Research Square

Preprints are preliminary reports that have not undergone peer review.
They should not be considered conclusive, used to inform clinical practice,
or referenced by the media as validated information.

Perceived facilitators and barriers to advance care planning participation among patients receiving palliative care in a Teaching Hospital in Ghana: a qualitative descriptive study

Erica Sackitey
St Martin de Porres Catholic hospital
Bisi Adewale
badewale@ug.edu.gh
University of Ghana
Sulleh Gbande
University of Health and Allied Sciences, School of Nursing and Midwifery

Research Article

Keywords: Advance care planning, Palliative care, End-of-life care, Barriers, Facilitators, Ghana, Patient perspectives, Qualitative research

Posted Date: November 25th, 2026

DOI: https://doi.org/10.21203/rs.3.rs-11578556/v1

License: This work is licensed under a Creative Commons Attribution 4.0 International License.
Read Full License

Additional Declarations: No competing interests reported.

Abstract

Background

Advance Care Planning (ACP) is a patient-centered process that enables individuals to discuss and document their values, goals, and preferences regarding future healthcare. ACP has been associated with improved quality of end-of-life care, enhanced patient autonomy, reduced unwanted interventions, and better alignment of care with patients' wishes. Despite its demonstrated benefits, ACP remains underutilized across many low- and middle-income countries, including Ghana. Limited evidence exists regarding patients' experiences, perceptions, and engagement with ACP within Ghanaian palliative care settings. Understanding the factors that facilitate or hinder participation in ACP is essential for developing culturally appropriate interventions and policies that support person-centered palliative care. This underscores the need for the study.

Methods

The study adopted a qualitative descriptive design to explore the perceived facilitators and barriers to advance care planning participation among patients receiving palliative care at Korle-Bu Teaching Hospital, Ghana. Thirty participants were purposefully sampled. Data were collected through semi-structured in-depth interviews and analysed using inductive content analysis. Ethical approval was obtained, and the study was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines.

Results

Four major themes and ten sub-themes emerged from the study. Participants described Advance Care Planning (ACP) as a means of communicating future care preferences, preparing families, and reducing uncertainty, although misconceptions about ACP and death, sociocultural beliefs, and health-system constraints influenced willingness and opportunities to engage in ACP.

Conclusion

Participants identified effective communication, family support, trust, perceived benefits, and readiness as key facilitators of ACP participation, while limited awareness, misconceptions, cultural and religious influences, fear of death, inadequate time, lack of privacy, and weak institutional processes were perceived barriers. Participants perceived that ACP participation among palliative care patients at Korle-Bu Teaching Hospital is influenced by interconnected interpersonal, sociocultural, and health-system factors.

Background

Advance care planning (ACP) is an ongoing process through which individuals communicate their values, preferences, and goals regarding future healthcare decisions, particularly when they may lose decision-making capacity (1). ACP promotes patient autonomy, shared decision-making, and person-centred care while facilitating timely discussions regarding future treatment preferences and end-of-life care(2).

Globally, ACP has gained recognition as a fundamental component of high-quality palliative care and serious illness management (2, 3). Evidence suggests that ACP improves communication among patients, families, and healthcare professionals, enhances satisfaction with care, reduces decisional conflict, and increases the likelihood that healthcare received aligns with patients' stated preferences (4, 5). Despite these documented benefits, ACP uptake remains suboptimal in many healthcare settings, particularly in low- and middle-income countries where limited awareness, sociocultural factors, inadequate healthcare infrastructure, and insufficient provider training may impede engagement(2, 6).

In Ghana, palliative care services have expanded considerably over the past decade, particularly in tertiary healthcare institutions such as Korle-Bu and Ho Teaching Hospitals, reflecting broader efforts to integrate palliative care into national health services (7, 8). However, discussions regarding prognosis, future treatment preferences, and end-of-life care decisions are often delayed or avoided altogether (9, 10). Cultural values that emphasize family-centred decision-making, reluctance to discuss death and dying, and spiritual interpretations of illness may influence individuals' willingness to engage in ACP discussions (9, 11). Additionally, healthcare professionals may encounter institutional, structural, and resource-related barriers that limit the effective implementation of ACP within routine clinical practice (2, 6).

Although previous studies have examined palliative care experiences among individuals living with life-limiting illnesses in sub-Saharan Africa (9, 12), empirical evidence regarding patients' understanding and perceptions of ACP in Ghana remains limited. Consequently, there is a critical need to explore the factors that facilitate and hinder ACP participation among patients receiving palliative care. Such evidence is essential for strengthening patient-centred care, informing culturally appropriate ACP interventions, and guiding the development of policies and implementation strategies within Ghanaian healthcare settings (1, 13). Therefore, this study explored the perceived facilitators and barriers to advance care planning participation among patients receiving palliative care at Korle-Bu Teaching Hospital, Ghana. The research question was: What are the perceived facilitators and barriers influencing ACP participation among patients receiving palliative care at Korle-Bu Teaching Hospital?

Methods

Study Design

This study employed a qualitative descriptive design to explore the perceived facilitators and barriers to Advance Care Planning (ACP) participation among patients receiving palliative care at Korle-Bu Teaching Hospital (KBTH), Ghana. A qualitative descriptive design is appropriate for exploring and providing a comprehensive description of participants' experiences, perceptions, views, and healthcare practices in their own words (14). This design enabled the study to capture how patients understood ACP, the factors that encouraged or discouraged participation, and the contextual circumstances shaping their willingness and ability to engage in ACP discussions and decision-making. In this study, Advance Care Planning (ACP) will refer to an ongoing process through which patients, in consultation with healthcare professionals and, where appropriate, family members or significant others, discuss and communicate their values, preferences, goals, and wishes regarding future healthcare and end-of-life care. The reporting of the study followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines to enhance methodological rigor, transparency, and completeness in reporting the research process(15).

Participants and Setting

The study was conducted at Korle-Bu Teaching Hospital (KBTH), Accra, Ghana between May and October 2026, a major tertiary healthcare facility that provides specialised medical and surgical services, including palliative care. As the largest teaching and referral hospital in Ghana, KBTH serves patients with advanced and life-limiting illnesses from across the country. The palliative care unit receives referrals from various clinical specialties, including oncology, internal medicine, surgery, and neurology, and manages a substantial caseload of patients with cancer and other chronic life-limiting conditions. Approximately 800-1,000 patients are reviewed annually through outpatient consultations, inpatient referrals, and follow-up services. The palliative care team consists of specialist physicians, nurses with training in palliative care, psychologists, social workers, pharmacists, and chaplaincy personnel. Nurses and physicians play central roles in discussing patients' goals of care, treatment preferences, and future healthcare needs, making them particularly relevant to Advance Care Planning (ACP) activities. ACP, including discussions about prognosis, treatment preferences, end-of-life care, and family involvement in decision-making are integrated into palliative care consultations at KBTH. The palliative care services provide an appropriate setting for exploring ACP, given the relevance of discussions concerning patients' goals, preferences, values, and future healthcare needs in the context of serious and life-limiting illness. Participation comprised adult patients aged 18 years and above who were receiving palliative care at KBTH. Participants were eligible if they were receiving palliative care for a serious or life-limiting illness, were clinically stable enough to participate in an interview, were able to communicate their views and experiences, and were willing to provide informed consent. Participants were also expected to have sufficient cognitive and communication capacity to engage meaningfully in discussions concerning ACP. Patients who were critically ill or experiencing acute clinical deterioration at the time of recruitment, those who were unable to participate in an interview because of severe physical or cognitive impairment, and those who were unable to provide informed consent were excluded. Patients experiencing significant distress or discomfort during recruitment or data collection were also not required to

participate or continue with the interview. These criteria were intended to minimise participant burden and ensure that participation was ethically appropriate and sufficiently meaningful.

Sampling and Recruitment/data Collection

Data were collected through in-depth, semi-structured individual interviews with patients receiving palliative care at Korle-Bu Teaching Hospital (KBTH). Ethical approval was obtained from the appropriate institutional review board prior to commencement of the study. Eligible participants were provided with detailed information about the study, including its purpose, procedures, potential risks and benefits, confidentiality measures, and their right to withdraw at any time without affecting their clinical care. Written informed consent was obtained from all participants before data collection.

The interviews were conducted by the first author, a female palliative care nurse specialist and nurse researcher who was, at the time of the study, a final-year trainee in the three-year Membership Fellowship Programme in Palliative Care at the Ghana College of Nurses and Midwives. She had received formal training in qualitative research methods, including qualitative data collection and analysis. The second and third authors, who are experienced researchers in palliative care, provided ongoing supervision throughout the study.

Prior to recruitment, the interviewer had no prior clinical or personal relationship with any of the participants and was not previously known to them. At the point of recruitment and consent, participants were informed of the interviewer's role as both a nurse researcher and a specialist in palliative care, as well as the purpose of the study. Although the interviewer acknowledged a professional interest in promoting patient-centred communication and understanding patients' preferences for future care, she remained aware that ACP is a relatively unfamiliar concept within the Ghanaian healthcare context and sought to minimise the influence of personal assumptions on data collection and interpretation. Reflexivity was maintained through field notes, regular discussions with the supervisory team, and continuous reflection on how the researcher's professional background and experiences might shape data collection, analysis, and interpretation. There was no indication that the researcher's professional role influenced participants' willingness to participate or the nature of their responses.

Participants were purposively recruited from patients attending the palliative care unit at KBTH between May and October 2026. Potential participants were screened by the first author against predefined eligibility criteria and approached after consultation with members of the clinical team to ensure that participation was appropriate and would not impose undue burden. Purposive sampling was employed to achieve maximum variation in participant characteristics, including age, sex, diagnosis, religious affiliation, and duration of engagement with palliative care services, thereby ensuring diverse perspectives on Advance Care Planning (ACP).

Interviews were conducted at times convenient for participants in a private and comfortable setting within the hospital to promote confidentiality and facilitate open discussion. A semi-structured interview

guide made up of sections A (Socio-demographic characteristics of participants) and section B (Interview Questions) was used to ensure consistency across interviews while allowing sufficient flexibility to explore issues emerging during data collection. The guide included questions relating to participants' understanding and awareness of ACP, experiences of discussing future healthcare preferences, willingness to engage in ACP, perceived facilitators and barriers to ACP participation, the influence of family members and significant others, communication with healthcare professionals, and the role of cultural, religious, and spiritual beliefs in decision-making. Probing questions were used to clarify responses and explore topics in greater depth (Appendix A). All participants elected to speak English but one. Interviews conducted in Twi was transcribed verbatim in Twi and subsequently translated into English by qualified person. The translated transcripts were compared with the original recordings to preserve meaning and culturally specific expressions. All interviews were audio-recorded with permission, and lasted approximately 45–60 minutes. Field notes were maintained throughout the study to document contextual observations, researcher reflections, and emerging insights.

Data Analysis

Data were analysed using an inductive content analysis approach, which allowed codes, sub-themes, and themes to emerge directly from participants' narratives rather than being imposed a priori. This approach was considered appropriate for exploring patients' perceptions and experiences of Advance Care Planning (ACP) participation, particularly the factors they perceived as facilitating or hindering their engagement in ACP within the palliative care context (16). The interviews were transcribed verbatim and reviewed repeatedly by the research team to facilitate immersion in the data and ensure familiarity with participants' accounts. Coding was conducted manually using a systematic, stepwise process. Initially, the transcripts were read line-by-line to identify meaningful units of text relevant to participants' understanding and experiences of ACP participation. These units were assigned initial codes that reflected participants expressed meanings, perceptions, and experiences. The initial codes were subsequently compared across transcripts, refined, and grouped into sub-themes based on similarities, differences, and conceptual relationships. Related sub-themes were then synthesised into overarching themes representing the perceived facilitators and barriers to ACP participation among patients receiving palliative care. Particular attention was given to both common and divergent perspectives, shaped participants' willingness or ability to engage in ACP. To enhance the rigour, credibility, and trustworthiness of the findings, transparent discussion and reflexive comparison process was employed. The first author conducted the initial coding of the transcripts, while a second and third coder independently coded a subset of the transcripts using the same raw data and coding framework. The resulting codes were compared, and areas of agreement and disagreement were identified. Differences in coding and interpretation were discussed iteratively among members of the research team until consensus was reached. These discussions resulted in further refinement of the coding framework and helped ensure consistency and clarity in the interpretation of participants' accounts. Data collection and analysis occurred at the same time till data saturation was achieved. Data saturation is when no new codes, sub-themes emerge from subsequent interviews (17). In this study, saturation was assessed

through ongoing comparison of emerging codes, sub-themes and themes across interviews, supported by a saturation-tracking process that documented the emergence of new concepts throughout data collection. By the 28th interview, no new codes relevant to the research question were identified. Two additional interviews (participants 29 and 30) were subsequently conducted as confirmation interviews and did not generate substantially new concepts. Therefore, a final sample of 30 participants was considered sufficient to achieve informational redundancy and provide a comprehensive understanding of patients' perceived facilitators and barriers to ACP participation.

Trustworthiness

Several strategies were employed to ensure the credibility, dependability, confirmability, and transferability of the study findings (18, 19). Data collection was conducted by the first author, a trained nurse researcher with experience in qualitative research, palliative care, and patient-centred communication. Prior to data collection, the interviewer received additional orientation on qualitative interviewing techniques, reflexivity, and the principles of Advance Care Planning (ACP) to promote consistency in interviewing and minimize potential interviewer bias. Throughout the study, the interviewer maintained a reflexive stance by critically examining personal assumptions, professional experiences, and potential influences on participants' accounts and their interpretation through reflective note-taking and regular discussions with the research team. The interviewer had no prior personal or therapeutic relationship with the participants before the study, thereby reducing the potential for undue influence or socially desirable responses. Consistency in data collection was supported through the use of a trained interviewer and a semi-structured interview guide developed to explore participants' experiences, perceptions, and views regarding ACP participation. Interviews were audio-recorded and transcribed verbatim to preserve the depth and authenticity of participants' accounts. Credibility was enhanced through member checking, whereby five participants were given an opportunity to clarify or confirm the accuracy of the researchers' interpretations of their experiences and perspectives by reading their transcript to them. Dependability was supported by maintaining a detailed audit trail documenting decisions related to participant recruitment, data collection, coding, and analysis. To enhance confirmability, multiple members of the research team participated in the coding and interpretation of the data, with regular discussions held to compare interpretations and resolve discrepancies. Finally, thick and rich descriptions of the study setting, participants, and contextual factors influencing ACP participation were provided to enhance transferability and enable readers to assess the applicability of the findings to similar palliative care settings and patient populations.

Ethical Considerations

Ethical clearance for the study was obtained from the Korle Bu Teaching Hospital Ethics and Protocol Review Committee (KBTH/00180/2026) before commencement of data collection. Administrative permission was also obtained from the management of Korle Bu Teaching Hospital and the Head of the Palliative Care Unit. The study adhered to the ethical principles of the Declaration of Helsinki and

relevant Ghanaian laws, regulations, and guidelines governing health research. Before enrolment, prospective participants received adequate information about the study, including its purpose, procedures, possible risks, anticipated benefits, and their role in the research. Participation was entirely voluntary, and written informed consent was obtained from each participant before any study-related data were collected. Participants were explicitly informed that they could refuse to participate or discontinue their involvement at any stage without penalty and without affecting the care or services they received at the hospital. Measures were implemented to protect participants' privacy, confidentiality, and anonymity throughout the research process. Participants were identified using study-specific codes rather than their names, and identifying information was excluded from transcripts, analyses, and research reports. Audio recordings and electronic transcripts were stored securely in password-protected files, with access restricted to authorized members of the research team. All information obtained during the study was used solely for research purposes, and findings were presented collectively to minimize the possibility of linking reported findings to individual participants

Results

Socio-demographic characteristics of participants

The study comprised of 30 participants who had a mean age of 53 years (range: 30–71 years), with females constituting the majority (56.7%). Breast cancer was the most common diagnosis (26.7%), while most participants were Christians (73.3%). More than half (56.7%) had received palliative care for 1–2 months

Table 1: Socio-demographic characteristics of participants

Characteristic	n (%)
Age, mean/median (range)	53.0/53.5 (30–71)
Gender	
Female	17 (56.7)
Male	13 (43.3)
Diagnosis	
Breast cancer	8 (26.7)
Prostate cancer	5 (16.7)
Cervical cancer	5 (16.7)
Hepatocellular carcinoma	5 (16.7)
Lung cancer	1 (3.3)
HIV/AIDS	1 (3.3)
Colorectal cancer	1 (3.3)
Ovarian cancer	2 (6.7)
Pancreatic cancer	1 (3.3)
Brain tumour	1 (3.3)
Religion	
Christian	22 (73.3)
Muslim	6 (20.0)
Traditional religion	2 (6.7)
Duration of palliative care	
<1 month	4 (13.3)
1–2 months	17 (56.7)
3–4 months	9 (30.0)

Note: Ca. = carcinoma; PC = palliative care.

Themes and Sub-themes

To answer the research question, "What are the perceived facilitators and barriers influencing Advance Care Planning (ACP) participation among palliative care patients at Korle-Bu Teaching Hospital?", four major themes and ten sub-themes emerged from the data (**Table 2 below**). Theme 1, Understanding,

Readiness, and Perceived Value of ACP, comprised three sub-themes: (a) knowledge and awareness; (b) perceived benefits and relevance; and (c) emotional readiness. Theme 2, Relational Conditions for ACP Participation, included three sub-themes: (a) healthcare provider communication; (b) family involvement and shared decision-making; and (c) trust and emotional safety. Theme 3, Sociocultural and Emotional Barriers, consisted of two sub-themes: (a) cultural, religious, and social influences; and (b) fear, stigma, and misconceptions. Theme 4, Health System Conditions Enabling or Constraining ACP, comprised two sub-themes: (a) time, privacy, and organisational resources; and (b) continuity, documentation, and institutional support.

Table 2: Themes and Sub-themes

Theme	Sub-theme
1. Understanding, readiness and perceived value of ACP	1. Knowledge and awareness 2. Perceived benefits and relevance 3. Emotional readiness
2. Relational conditions for ACP participation	1. Healthcare-provider communication 2. Family involvement and shared decision-making 3. Trust and emotional safety
3. Sociocultural and emotional barriers	1. Cultural/religious/social influences 2. Fear, stigma and misconceptions
4. Health-system conditions enabling or constraining ACP	1. Time, privacy and organisational resources 2. Continuity, documentation and institutional support

Theme 1: Understanding, Readiness, and Perceived Value of ACP

Three sub-themes emerged under this theme: knowledge and awareness of ACP; perceived benefits and relevance; and emotional readiness.

- Knowledge and awareness of ACP

Limited familiarity with ACP was evident in accounts describing uncertainty about its purpose, timing, and relationship to treatment decisions. Some accounts also reflected misconceptions that ACP was primarily associated with dying or discontinuing treatment.

“I had not heard the term advance care planning before. I knew that patients could tell the doctors what they wanted, but I did not know that these discussions could be made in advance, before a person becomes too sick to decide.” (P1)

“I used to think that when the doctors start talking about planning for future care, it means there is nothing more they can do. I did not understand that it is also about making sure your wishes are known.” (P30)

- Perceived benefits and relevance

ACP was valued as a means of preserving patients’ preferences, preparing families for future decisions, and reducing uncertainty when patients may no longer be able to communicate their wishes.

“If I tell my family and the healthcare workers what I want now, they will not be confused later. Even if I cannot speak for myself, they will have something to guide them.” (P5)

“It can prevent problems in the family because everybody will know what the patient wants. When there is no discussion, different people may have different ideas about what should be done.” (P11)

- Emotional readiness

Readiness to engage in ACP appeared to develop alongside greater understanding and acceptance of future-care discussions. Although conversations about death could initially evoke fear or discomfort, some accounts reflected willingness to engage when discussions were approached sensitively and at an appropriate time.

“When the topic first came up, I became worried because I thought they were saying my condition was getting worse. After I understood what the discussion was about, I realised that it was about preparing for my care, not giving up on me.” (P6)

“I would rather talk about these things while I can still make decisions. It may not be easy to talk about death, but I think my family should know what I want instead of making decisions for me without knowing.” (P14)

Theme 2: Relational Conditions for ACP Participation

Three sub-themes emerged under this theme: healthcare provider communication; family involvement and shared decision-making; and trust and emotional safety.

- Healthcare provider communication

The quality and clarity of communication shaped willingness to participate in ACP. Clear explanations, opportunities to ask questions, and patient-centred conversations appeared to make ACP more accessible, whereas unfamiliar medical terminology could discourage engagement.

“What helped me was that the nurse explained it in a simple way and allowed me to ask questions. I did not feel that a decision was being forced on me; I felt that they wanted to know what was important to me.” (P7)

“Sometimes the healthcare workers use words that ordinary people may not understand. If they explain ACP using simple language, I think more patients will feel comfortable discussing their wishes.” (P12)

- Family involvement and shared decision-making

Family participation was viewed as important within the context of serious illness, particularly for providing support and understanding patients’ preferences. At the same time, the accounts emphasised the importance of ensuring that family involvement does not displace the patient’s own wishes.

“I would want my children to hear what I want because they may be the ones supporting me later. If they know my wishes now, they will not have to make difficult decisions without knowing what I would have chosen.” (P9)

“The family should be involved because they are part of the patient’s life, but they should not decide everything for the patient. The healthcare provider should make sure that the patient is also given the opportunity to say what he or she wants.” (P15)

- Trust and emotional safety

Trust in healthcare providers and a sense of emotional safety facilitated openness about personal concerns, fears, and preferences. Respectful listening appeared particularly important when discussing sensitive issues related to future care and death.

“I would not tell just anybody about these things. When the nurse listens carefully and does not judge me, I feel that I can talk about my fears and what I would want if my condition becomes worse.” (P4)

“When the healthcare provider gives you time and treats you with respect, you feel that your concerns matter. That kind of support makes it easier to talk about things that are difficult to discuss with other people.” (P10)

Theme 3: Sociocultural and Emotional Barriers

Two sub-themes emerged under this theme: cultural, religious, and social influences; and fear, stigma, and misconceptions.

- Cultural, religious, and social influences

Cultural expectations surrounding family authority and religious beliefs concerning death shaped how ACP was understood and approached. For some, discussing future care was viewed as a matter that should involve family members, while religious interpretations could make conversations about death more sensitive.

“In my family, when someone is seriously ill, important decisions are discussed with the family. I would not want to make such a decision completely by myself because my relatives are also the people who will

support me." (P6)

"My religion teaches me to trust God concerning life and death. Because of this, some people may feel uncomfortable discussing death too directly. They may think that doing so shows that they have lost faith." (P13)

- Fear, stigma, and misconceptions

Emotional and cognitive barriers were reflected in fears that ACP could signify treatment failure, loss of hope, or an expectation of imminent death. Such interpretations could make individuals reluctant to initiate or participate in discussions about future care.

"When they first mentioned planning for future care, I became frightened. I thought perhaps the doctors had reached the end of the treatment and were preparing me to die." (P2)

"Some people are afraid to talk about death because they believe that mentioning it can bring it closer. I also had that feeling before, but later I understood that discussing my wishes does not mean that I have stopped hoping for better health." (P9)

Theme 4: Health System Conditions Enabling or Constraining ACP

Two sub-themes emerged under this theme: time, privacy, and organisational resources; and continuity, documentation, and institutional support.

- Time, privacy, and organisational resources

The opportunity to engage meaningfully in ACP was influenced by the availability of consultation time, privacy, and organisational capacity. Busy clinical environments and brief consultations could limit opportunities for patients to explore complex and sensitive future-care preferences.

"There are times when the nurses and doctors have many patients to attend to, so the consultation is very short. ACP needs more time because patients may have questions and may need to think before explaining what they want." (P5)

"I would feel more comfortable discussing personal matters in a place where other people cannot hear us. When the environment is crowded or the healthcare provider is in a hurry, you may decide not to talk about certain things." (P12)

- Continuity, documentation, and institutional support

Consistent institutional processes and accessible documentation were perceived as important for maintaining continuity when several healthcare providers are involved in a patient's care. Clear procedures could reduce the need for patients to repeatedly communicate the same preferences and help ensure that previously expressed wishes remain visible to the care team.

“There should be a clear way of doing advance care planning in the hospital so that patients are not given different information by different healthcare workers. If everyone follows the same process, it will be easier for patients to understand what is expected.” (P7)

“If I have already discussed my wishes with one healthcare provider, the next person should be able to see what was discussed. Keeping it in the patient’s records would help because I may not always be able to repeat everything each time I come to the hospital.” (P16)

Discussion

This study explored the perceived facilitators and barriers influencing Advance Care Planning (ACP) participation among palliative care patients at Korle-Bu Teaching Hospital (KBTH). The findings indicate that ACP participation is a multifaceted and relational process shaped by patients’ knowledge and perceptions, communication with healthcare professionals and family members, cultural and religious beliefs, and health-system conditions. Importantly, the findings should be interpreted within the Ghanaian and broader African context, where decisions concerning serious illness and end-of-life care are often embedded within family relationships, spirituality and communal responsibilities. Recent Ghanaian literature similarly characterises death and dying as culturally, spiritually and communally situated experiences, with family members playing important roles in caregiving and decision-making (20). Thus, ACP participation in this setting may be better understood as a process of relational engagement rather than solely as an individual decision or documentation exercise.

Understanding and perceptions of ACP

A major finding was that limited knowledge and misconceptions about ACP constrained willingness to participate. Some participants initially associated ACP with imminent death, treatment failure, or abandonment of active care. This finding is particularly relevant in Ghana, where awareness and understanding of palliative care remain uneven. A qualitative study among people living with cancer in Ghana found that patients expected meaningful information about their condition and prognosis but also identified limited awareness of palliative care services as a barrier to accessing appropriate care (21). Although that study did not specifically examine ACP, its findings provide an important contextual explanation for the limited ACP literacy observed in the present study.

Evidence from elsewhere in Africa similarly indicates that ACP remains insufficiently integrated into routine palliative care. In Uganda, Guma et al. (22) identified sociocultural beliefs, family influence, religious beliefs, limited professional time, lack of a legal framework, denial and information-sharing practices as barriers to ACP implementation among professionals caring for patients with advanced cancer. Basirika et al. (23) likewise observed that ACP remains relatively under-researched and inconsistently implemented across African palliative care settings. These African findings suggest that limited ACP participation should not necessarily be interpreted as patient unwillingness; rather,

participation may depend on whether patients have been given accessible information and opportunities to understand ACP within their own cultural and clinical context.

The finding that participants became more receptive after receiving clear explanations further supports this interpretation. It suggests that apparent resistance may partly reflect unfamiliarity with ACP and concerns about what it signifies. This is consistent with evidence that ACP conversations can become more acceptable when introduced gradually, with adequate explanation and attention to patients' readiness. International evidence similarly suggests that ACP is more appropriately conceptualised as an ongoing process of communication than as a one-time completion of an advance directive (1). In Ghana, therefore, improving ACP literacy may require repeated, plain-language conversations integrated into routine palliative care rather than relying on patients to initiate ACP independently.

Communication, trust and disclosure

Communication and trust were important facilitators of ACP participation. Participants preferred conversations that were respectful, understandable and responsive to their emotional needs, particularly when discussing prognosis, future care and death. This finding is strongly supported by Ghanaian evidence. Caulfield et al. (24), in a qualitative study of physicians communicating poor prognosis at Cape Coast Teaching Hospital, found that communication about poor prognosis was complex and highly dependent on contextual circumstances, with implications for autonomy, family involvement and ethical decision-making. Similarly, Ghanaian patients receiving palliative care have expressed expectations for meaningful communication about their condition and prognosis and active involvement in decisions concerning their care (21).

These findings are important because communication about death in Ghana cannot be separated from broader cultural meanings attached to dying. Recent Ghanaian scholarship describes death and dying as subjects influenced by communalism, spirituality and cultural norms, including reluctance to speak directly about death. Such norms may result in the use of euphemisms, avoidance of explicit prognostic discussions, or attempts to protect patients from distressing information (20). Consequently, effective ACP communication in Ghana may require clinicians to balance honesty and transparency with sensitivity to patients' emotional readiness, cultural expectations and preferred involvement of family members.

The present finding that trust facilitated ACP participation is also consistent with the broader African palliative care literature. The African Palliative Care Association recommends communication that addresses prognosis, goals of care, fears, concerns, end-of-life issues, family roles and patients' and families' beliefs about death and dying (25). Thus, culturally responsive ACP communication should not simply transfer communication models developed in high-income countries into Ghanaian practice. Instead, conversations should allow patients to determine how much information they want, who should be involved, and how spiritual and family concerns should be incorporated into discussions (26).

Family involvement and relational decision-making

Family involvement emerged as an important facilitator of ACP participation. Participants viewed relatives as essential partners in future care decisions, particularly if they subsequently became unable to make decisions for themselves. At the same time, participants indicated that family involvement should complement rather than replace their own preferences. This finding is particularly significant in the Ghanaian context, where family relationships constitute an important component of illness, caregiving and end-of-life decision-making. Recent Ghanaian literature identifies the family as a central stakeholder in the dying process and describes family involvement in caregiving, decision-making and bereavement as an important feature of Ghanaian palliative care (20). Similarly, Ghanaian patients with cancer receiving palliative care have expressed the expectation that they and their families should be actively involved in decision-making throughout the palliative-care trajectory (8, 21). This supports the present finding that ACP may be more acceptable when it recognises the patient's family as an important partner while preserving the patient's opportunity to express personal preferences.

African literature further supports the need for a culturally sensitive approach to autonomy. The African Cultural Concept of Death and the Idea of Advance Care Directives argues that conventional advance directives may appear overly individualistic within communitarian African contexts and emphasises the importance of involving family members while maintaining respect for patient autonomy (27). Evidence from Uganda similarly identifies family influence in decision-making as an important factor affecting ACP practice (28). Therefore, the findings from KBTH suggest that culturally appropriate ACP should not frame autonomy and family involvement as mutually exclusive. Rather, ACP conversations could explicitly explore the patient's preferred level of family involvement, identify a trusted surrogate decision-maker where appropriate, and clarify whose preferences should guide decisions if the patient loses decision-making capacity.

Cultural and religious beliefs

Cultural and religious beliefs also influenced ACP participation. Some participants perceived discussions about death as potentially undermining hope or conflicting with beliefs concerning divine control over life and death. These findings are consistent with Ghanaian literature describing the influence of religious and spiritual beliefs on perceptions of terminal illness and end-of-life care. Okyere (20) notes that beliefs in divine healing and spiritual intervention can shape responses to terminal illness and may sometimes contribute to reluctance to accept prognostic information or palliative care.

Similar patterns have been reported elsewhere in sub-Saharan Africa. Guma et al. (22) identified religious beliefs that may conflict with palliative-care practices as one of the barriers affecting ACP implementation in Uganda. However, spirituality should not be regarded only as a barrier. As reported by Selman et al. the African Palliative Care Association recognises spiritual beliefs as an important source of meaning, hope, comfort and support and recommends that patients' and families' spiritual values and practices be respected within palliative care (25). This distinction is important for interpreting the present findings: participants' religious beliefs did not necessarily represent rejection of ACP, but rather influenced the language, timing and framing through which ACP could be discussed (29).

Accordingly, ACP in Ghana may be more acceptable when conversations are framed around preparation, dignity, symptom relief, family wellbeing and maintaining meaningful goals rather than around death alone. Such an approach may allow healthcare professionals to acknowledge hope and spiritual beliefs while still facilitating realistic discussions about future care. Rather than positioning religious beliefs in opposition to ACP, culturally adapted ACP could incorporate patients' spiritual values and, where desired, involve appropriate family members or spiritual-care providers. This approach is consistent with African palliative-care standards, which emphasise assessment and respect for patients' and families' spiritual needs and collaboration with spiritual-care providers when appropriate.

Fear, stigma and communication about death

Fear of death and negative meanings attached to ACP constituted additional barriers. Participants associated ACP with impending death, particularly when discussions occurred during periods of clinical deterioration. This finding is consistent with the broader Ghanaian context, in which direct discussion of death may be culturally sensitive or avoided. Okyere (20) describes death as a subject surrounded by cultural and emotional sensitivities in Ghana and notes that reluctance to discuss dying may interfere with open conversations about prognosis and advance care planning. The African literature similarly identifies fear of death, grief, limited awareness and cultural beliefs as potential barriers to advance directives and ACP. These findings also suggest that the timing of ACP is important. If ACP is first introduced when patients are clinically deteriorating, it may be interpreted as an indication that death is imminent or that healthcare professionals have abandoned curative treatment. Earlier introduction within the palliative-care trajectory may therefore provide patients with greater opportunity to understand ACP, reflect on their values and involve family members before a crisis occurs. This interpretation is consistent with the conceptualisation of ACP as an ongoing process rather than an intervention reserved for the final days of life (1, 23).

Importantly, Ghanaian evidence indicates that structured approaches to end-of-life decision-making can improve aspects of care. A study conducted at a teaching hospital in Ghana found that a structured interdisciplinary approach to end-of-life decision-making was associated with improvements in pain control, completion of relationships and emotional responses to dying compared with usual care (30). Although this study was not specifically an ACP intervention, it provides local evidence that structured communication and decision-making processes can support quality end-of-life care. This strengthens the rationale for integrating ACP into routine palliative-care practice at KBTH rather than treating it as a separate or crisis-driven activity.

Health-system and organisational barriers

Finally, organisational and health-system factors influenced ACP participation. Participants identified limited consultation time, privacy concerns, staff workload, inconsistent communication and poor continuity of care as barriers to meaningful ACP conversations. These findings are consistent with evidence from Ghana and other African settings that palliative-care delivery is constrained by limited resources, service availability, referral pathways, public awareness and organisational support. In Ghana,

patients with cancer have reported difficulties related to appointment schedules, referral and follow-up, access to services and inadequate awareness of palliative care (21). Evidence from Uganda provides a particularly relevant African comparison. Guma et al. (22) reported limited professional time and the absence of a formal legal framework for ACP among barriers to its implementation. Basirika et al. (23) similarly noted that ACP remains insufficiently researched and implemented within African healthcare systems. These findings suggest that ACP participation cannot be addressed solely through patient education; organisational conditions must also support clinicians to initiate, document and revisit ACP conversations.

The participants' concern about having to repeatedly explain their preferences to different healthcare professionals further highlights the importance of continuity and documentation. In a busy tertiary hospital such as KBTH, ACP may be difficult to sustain when information is dispersed across providers or when no consistent institutional process exists for recording and communicating patients' preferences. As reported by Rhee et al. (31) the African Palliative Care Association's standards emphasise systematic communication, documentation, involvement of patients and families, and attention to psychosocial, spiritual and cultural needs as components of quality palliative care. Establishing a consistent ACP pathway, supported by appropriate documentation and staff training, could therefore help reduce fragmented communication and improve continuity.

Implications for palliative care practice

The findings have several implications for palliative care practice at KBTH and potentially similar palliative care settings. First, ACP education should be incorporated into routine palliative-care communication rather than introduced only when death is perceived to be imminent. Second, healthcare professionals require communication skills that enable them to explain ACP in clear, culturally appropriate language and respond to emotional reactions. Third, patients should be supported to determine the extent and nature of family involvement while ensuring that their preferences remain central. Fourth, healthcare institutions should consider establishing standardised ACP procedures, including documentation and mechanisms for communicating preferences across providers. Finally, organisational barriers such as insufficient consultation time and lack of privacy need to be recognised as implementation issues rather than simply patient-related barriers. These measures may help move ACP from an individually initiated conversation to a more systematic component of palliative care.

Limitation

Notwithstanding the methodological robustness and in-depth finding the study has several limitations that should be considered when interpreting the findings. First, it was conducted at a single tertiary healthcare facility, Korle-Bu Teaching Hospital (KBTH), and the experiences of patients receiving palliative care in this setting may differ from those in other hospitals or community-based palliative care services. Second, purposive sampling was used, meaning that participants were deliberately selected rather than randomly sampled; therefore, the sample may not capture the full range of perspectives among patients receiving palliative care. Third, patients who were unable to provide informed consent

because of severe cognitive or communication impairment were excluded, which may have limited representation of patients with more advanced illness or greater communication difficulties.

There is also the possibility of self-selection bias, as patients who agreed to participate and discuss ACP may have been more receptive to ACP-related conversations than those who declined. In addition, the involvement of a healthcare professional/nurse as the interviewer may have influenced participants' responses, particularly because participants may have perceived the interviewer as part of the healthcare system. Although efforts were made to create a supportive interview environment, such professional positioning may have introduced interviewer-related influence. Interviews conducted in Twi may also have involved translation-related interpretive challenges, whereby nuances, meanings, or culturally specific expressions may not have been fully retained in the English transcripts or reported quotations. Furthermore, social desirability bias cannot be excluded, as participants may have expressed views that they perceived as acceptable or favourable to healthcare professionals.

Finally, the findings have limited transferability beyond the study context. They should therefore not be interpreted as representative of all patients receiving palliative care in Ghana. Rather, the findings provide context-specific insights into how patients at KBTH perceive and experience factors influencing participation in ACP.

Conclusion

Patients' participation in advance care planning (ACP) at Korle-Bu Teaching Hospital was shaped by the interaction of interpersonal, sociocultural, and health-system factors. Effective communication, family support, trust, perceived benefits, and readiness appeared to facilitate engagement, whereas limited awareness, misconceptions, cultural and religious influences, fear of death, and constraints within the healthcare environment could hinder participation. These findings suggest that ACP in this setting needs to be approached as a relational and context-sensitive process that recognises patients' preferences while appropriately engaging families and addressing sociocultural and health-system barriers. Strengthening ACP communication, opportunities for private discussions, and institutional processes may help create a more supportive environment for ACP participation among patients receiving palliative care.

Declarations

Ethics approval and consent to participate

Ethical clearance for the study was obtained from the Korle Bu Teaching Hospital Ethics and Protocol Review Committee (KBTH/00180/2026) before commencement of data collection. Administrative permission was also obtained from the management of Korle Bu Teaching Hospital and the Head of the Palliative Care Unit. The study adhered to the ethical principles of respect for persons, beneficence, and

justice outlined in the Belmont Report and the principles of the Declaration of Helsinki. Written informed consent was obtained from all participants before their participation in the study.

Consent for publication

Not Applicable

Competing interests

The authors declare that they have no competing interests

Funding

The study received no founding

Author Contribution

E. S. Principal Investigator, Conceptualization, Methodology, Investigation, Formal analysis, Data curation, Writing – review & editing, approval of final manuscript BA: Co-Principal Investigator, Conceptualization, Methodology, Data curation, Formal analysis, Writing – review & editing, Supervision and approval of final manuscriptSG: Conceptualization, methodology, Writing – original drafting manuscript-editing, and approval of final manuscript

Acknowledgements

The authors acknowledge the staff and patients of Pediatric Oncology Unit, Korle-Bu Teaching Hospital for their assistance and support for this study. Also, the World Child Cancer, Ghana.

Data Availability

All data supporting the findings of this study are available within the paper and its Supplementary Information.Table 1: Socio-demographic characteristics of all participants .

References

1. Sudore RL, Lum HD, You JJ, Hanson LC, Meier DE, Pantilat SZ, et al. Defining advance care planning for adults: a consensus definition from a multidisciplinary Delphi panel. J Pain Symptom Manag. 2017;53(5):821–32.

2. Rietjens JAC, Sudore RL, Connolly M, van Delden JJ, Drickamer MA, Droger M, et al. Definition and recommendations for advance care planning: an international consensus supported by the European Association for Palliative Care. Lancet Oncol. 2017;18(9):e543–51.
3. World Health Organization. World Health Organization Definition of Palliative Care: World Health Organisation. 2023[Available from: https://www.publichealth.com.ng/who-definition-of-palliative-care/
4. Brinkman-Stoppelenburg A, Rietjens JAC, Van der Heide A. The effects of advance care planning on end-of-life care: a systematic review. Palliat Med. 2014;28(8):1000–25.
5. Detering KM, Hancock AD, Reade MC, Silvester W. The impact of advance care planning on end of life care in elderly patients: randomised controlled trial. BMJ. 2010;340.
6. Sleeman KE, De Brito M, Etkind S, Nkhoma K, Guo P, Higginson IJ, et al. The escalating global burden of serious health-related suffering: projections to 2060 by world regions, age groups, and health conditions. Lancet Global Health. 2019;7(7):e883–92.
7. Tackie-Martey NM, Adewale B, Gbande S. Caregivers' adoption of telemedicine for children with acute lymphoblastic leukaemia receiving oral chemotherapy in palliative care settings in Ghana: a qualitative study. BMC Palliat Care. 2026.
8. Gbande S, Maree JE, Obiora OL. A nurse-led palliative care programme for women receiving palliative chemotherapy for breast cancer. BMC Palliat Care. 2026.
9. Gysels M, Pell C, Straus L, Pool R. End of life care in sub-Saharan Africa: a systematic review of the qualitative literature. BMC Palliat care. 2011;10(1):6.
10. Evans N, Pasman HRW, Donker GA, Deliens L, Van den Block L, Onwuteaka-Philipsen B, et al. End-of-life care in general practice: a cross-sectional, retrospective survey of 'cancer','organ failure'and '. Palliat Med. 2014;28(7):965–75. old-age/dementia'patients.
11. McDermott E, Selman LE. Cultural factors influencing advance care planning in progressive, incurable disease: a systematic review with narrative synthesis. J Pain Symptom Manag. 2018;56(4):613–36.
12. Grant L, Brown J, Leng M, Bettega N, Murray SA. Palliative care making a difference in rural Uganda, Kenya and Malawi: three rapid evaluation field studies. BMC Palliat care. 2011;10(1):8.
13. World Health Organisation. Palliative care key facts [Online]. Geneva: World Health Organization 2020[Available from: https://www.who.int/news-room/fact-sheets/detail/palliative-care
14. Creswell JW, Creswell JD. Research design: Qualitative, quantitative, and mixed methods approaches. Sage; 2017.
15. Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int J Qual Health Care. 2007;19(6):349–57.
16. Kyngäs H. Inductive Content Analysis. In: Kyngäs H, Mikkonen K, Kääriäinen M, editors. The Application of Content Analysis in Nursing Science Research. Cham: Springer International Publishing; 2020. pp. 13–21.

17. Rahimi S, Khatooni M. Saturation in qualitative research: An evolutionary concept analysis. Int J Nurs Stud Adv. 2024;6:100174.
18. Lincoln YS, Guba EG. Naturalistic inquiry: sage; 1985.
19. Shenton A. Strategies for Ensuring Trustworthiness in Qualitative Research Projects. Educ Inform. 2004;22:63–75.
20. Okyere J. Death and dying in Ghana: Implications for palliative and end-of-life care. Palliat Care Soc Pract. 2025;19:26323524251376029.
21. Mensah ABB, Poku AA, Mensah KB, Okyere J, Mikare M, Apiribu F, et al. Expectations and barriers to the utilization of specialist palliative care services among persons living with cancer in Ghana: an exploratory qualitative study. Palliat Care Soc Pract. 2023;17:26323524231193042.
22. Guma S, Namisango E, Ddungu H. Advance Care Planning and palliative care for patients with advanced cancer in Uganda. Z Evid Fortbild Qual Gesundhwes. 2023;180:29–35.
23. Basirika D, Merriman A, Gumoyesige N, Namisango E, Matthews E, Guma S. Insights into Advance Care Planning in Africa. Z Evid Fortbild Qual Gesundhwes. 2023;180:16–20.
24. Caulfield A, Plymoth A, Nartey YA, Mölsted-Alvesson H. The 6-star doctor? Physicians' communication of poor prognosis to patients and their families in Cape Coast, Ghana. BMJ Global Health. 2020;5(6):e002334.
25. African Palliative Care Association. Standards for Providing Quality Palliative Care Across Africa 20211 [Available from: https://www.africanpalliativecare.org/web/sites/default/files/2023-10/APCA_StandardsStandards-for-Providing-Quality-Palliative-Care-Across-Africa.pdf?utm_source=chatgpt.com
26. Dix O. Impact of the APCA African Palliative Outcome Scale (POS) on care and practice. Health Qual Life Outcomes. 2012;4(1):11.
27. Ekore RI, Lanre-Abass B. African Cultural Concept of Death and the Idea of Advance Care Directives. Indian J Palliat Care. 2016;22(4):369–72.
28. Guma S, Namisango E, Ddungu H. Advance care planning and palliative care for patients with advanced cancer in Uganda. Zeitschrift für Evidenz, Fortbildung und Qualität im Gesundheitswesen. 2023;180:29–35.
29. Selman L, Harding R, Agupio G, Fox P, Galimaka D, Mmoledi K, et al. Spiritual care recommendations for people receiving palliative care in sub-Saharan Africa. London: With special reference to Uganda and South Africa Kings College; 2010.
30. Edwin AK, Johnson McGee S, Opare-Lokko EA, Gyakobo MK. A Structured Approach to End-of-Life Decision Making Improves Quality of Care for Patients With Terminal Illness in a Teaching Hospital in Ghana. Am J Hosp Palliat Care. 2016;33(2):144–9.
31. Rhee JY, Garralda E, Namisango E, Luyirika E, de Lima L, Powell RA, et al. The African Palliative Care Association (APCA) atlas of palliative care development in Africa: a comparative analysis. Lancet Global Health. 2018;6:S21.

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- APPENDIXASEMISTRUCTUREDINTERVIEWGUIDE.pdf
- Table11.docx