for patients and families facing serious illness [7,8].

Meeting these challenges will require not only expanded access to services, but also stronger collaboration, knowledge exchange, and capacity-building across diverse settings [7,8]. Although important advances have been made, many challenges remain shared across countries, disciplines and health systems. The need for a dedicated symposium emerged from recognition that meaningful progress in PPEoLC requires opportunities for collective reflection, interdisciplinary dialogue and the identification of priorities to guide future work across the continent.

Symposium overview

The PPEoLC in Africa Symposium was a two-day virtual symposium held on February 18–19, 2025, co-hosted by the African Palliative Care Association (APCA) and the Global Institute of Psychosocial, Palliative, and End-of-Life Care at the Princess Margaret Cancer Centre. The primary objective of the symposium was to convene clinicians, researchers, policymakers, and community partners to examine current challenges in PPEoLC across African contexts and to identify priorities for research, implementation and collaboration.

A total of 222 attendees, including 24 speakers and 6 moderators, represented a multidisciplinary and international community spanning clinical care, research, policy and community-based practice. This included representation from Uganda, Cameroon, Eswatini, Sudan, Seychelles, Nigeria, Malawi, Canada, the United States, the United Kingdom and Australia.

The symposium programme was structured around 7 topic areas: (1) psychotherapy in patients with advanced cancer; (2) quality of dying and death research; (3) symptom management; (4) dementia and advanced disease; (5) ageing; (6) grief and bereavement care and (7) advance care planning (ACP). Sessions included invited presentations, moderated discussions and a collaborative working session focused on shared challenges and emerging priorities. A consensus emerged from participants regarding the need to integrate domains of PPEoLC that are often addressed separately, and to shift from documenting unmet need towards developing and implementing culturally responsive, context-specific models of care.

Methods: approach to synthesis

The development of key learnings presented in this report was derived through a review of material generated during and following the symposium. Symposium presentations, session recordings and transcripts, audience questions, moderated discussions and collaborative working-session content were thematically analysed to identify recurring challenges, innovations and priorities across the programme. These observations across sessions were organised into broader thematic domains that extended beyond individual presentations or clinical topics.

The synthesis was additionally informed by an anonymous post-symposium survey ($n = 12$). The preliminary thematic domains and conceptual framework were then circulated among the manuscript authors for review, comment and endorsement. Through the iterative process, overlapping concepts were consolidated, the scope and interpretation of each domain were refined, and the final set of cross-cutting priorities was agreed upon by the author group. This approach was designed to produce a collaborative, conference-derived synthesis of the principal learnings and future research directions identified across the symposium.

Results: key learnings from the symposium

The synthesis identified 6 interconnected priorities for advancing PPEoLC across African contexts: (1) strengthening community and family support structures; (2) integrating cultural and spiritual dimensions of care; (3) developing culturally relevant assessment and outcome measures; (4) strengthening health systems and access to care; (5) evaluating digital health and technological innovations and (6) building workforce capacity. These priorities emerged across multiple symposium topics and reflected a shared need for models of care that are locally responsive, relationally grounded, and feasible within existing resource constraints. Together, they informed the conceptual framework shown in Figure 1. These priorities were also reflected in post-symposium survey responses, in which respondents most frequently identified workforce development and capacity-building (83%), paediatric PC and family support (83%), culturally grounded grief interventions (75%), digital health innovations (75%), community-led care models (75%) and policy and health-system integration (75%) as priorities for future research and development.



Figure 1. Conceptual framework of emerging priorities in psychosocial, palliative and end-of-life care (PPEoLC) in African contexts.

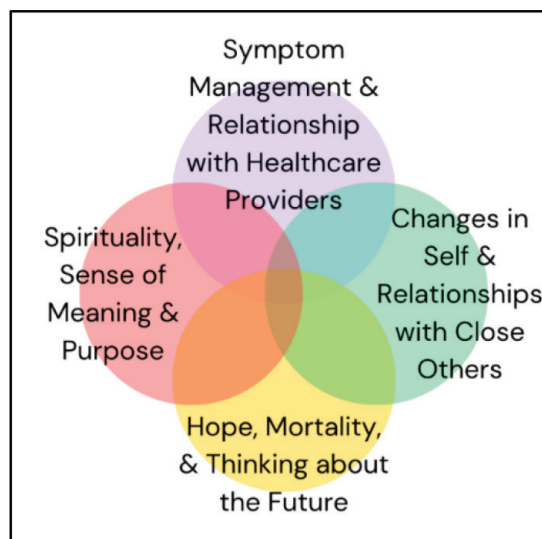


Figure 2. Four domains of CALM.

Community and family support structures

Family and community support emerged as a cross-cutting priority from discussions of advanced cancer, dementia, ageing, grief and bereavement. Families were described as playing central roles in caregiving, emotional support, decision-making and the coordination of care, particularly where formal psychosocial and PC services are limited. At the same time, symposium presentations demonstrated that family relationships may be sources of both support and distress. In that regard, caregiving responsibilities, financial pressures, changing family structures, abandonment and unequal access to family resources may increase the vulnerability of patients and caregivers. The importance of family and community support was further reflected in post-symposium survey responses, in which paediatric PC and family support structures and community-led models of care were among the most frequently identified priorities for future research (10/12 and 9/12 respondents, respectively).

Depression, demoralisation and death anxiety are common manifestations of distress among patients with advanced cancer, supporting the need for interventions that address psychological and existential concerns alongside physical symptoms [9,10]. Managing Cancer and Living Meaningfully (CALM), an evidence-based, brief supportive-expressive psychotherapy, developed for patients with advanced cancer and their caregivers [11], was highlighted as a framework for the delivery of psychological care to this population across diverse cultural and geographic settings.

CALM addresses four interrelated domains: (1) symptom management and communication with healthcare providers; (2) changes in self and relationships with close others; (3) spiritual well-being and meaning and (4) mortality and future-oriented concerns. Central to CALM is the facilitation of 'double awareness', or the dual capacity to remain engaged in life while also facing and planning for its end [12,13]. Evidence from a large randomised controlled trial supports the effectiveness of CALM in reducing depressive symptoms and death anxiety among patients with advanced cancer and improving communication with health care providers and family, as well as planning for the EoL [14].

The experience of providers delivering CALM in Uganda highlighted the potential dual impact of family relationships in serious illness. Some patients described support from their family as an important source of strength, while others reported feelings of isolation or rejection by their partners or family or the loss of financial and housing stability following the diagnosis of advanced cancer. These challenges were particularly

evident in accounts from women whose access to property, income and family decision-making was limited. CALM provided a structured setting in which these patients could discuss family relationships, fears about leaving loved ones behind and unfinished responsibilities.

Similar concerns emerged in presentations on dementia and ageing. Family members, particularly spouses and daughters, frequently assume primary responsibility for caring for older adults living with dementia [15]. As cognitive, functional and behavioural symptoms progress, these responsibilities may become increasingly demanding physically, psychologically and financially [16]. Symposium discussions also highlighted how migration, urbanisation and changing family structures may reduce the availability of traditional forms of support for older adults. The migration of adult children and the financial demands of care may leave some people living with dementia and their caregivers increasingly unsupported. Bereavement presentations similarly highlighted the importance of community-based support models, including the training of lay community grief counsellors (LCGC), reinforcing the central role of families, caregivers and communities in supporting individuals throughout serious illness, death and bereavement [17–19].

Cultural and spiritual dimensions of care

Cultural and spiritual dimensions of care emerged as important influences on how individuals and families experience serious illness, caregiving and end-of-life decision-making. Presentations emphasised that psychosocial support must be responsive to local values, spiritual beliefs, caregiving traditions and family structures.

Experiences from CALM implementation in Uganda highlighted the central role of spirituality in coping, meaning-making and understanding of illness. Patients described beliefs related to divine timing, moral responsibility and supernatural causation, while fears surrounding death were often closely linked to concern for surviving family members and unfinished responsibilities. CALM provided a structured space in which patients could explore these concerns, strengthen relationships and find meaning while living with advanced illness [9–14,20].

Discussions of ACP further illustrated the importance of cultural context. Work presented from Mozambique highlighted how linguistic diversity, health literacy, resource constraints and culturally grounded understandings of personhood may influence the balance between shared decision-making and what has been called compassionate paternalism [21–27]. Presenters emphasised the need for culturally responsive approaches that support meaningful conversations about serious illness while respecting local values and traditions. The discussion emphasised the need for culturally appropriate training to support healthcare professionals in initiating and navigating ACP conversations with patients and families [21–27].

Culturally relevant assessment and outcome measures

A major learning from the symposium was the need for assessment and outcome measures that are culturally relevant and contextually valid across diverse African settings. Presenters emphasised that evaluating PPEoLC requires tools that accurately reflect local experiences, values, languages and care priorities.

The Quality of Dying and Death-Revised Global Version questionnaire was presented as one example of ongoing efforts to strengthen measurement in this field. Developed through collaboration among experts from Uganda, Malawi, Canada, the United States and the United Kingdom, this 26-item instrument was designed to minimise the limitations of the original QODD related to cultural relevance, respondent burden and missing responses [28–32]. Validation activities currently underway in Malawi and Uganda include translation processes and cognitive interviews with bereaved caregivers to ensure cultural appropriateness. Presenters noted that caregivers generally viewed participation in such research positively when assessment processes are conducted in culturally and spiritually sensitive ways, suggesting that discussions of end-of-life experiences are feasible and acceptable in these settings [28–32].

Similar challenges were identified in dementia care. Neurocognitive assessment remains limited and fragmented in many African settings, while relatively few psychological and cognitive tools have been validated across diverse languages and cultural contexts [33,34]. Symposium discussions emphasised that culturally relevant measurement extends beyond translation and must consider literacy, feasibility, emotional experience, respondent burden and outcomes that patients and families regard as meaningful.

Health-system strengthening and access to care

Health-system constraints were identified across discussions of cancer, symptom management, dementia, ageing, grief and bereavement and ACP. Presenters described limited availability of essential medicines, shortages of trained providers, fragmented referral pathways, delayed presentation, financial barriers and the weak integration of palliative and psychosocial care within general healthcare services. These constraints limited both access to care and the ability of providers to implement promising interventions at scale.

Communication gaps were also identified in the Ugandan CALM pilot involving 41 patients with advanced cancer. Nearly 90% had not discussed their treatment plan with healthcare providers, and few had received information about prognosis, contributing to limited disease understanding, misconceptions and stigma. It was noted that CALM supported patients in developing a clearer understanding of their illness and engaging more meaningfully in care.

Adolescents and young adults (AYA) receiving lymphoma care in Malawi experience substantial quality-of-life and symptom-management needs during treatment [35]. These needs may be affected by disease characteristics, treatment abandonment, treatment-related toxicities and resource limitations [36,37]. The Malawi Symptom Toolkit has been found to be a practical response to these challenges. Designed for AYA receiving lymphoma care at the Kamuzu Central Hospital Oncology Clinic, the toolkit includes medications for pain, nausea and vomiting, constipation, mucositis, insomnia and gastritis. Pictorial medication labels, patient and family education and symptom diaries are used to support symptom management outside the clinic. This example highlighted the importance of designing interventions around the practical realities of medication availability, health literacy, travel and home-based care [38].

Dementia presentations similarly demonstrated the consequences of limited health system capacity. Dementia in Africa is often recognised only after behavioural, psychological or functional symptoms have become pronounced, while access to psychogeriatric and specialist assessment remains limited even at this stage of disease. Presenters identified caregiver knowledge, limited clinical records, provider emphasis on physical rather than cognitive or psychological symptoms and shortages of trained personnel as contributors to delayed identification and care [39–45,33,34]. Community-linked screening and referral were presented as possible strategies for improving connections between households and formal services.

Population ageing has important implications for healthcare, social protection and economic development across Africa [46,47]. The example of Ghana illustrates how falling mortality and fertility contribute to a growing population of older individuals [48,49]. Symposium discussions highlighted the intersecting effects of chronic illness, limited pension coverage, reliance on informal employment and inadequate social safety nets [50–52]. Traditional family support may also be weakened by urbanisation, migration and changing household structures, increasing the risk of isolation and financial insecurity among older adults [53–55].

Ghana's Livelihood Empowerment Against Poverty program and National Health Insurance Scheme were identified as important policy responses. However, presenters noted continuing concerns regarding programme coverage, enrolment, payment regularity and out-of-pocket costs for medications and treatments [56–59]. Shortages of geriatric specialists and long-term-care services further constrain access [60], while poverty, isolation, neglect and exclusion from care decisions may disproportionately affect older women [61]. These discussions demonstrated that support for dignified ageing depends on coordinated health and social-policy responses rather than clinical services alone.

ACP also depends on health-system conditions. Even where patients and families are willing to discuss future care, limited legal frameworks, uncertain clinical responsibilities, communication barriers and restricted access to treatments may constrain the ability of health professionals to respond to expressed preferences.

Digital health and technological innovation

The value of digital health care emerged through discussions of access, community-based care, symptom monitoring, professional communication and future research. Mobile phones are commonly used in resource-limited PC settings to facilitate communication among patients, caregivers and providers [62]. Remote symptom-monitoring initiatives in African settings have also shown the feasibility of collecting symptom information and supporting care outside conventional clinical encounters [63]. Digital tools were identified as potential ways to facilitate follow-up, extend education and psychosocial support and connect patients and caregivers with providers beyond specialist facilities.

Interest in digital innovations was also reflected in the post-symposium survey, in which 75% of respondents identified digital health tools and technologies as a priority area for future research and service development.

The symposium included examples of mobile and community-linked approaches that may inform future digital models. Mobile Outreach Psychosocial Services for older adults in Uganda demonstrated the potential to extend psychosocial support into community settings, while discussions of symptom monitoring and home-based care highlighted opportunities for more timely communication between patients, caregivers and clinical teams. Digital platforms may also support continuing education, mentorship and collaboration among providers working across geographically dispersed settings.

At the same time, participants recognised that technological innovation does not automatically improve access or equity. Digital infrastructure, device and data costs, digital literacy, privacy, regulatory requirements and differences between urban and rural access must be considered when designing and evaluating such interventions. Symposium discussions emphasised that digital technologies should complement rather than replace in-person relationships and should be designed around the needs, capabilities and resources of patients, caregivers, communities and providers.

Workforce development and capacity building

Workforce limitations were evident across all symposium topics. Shortages of specialists in PC, psychosocial oncology, mental health, dementia, geriatrics, grief and bereavement and ACP restrict access to appropriate support. The symposium therefore highlighted the need to increase specialist capacity and to strengthen the skills of non-specialist providers, community health workers (CHWs), lay counsellors, volunteers and family caregivers. Consistent with symposium discussions, workforce development and capacity-building was the most frequently identified priority in the post-symposium survey, selected by 83% of respondents.

The CALM presentations demonstrated the importance of training and supervision when adapting psychotherapeutic interventions. Clinicians reflected that conversations concerning prognosis, relationships, death and existential distress can be emotionally challenging, but that structured training in CALM and continued supervision helped build confidence and competence. This experience indicated that cultural adaptation must include attention to how providers are selected, trained, mentored and supported.

The symptom-management and dementia sessions provided further examples of task-sharing. In Malawi, a palliative-care-trained research nurse educated patients and families in the use of symptom medications and diaries. In Uganda, CHWs showed high agreement with psychiatric clinical officers when identifying possible cognitive impairment and referring older adults for assessment [64]. These examples suggested that appropriately trained non-specialist providers may extend access to care where specialist services are scarce, particularly when their roles, referral pathways and supervision arrangements are clearly defined.

The grief and bereavement pilot similarly demonstrated the potential contribution of lay community providers. Community members with lived experience participated in co-creating the intervention and were trained to provide tailored grief support. Individuals with more complex needs were connected with professionally trained providers, allowing support to be matched to the level of need. This model highlighted the importance of maintaining clear boundaries between community-based support and specialist care.

Across the symposium, workforce development was therefore understood as a multilevel priority encompassing professional education, task-sharing, caregiver training, mentorship, supervision and organisational support. Participants emphasised that expanding the responsibilities of community and lay providers without adequate training, support, referral pathways or recognition could undermine both quality of care and workforce sustainability.

Discussion

The symposium identified 6 interconnected priorities for advancing PPEoLC across African contexts: (1) community and family support; (2) cultural and spiritual dimensions of care; (3) culturally relevant assessment and outcome measures; (4) health-system strengthening and

access; (5) digital health and (6) workforce development. Taken together, these findings suggest that improving PPEoLC requires more than expanding the availability of services. Models of care must also be responsive to local cultural and spiritual contexts, grounded in relationships among patients, families, communities and providers, supported by valid measures and embedded within functioning health systems. This broader orientation is consistent with calls to rebalance serious illness care towards dignity, psychosocial support, relational care, cultural context and the alleviation of suffering as core outcomes [65].

Implications for practice

The symposium findings reinforce the central role of families and communities in serious illness care. Families commonly contribute to health promotion, care coordination, emotional support, caregiving and decision-making [66]. These responsibilities become particularly important where access to formal palliative and psychosocial services remains limited. Reviews of PC development in Africa continue to document gaps in service coverage, workforce capacity, essential medicines, education, policy integration and community empowerment [67,64]. Community-based PC programmes may help address some of these gaps through interdisciplinary coordination, volunteer engagement, caregiver support and earlier connections to care, although evidence regarding which programme components are most effective in LMICs remains limited [64].

The findings of the symposium support models of practice that recognise family caregivers, CHWs, LCGCs and other community members as contributors to care. In Uganda, the high agreement observed between CHWs and psychiatric clinical officers in identifying possible cognitive impairment illustrates the potential for community-linked screening and referral [68]. However, the expansion of community roles should be accompanied by clearly defined responsibilities, appropriate training, supervision, referral pathways and mechanisms for identifying patients and families who require specialist support. Caregiver needs should also be assessed directly, rather than assuming that families have adequate financial, emotional and practical capacity to provide care.

Cultural and spiritual dimensions should similarly be integrated into routine practice, rather than treated as supplementary concerns. Existing evidence demonstrates that understandings of serious illness, dying, family responsibility, bereavement and a good death are culturally situated [69]. Research on dementia has also shown that interpretations involving witchcraft or other supernatural explanations may contribute to stigma, social isolation, delayed diagnosis and barriers to care [70]. Spiritual-care frameworks developed for African contexts emphasise that physical and psychosocial care should be accompanied by attention to spiritual suffering, while emerging scholarship highlights the relevance of traditional healing systems, oral traditions and community-based knowledge to care design [71,72].

These findings have practical implications for communication, psychosocial support, grief and bereavement care and ACP. Interventions should be adapted in ways that recognise local understandings of personhood, family involvement, autonomy, truth-telling, spirituality and decision-making. Cultural adaptation should not be limited to translation or minor changes in terminology. It should involve meaningful engagement with patients, families, clinicians and communities to determine how care can be delivered respectfully and ethically while maintaining the essential functions of an intervention.

Implications for policy and health systems

The symposium findings demonstrate that culturally responsive interventions cannot be sustained without supportive health-system conditions. The Public Health Strategy for Palliative Care identifies policy, education, medicine availability and service implementation as four essential components of PC development [73]. The Cape Town Palliative Care Declaration similarly calls for African-led, system-level approaches that embed PC within national health priorities and promote equitable access [74]. Evidence from Uganda, Kenya and Malawi indicates that community-based PC can improve access and quality, but its implementation remains constrained by limited resources, workforce shortages and challenges integrating and sustaining services within formal health systems [75].

These findings support greater integration of PPEoLC into primary healthcare, cancer and non-communicable disease services, dementia and ageing care and universal health coverage frameworks. Policy responses should: strengthen coordination between community-based, primary, secondary and specialist services; clarify referral pathways; and ensure that psychosocial, spiritual, caregiver and bereavement needs

are addressed alongside physical symptoms. Sustainable financing and social-protection mechanisms are also important because patients and families may experience substantial out-of-pocket costs, income loss and caregiving-related financial strain.

Access to essential medicines remains a particularly important structural challenge. Although morphine is classified as an essential medicine, the global distribution of opioid analgesics remains highly unequal, with limited availability across many African settings [76,77]. Opioid consumption in Africa has remained low and largely stagnant, reflecting barriers in procurement, regulation, prescribing, workforce capacity and health-system implementation, rather than an absence of clinical need [78]. Restrictive regulatory frameworks, fragmented governance, weak supply chains, limited prescribing authority and insufficient professional training may prevent PC policies from being translated into practice [79,80].

Policy and health-system research should therefore move beyond repeatedly describing barriers to evaluating actionable strategies for improving access. Priorities include strengthening supply chains for essential medicines, assessing appropriate regulatory reform, improving coordination across levels of care, developing sustainable financing approaches and determining how CHWs and other non-specialist providers can be integrated safely and sustainably into formal systems. Implementation science will be important for understanding how effective interventions can be adapted, scaled and maintained across settings with different resources, populations and health-system structures.

Implications for education and workforce development

Workforce development is essential to implementing each of the symposium's priority domains. Evidence from LMICs indicates that CHWs and other non-specialist providers can contribute to symptom management, psychosocial support, identification of patients in need, coordination of home-based services and continuity of care [73,81]. A systematic scoping review found that CHWs can play important roles in holistic, community-based palliative care, especially in rural and underserved settings where specialist services are limited [81]. These findings are consistent with broader evidence supporting task-sharing as a strategy for addressing workforce shortages in resource-constrained settings [83].

Task-sharing should not, however, be treated simply as the transfer of additional responsibilities to an already constrained workforce. Volunteers and community-based providers too often have had inconsistent training, limited supervision, unclear role boundaries and insufficient financial or organisational support, all of which can affect retention and sustainability of their care [81,83]. However, the effectiveness of community-based workforce models depends on structured education, mentorship, supervision, referral pathways and recognition within the broader health system.

Education in PPEoLC should therefore extend across specialist and non-specialist pathways. Relevant competencies should be incorporated into the education of physicians, nurses, social workers, psychologists, spiritual-care providers, CHWs and other professionals involved in serious illness care. Training should address physical symptom management, as well as psychological distress, communication, caregiver support, dementia, grief and bereavement, cultural and spiritual care and ACP. Community-based education for family caregivers may also be valuable in settings where families hold substantial responsibility for care.

Structured, multicomponent training programmes that combine knowledge development, experiential learning, mentorship and supervision may improve confidence and competence in PC delivery [84]. Tele-mentoring approaches, including Project ECHO, may also offer opportunities to connect geographically dispersed providers with specialist knowledge and peer support [91]. Future educational initiatives should be evaluated not only for short-term gains in knowledge but also for changes in clinical practice, quality of care, workforce retention, patient and caregiver outcomes and long-term sustainability.

Implications for measurement and research

Strengthening measurement science is necessary to evaluate whether PPEoLC interventions produce outcomes that are meaningful to patients and families. The historical lack of validated outcome measures for diverse African populations has constrained clinical evaluation and cross-context comparison. Instruments such as the African Palliative Outcome Scale have demonstrated strong psychometric properties

across several African settings and languages, while also illustrating the importance of grounding measures in locally identified patient and caregiver priorities [86].

Palliative care needs in African contexts are multidimensional and may include physical symptoms, psychological distress, stigma, financial hardship, caregiver burden, spiritual concerns and disruptions to family and community relationships [7]. These dimensions may not be adequately captured by measures developed in high-income settings. Even where translated instruments are available, validation across diverse populations, disease groups and care settings remains limited.

Future research should prioritise the co-development, adaptation and validation of measures that reflect the priorities of patients, families, caregivers, clinicians and communities. Qualitative and participatory approaches can help determine whether instruments adequately capture locally meaningful concepts and whether questions are understandable, acceptable and emotionally appropriate. Research should also examine the feasibility and respondent burden of assessment, particularly where illness severity, literacy, language and limited clinical resources may affect implementation. Improved measurement will support clinical decision-making, intervention evaluation, service planning, policy development and comparison across settings.

The cultural and spiritual findings presented at the Symposium also pointed to important areas for further study. There was agreement that research should move beyond documenting cultural influences on outcomes and examine how cultural and spiritual dimensions can be integrated meaningfully and ethically into clinical care. Priorities include developing culturally grounded approaches to spiritual assessment, examining appropriate partnerships with faith leaders and traditional healers, evaluating community education intended to reduce stigma, and determining how adaptation influences communication, trust, service uptake and patient and caregiver outcomes [63,69–72].

Research on community-integrated care should define the roles of family caregivers, CHWs, lay grief counsellors, volunteers and specialist providers. It should also evaluate supervision structures, caregiver training, caregiver burden and well-being, referral pathways, cost, scalability and integration with primary and PC services. Community-based grief and bereavement interventions warrant particular attention, given the limited availability of formal support following a patient's death.

The post-symposium survey also identified paediatric PC and family support as areas warranting further consideration. Although this feedback was based on a small number of respondents and cannot be considered representative, it highlights a potential gap in the symposium programme and the resulting framework. Future work should consider how the psychosocial, developmental, family and bereavement needs of AYA intersect with the six cross-cutting priority domains.

Digital health and innovation

Digital technology provides new opportunities to support symptom monitoring, communication, caregiver education and continuity of care. Mobile applications and remote-monitoring systems have been used to collect patient-reported outcomes, monitor symptoms, facilitate communication with care teams and support responsiveness outside conventional healthcare settings [87,98,89]. Remote symptom-monitoring initiatives in African settings have also demonstrated the feasibility of collecting longitudinal information and supporting clinical decision-making beyond facility-based care [90]. Digital platforms may further provide caregivers with education, emotional support and practical guidance while reducing travel demands and supporting home-based care [73,90].

However, the current evidence base for digital technology in the palliative care setting in Africa remains limited. Many digital health interventions in sub-Saharan Africa are pilot or early-stage initiatives focused on communication and coordination, rather than on integration across care systems [82]. Evidence regarding long-term effectiveness, large-scale implementation and equity also remains limited [83]. Barriers include inadequate digital infrastructure, regulatory uncertainty, low digital literacy, privacy concerns, device and data costs and unequal access between urban and rural populations [84]. Although mobile-phone-based approaches may be adaptable to resource-constrained settings, hybrid models combining digital support with in-person care may be more appropriate than fully remote delivery [81].

Future studies should evaluate the effectiveness, acceptability, feasibility, equity, scalability, cost and health-system integration of digital interventions. They should also examine whether digital tools improve clinical decision-making and patient or caregiver outcomes, rather

than assessing technical feasibility alone. Digital innovation should complement, rather than replace, the relational and human elements of psychosocial and PC.

Knowledge gaps and limitations

Several cross-cutting knowledge gaps remain. Evidence is limited regarding the long-term effectiveness and scalability of community-integrated care, culturally adapted psychosocial interventions, grief and bereavement services, digital-health models and task-sharing approaches. Further research is also needed on caregiver outcomes, health-economic effects, sustainable financing, dementia and ageing-related PC, paediatric PC and the integration of PPEoLC into primary healthcare and universal health coverage. Greater investment in African-led research infrastructure, international collaboration and implementation research will be necessary to address these gaps without treating African contexts as uniform.

There are limitations to the findings of the Symposium that have been reported here. The priority domains were identified through a review of symposium materials rather than a formal qualitative analysis. Although the symposium brought together a multidisciplinary and international audience, it did not include representation from every African country or health-system context. The anonymous post-symposium survey had a small number of respondents and was used only as supplementary input. The framework should therefore be understood as a conference-derived agenda for continued refinement rather than as a definitive or representative statement of priorities across the African continent.

Conclusion

The 2025 PPEoLC in Africa symposium highlighted that advancing PPEoLC across African contexts requires more than expanding access to services. Effective care of this kind must also be culturally and spiritually responsive, grounded in family and community relationships, evaluated using contextually relevant measures, supported by a trained and appropriately supervised workforce and integrated within accessible and sustainable health systems. Digital innovation may contribute to these efforts when it is implemented equitably and complements, rather than replaces, relational care.

The six interconnected priorities identified through the symposium provide a conference-derived framework for action across clinical practice, policy, education and research. Progress will require coordinated efforts to strengthen community-integrated care, workforce capacity, measurement, health-system implementation and the development and evaluation of locally responsive models of care. Together, these priorities support a shift from documenting unmet need towards implementing and evaluating equitable PPEoLC that reflects what matters to patients, families and communities across diverse African settings. Continued dialogue was advanced at the 8th International African Palliative Care and Allied Services Conference in Botswana, where stakeholders further refined this agenda to support equitable and sustainable improvements in palliative and supportive care across Africa and to address what has been called the human crisis in cancer [65].

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List of abbreviations

ACP, Advance Care Planning; AYA, Adolescent and Young Adult; CHWs, Community Health Workers; EoL, End of life; LCGC, Lay Community Grief Counsellor; LMIC, Low- and Middle-Income Countries; CALM, Managing Cancer and Living Meaningfully; PC, Palliative Care; PPEoLC, Psychosocial, Palliative, and End-of-Life Care; QODD, Quality of Dying and Death Questionnaire.

Conflicts of interest

The authors declare that there are no potential conflicts of interest to disclose.

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