



CONFIGURATIONS OF COMPASSIONATE COMMUNITIES FOR THE PROVISION OF PALLIATIVE CARE: A SCOPING REVIEW

CONFIGURAÇÕES DE COMUNIDADES COMPASSIVAS PARA A OFERTA DE CUIDADOS PALIATIVOS: SCOPING REVIEW

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How to cite: Martins MR, Silva AE, Lima ALA, Jesus MLCSR, Raizaro EP, Silva KL. Configurations of compassionate communities for the provision of palliative care: a scoping review. *Online Braz J Nurs.* 2025;24(Suppl 2):e20256858. <https://doi.org/10.17665/1676-4285.20256858>

RESUMO

Objetivo: Mapear evidências científicas sobre as configurações de comunidades compassivas voltadas ao cuidado de pacientes, familiares e cuidadores com necessidades de cuidados paliativos. **Método:** Revisão de escopo, conduzida conforme as diretrizes do Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) e do JBI. A busca foi realizada nas bases de dados BVS, MEDLINE, SCOPUS e Web of Science, utilizando termos relacionados a "Comunidades Compassivas". Foram incluídos estudos quantitativos e qualitativos, sem restrições de idioma ou ano de publicação. O processo de seleção foi realizado no software Rayyan e, para a análise bibliométrica, utilizou-se o software R. **Resultados:** A busca identificou 667 estudos, dos quais 30 foram incluídos após triagem. As publicações, datadas entre 2013 e 2025, tiveram um pico em 2024, com a Espanha liderando o número de estudos (n=7). Allan Kellehear é a principal referência teórica. Identificaram-se 41 ações distribuídas em atividades culturais/educativas (34,2%), clínicas (26,3%), e ações normativas, de articulação intersetorial e de mobilização comunitária (13,1% cada). **Conclusão:** As comunidades compassivas promovem o debate sobre morte, luto e cuidados paliativos, valorizando atividades de promoção à saúde como elemento central. Elas fortalecem redes de suporte comunitário para abordagens paliativas mais inclusivas e equitativas.

Descritores: Cuidados Paliativos; Participação da Comunidade; Equidade.

ABSTRACT

Objective: To map the scientific evidence on the configurations of compassionate communities aimed at the care of patients, families, and caregivers with palliative care needs. **Method:** This is a scoping review conducted in accordance with the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) and JBI guidelines. The search was performed in the VHL, MEDLINE, SCOPUS, and Web of Science databases using terms related to "Compassionate Communities". Quantitative and qualitative studies were included, with no language or year of publication restrictions. The selection process was carried out using Rayyan software, and R software was used for bibliometric analysis. **Results:** The search identified 667 studies, of which 30 were included after screening. The publications, dated between 2013 and 2025, peaked in 2024, with Spain leading the number of studies (n=7). Allan Kellehear is the main theoretical reference. A total of 41 actions were identified, distributed among cultural/educational activities (34.2%), clinical activities (26.3%), and normative, intersectoral articulation, and community mobilization actions (13.1% each). **Conclusion:** Compassionate communities promote the discussion of death, grief, and palliative care, emphasizing health promotion activities as a central element. They strengthen community support networks for more inclusive and equitable palliative approaches.

Descriptors: Palliative Care; Community Participation; Equity.

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What is already known:

- Compassionate communities propose extending palliative care beyond formal health services by integrating community-based actions;
- Education on death, dying, grief, and palliative care is a frequent strategy within the scope of compassionate communities;
- There are still gaps in the structured provision of bereavement support, especially for individuals not covered by specialized teams.

What this article adds:

- Most of the mapped interventions focus on community education and strengthening support networks for care in vulnerable contexts;
- Nurses play a central role in care coordination and intersectoral articulation, expanding access to and continuity of palliative care;
- Compassionate practices are being incorporated into institutional policies in universities and companies, including benefits for employees and students.

INTRODUCTION

Compassionate communities are developed to support patients, families, and caregivers experiencing illness processes or life-threatening conditions. This movement offers community-based palliative care, with a primary focus on those requiring end-of-life assistance, also extending to issues related to death and bereavement⁽¹⁻²⁾.

The concept of compassionate communities, introduced by Allan Kellehear in Australia in the early 2000s, is based on the principle that health is a collective responsibility that transcends the exclusive role of health services. In this sense, just as it is fundamental to promote community initiatives aimed at disease prevention, it is also essential to foster palliative care, ensuring the correct identification and adequate treatment of multidimensional suffering⁽³⁾.

This approach seeks to encourage reflections on the natural process of dying, recognizing it as an inevitable dimension of the human condition. However, it is emphasized that while death is a natural outcome, the unnecessary suffering associated with the course of illness can be prevented through compassionate interventions⁽⁴⁾.

Thus, by stimulating initiatives that strengthen social mobilization, such as compassionate communities, residents of certain territories are enabled to actively participate in the construction of mutual care practices within their own communities. As an intersectoral model, compassionate communities encourage the collaboration of schools, community organizations, religious groups, health institutions, as well as patients, families, neighbors, and other citizens to create local support networks⁽⁵⁾.

This collaborative movement has been gaining global prominence as an important element in ensuring access to palliative care. Research conducted by Rolston et al.⁽⁶⁾ identified a significant increase in the production of studies on interventions related to compassionate communities, particularly in European countries such as the United Kingdom, Austria, Spain, Ireland, Sweden, Germany, Poland, and Portugal. A significant concentration of research was also observed in Canada and Australia. On a smaller scale, studies have been documented in locations such as Taiwan, India, Hong Kong, and Mexico.

Despite the increase in research on compassionate communities and the various interventions identified—including popular education actions in palliative care, cultural gatherings, volunteer initiatives, and clinical and multidimensional interventions⁽⁶⁾—gaps still persist in understanding how these practices can be implemented and adapted in different sociocultural and economic contexts, such as in developing countries and in areas of social vulnerability⁽⁵⁾.

Corroborating this perspective, a scoping review aimed at describing the practical implementation of compassionate communities and analyzing the methods for evaluat-

ing the effectiveness of their actions highlighted that adaptation to the sociocultural context is the main barrier to their implementation. Among the identified obstacles are local perceptions about asking for and offering help at the end of life, as well as the need to align proposed activities with cultural specificities, such as the language used, religious beliefs, and the inclusion of ethnic minorities in the provision of this type of care⁽⁵⁾.

In this context, this review is justified by the need to broaden the understanding of how compassionate communities are configured globally, considering the different economic, social, political, and cultural contexts. Considering these considerations, the following objective was defined: to map the scientific evidence on the configurations of compassionate communities aimed at the care of patients, families, and caregivers with palliative care needs.

METHOD

This is a scoping review developed according to the guidelines of the international guide Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR)⁽⁷⁾ and JBI⁽⁸⁾, with a protocol registered in the Open Science Framework (OSF).

The study was conducted between February and June 2025, following eight recommended methodological steps: (1) construction of the research protocol; (2) definition of the guiding question; (3) development of search strategies; (4) definition of inclusion criteria; (5) selection of evidence sources; (6) extraction of results; (7) analysis of the evidence; and (8) presentation of the synthesis of the evidence⁽⁸⁾.

The research protocol was developed as part of the Scoping Review course offered by the *stricto sensu* Public Health Graduate Program at the School of Medicine of the Federal University of Minas Gerais. The purpose of the protocol was to define the methodological criteria and ensure the transparency and reproducibility of the review. It was registered with the OSF under the DOI identifier: 10.17605/OSF.IO/JVBP6.

For the definition of the guiding question, the elements of the PCC acronym—Population (P), Concept (C), and Context (C)—proposed for this type of review were used⁽⁷⁻⁹⁾. Thus, the following research question was defined: "What are the configurations of compassionate communities, in a global context, for the care of patients, families, and caregivers with palliative care needs?" The components of the question were: Population - patients, families, and caregivers with palliative care needs; Concept - configurations of compassionate communities; and Context - global level.

Regarding the construction of the search strategy, the free terms "Comunidade Compassiva", "Comunidades Compassivas", "Compassionate Community", and "Compassion-

ate Communities" were used, combined with the Boolean operator "OR" (Chart 1), in the following databases: Virtual Health Library (VHL), USA National Library of Medicine (MEDLINE/PubMed), SCOPUS, and Web of Science.

Chart 1 - Search strategy. Belo Horizonte, MG, 2025

Database	Search strategy
Virtual Health Library	"Comunidade Compassiva" OR "Comunidades Compassivas" OR "Compassionate Community" OR "Compassionate Communities"
MEDLINE via PubMed SCOPUS Web of Science	"Compassionate Community" OR "Compassionate Communities"
Search strategy developed by the library service of the Federal University of Minas Gerais on 10/09/2024.	

As for the inclusion criteria, the Population (P) was defined as patients, families, and caregivers with palliative care needs. Patients are people who are experiencing serious, progressive, and life-threatening illnesses or conditions, and who may need relief from pain and other physical, psychological, social, and spiritual symptoms. Families and caregivers are part of the support network and therefore need guidance, psychological and social support, and preparation to deal with both the challenges of daily care and the bereavement process.

The Concept (C) corresponds to the configurations of compassionate communities, understood as initiatives that mobilize social networks, civil organizations, and local health services to offer support to people in palliative care. These communities can be realized through different strategies, such as educational activities in palliative care, cultural gatherings, volunteer actions, and clinical interventions.

Finally, the Context (C) refers to the global level. The actions developed by compassionate communities vary according to the historical, social, and economic characteristics of each country.

Therefore, for the selection of evidence sources, studies with quantitative and qualitative approaches were considered, with no restrictions on language or year of publication. Theses, dissertations, manuals, books, and government documents were also eligible. As exclusion criteria, studies that were not conducted in the context of compassionate communities or that only proposed the model without describing its application were disregarded. Additionally, duplicate studies and manuscripts that did not address the guiding question were excluded.

Regarding data extraction, the materials were submitted to an eligibility process using the Rayyan Qatar Computing Research Institute (Rayyan QCRI) software⁽¹⁰⁾, which was used to organize the process of reading and selecting studies. For this, two independent, previously trained researchers evaluated the titles and abstracts of the articles. Subsequently, the included studies were read in full to verify and exclude those that did not meet the established criteria. In cases of doubt about the eligibility of the material, a third trained researcher was called upon for the final decision.

After this step, the data were extracted using a form created by the authors themselves in a Microsoft Excel 2017 spreadsheet. Regarding the analysis and synthesis of the evidence, the data were presented descriptively and critically analyzed considering the literature. Additionally, a bibliometric analysis was performed with the help of R software,

which generated visual maps to identify trends and relationships between authors, citations, scientific production by country, among other indicators. This analytical approach favors the visualization of maps that facilitate a better interpretation of the data.

RESULTS

The search strategies resulted in a total of 667 articles. After the exclusion of 393 duplicate studies, 274 remained for analysis. In the first evaluation phase, based on the reading of titles and abstracts, 97 studies were excluded for not describing the application of a compassionate community, addressing the topic only theoretically. Of the 177 articles selected for full-text reading, 30 were included in the final review. Figure 1 presents the flow diagram for each step of the review process.

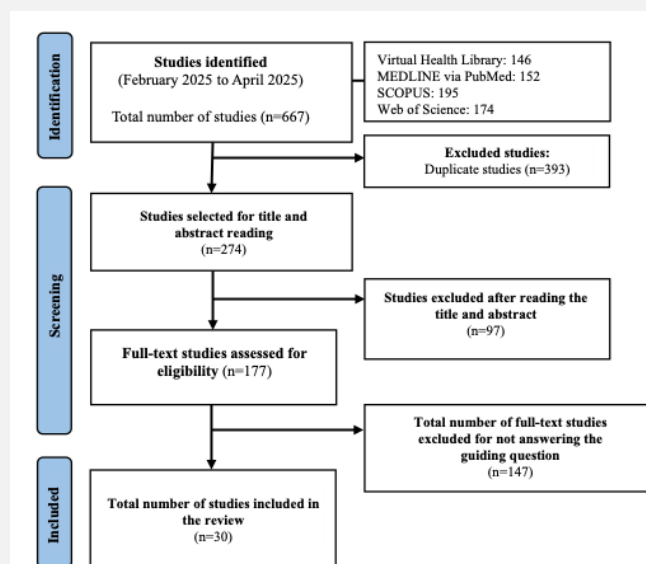


Figure 1 - Flowchart of the literature search and article selection, according to the PRISMA-ScR 2020 guidelines. Belo Horizonte, Minas Gerais, 2025

The analysis of the characteristics of the selected studies indicates a predominance of experience reports (n=8; 26.6%), followed by qualitative studies (n=7; 23.3%) and narrative reviews (n=4; 13.3%). Theoretical studies and mixed methods studies each accounted for (n=3; 10%). Less frequently, quantitative studies (n=2; 6.6%), a case study (n=1; 3.3%), action research (n=1; 3.3%), a scoping review (n=1; 3.3%), and a systematic review of mixed methods (n=1; 3.3%) were identified. The data describing the characteristics of the studies were compiled in Chart 2.

Regarding the publication period, the selected studies were published between 2013 and 2025. The year 2024 stood out with the highest number of publications (n=8; 26.7%), which indicates a recent increase in interest in the topic (Figure 2).

The average number of citations per article was 25.8, with the study by Allan Kellehear⁽³⁾ standing out, having accumulated 334 citations as of April 2025 (Figure 3).

The analysis of the co-authorship network reveals little connection between authors, demonstrating that the topic is still studied in isolation by different research groups (Figure 4).

Chart 2 - Characteristics of the selected studies. Belo Horizonte, MG, 2025

ID*	Title	Year	Country	Journal	Type of study
1	Assessing and comparing compassionate communities benefits across cities in diverse cultural contexts: a step toward the identification of the most important ones ⁽¹¹⁾	2025	Switzerland; Argentina; Colombia	Palliative Care & Social Practice.	Mixed methods study
2	A compassionate university for serious illness, death, and bereavement: Qualitative study of student and staff experiences and support needs ⁽¹²⁾	2024	Belgium	Death Studies	Qualitative study
3	A dimensão espiritual de pacientes em cuidados paliativos e seus cuidadores de uma comunidade compassiva de favela: estudo de método misto ⁽¹³⁾	2024	Brazil	Portal Regional da BVS	Mixed methods study
4	Advanced practice nursing in palliative care within the compassionate favela community: an experience report ⁽¹⁴⁾	2024	Brazil	Online Brazilian Journal of Nursing	Experience report
5	Age-Friendly Communities: Are they also "Friendly" for Death, Dying, Grief, and Bereavement? ⁽¹⁵⁾	2024	Canada	Canadian Journal on Aging La Revue canadienne du vieillissement	Theoretical study
6	Barriers and drivers of public engagement in palliative care, Scoping review ⁽¹⁶⁾	2024	Spain	BMC Palliative Care	Scoping review
7	Belonging, care, and support: findings from Ottawa's healthy end of life project ⁽¹⁷⁾	2024	Canada	Journal of Religion Spirituality & Aging	Case study
8	Caring neighbourhoods in Belgium: lessons learned on the development, implementation and evaluation of 35 caring neighbourhood projects ⁽¹⁸⁾	2024	Belgium	Palliative Care & Social Practice	Qualitative study
9	Comunidades Compassivas: uma resposta aos desafios em Cuidados Paliativos ⁽¹⁹⁾	2024	Portugal	Motricidade	Qualitative study
10	Bereavement care reimagined ⁽²⁰⁾	2023	United Kingdom, United States, Australia	Annals of Palliative Medicine	Narrative review
11	Comunidades Compasivas: intervención comunitaria para la prevención del duelo complicado. Modelo implantado por Madrid Salud ⁽²¹⁾	2023	Spain	Psicooncología	Mixed methods study
12	Civic engagement in serious illness, death, and loss: A systematic mixed-methods review ⁽²²⁾	2022	Belgium	Palliative Medicine	Systematic review of mixed methods
13	Community Based Participatory Research For The Development of a Compassionate Community: The Case of Getxo Zurekin ⁽²³⁾	2022	Spain	International Journal of Integrated Care	Action research
14	A Compassionate Communities Approach ⁽²⁴⁾	2021	Mexico	Journal of Social Work in End-of-Life & Palliative Care	Quantitative study
15	Centering sexual and gender diversity within Compassionate Communities: insights from a community network of LGBTQ2S+ older adults ⁽²⁵⁾	2021	Canada	Palliative Care and Social Practice	Qualitative study
16	A Public Health Approach to Palliative Care in the Canadian Context ⁽²⁶⁾	2020	Canada	American Journal of Hospice & Palliative Medicine	Qualitative study
17	Bereavement support: From the poor cousin of palliative care to a core asset of compassionate communities ⁽²⁷⁾	2020	Australia	Progress in Palliative Care	Quantitative study
18	Choice depends on options: A public health framework incorporating the social determinants of dying to create options at end of life ⁽²⁸⁾	2020	Australia	Progress in Palliative Care	Theoretical study
19	Compassionate communities and collective memory: A conceptual framework to address the epidemic of loneliness ⁽²⁹⁾	2019	United Kingdom	British Journal of Community Nursing	Theoretical study
20	Comunidades compasivas en Colombia para el apoyo a personas con enfermedad avanzada y al final de la vida: uniendo esfuerzos ⁽³⁰⁾	2019	Colombia	Medicina Paliativa	Experience report
21	All with you: A new method for developing compassionate communities—experiences in Spain and Latin-America ⁽³¹⁾	2018	Spain	Annals of Palliative Medicine	Experience report
22	A new method for developing compassionate communities and cities movement-"Todos Contigo" Programme (We are All With You): experience in Spain and Latin America countries ⁽³²⁾	2018	Spain	Annals of Palliative Medicine	Experience report
23	Building a narrative for compassionate communities: the case of Getxo Zurekin ⁽³³⁾	2018	Spain	International Journal of Integrated Care	Qualitative study
24	Celebrating indigenous communities compassionate traditions ⁽³⁴⁾	2018	Canada	Annals of Palliative Medicine	Experience report
25	Compassionate communities: Design and preliminary results of the experience of Vic (Barcelona, Spain) caring city ⁽³⁵⁾	2018	Spain	Annals of Palliative Medicine	Experience report
26	Compassionate communities in Canada: It is everyone's responsibility ⁽³⁶⁾	2018	Canada	Annals of Palliative Medicine	Narrative review
27	Compassionate Communities - From frailty to community resilience – making a public health approach to end of life care a reality ⁽³⁷⁾	2017	United Kingdom	International Journal of Integrated Care	Experience report
28	Comunidades compasivas en cuidados paliativos: Revisión de experiencias internacionales y descripción de una iniciativa en Medellín, Colombia ⁽³⁸⁾	2017	Colombia	Psicooncología	Narrative review
29	Compassionate communities: Case studies from Britain and Europe ⁽³⁹⁾	2016	United Kingdom	Routledge Key Themes in Health and Society	Experience report
30	Compassionate communities: End-of-life care as everyone's responsibility ⁽³⁾	2013	United Kingdom	QJM (Quarterly Journal of Medicine)	Narrative review

*ID: identification.

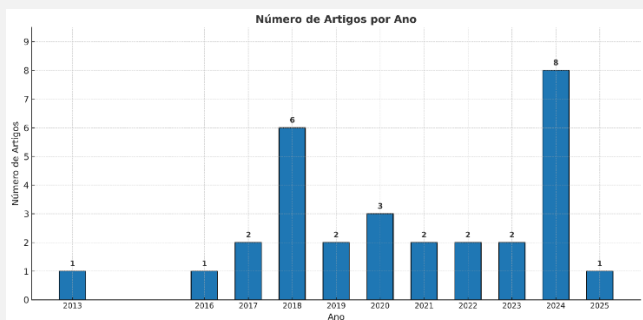


Figure 2 - Distribution of study publications by year. Belo Horizonte, MG, 2025

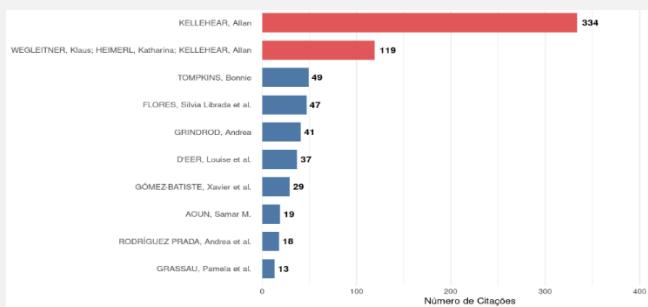


Figure 3 - Relationship of most cited authors. Belo Horizonte, MG, 2025.

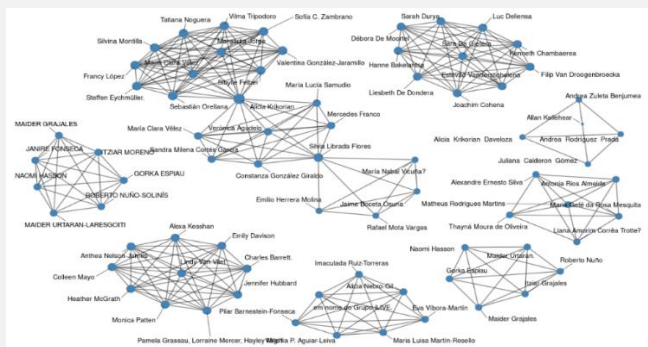


Figure 4 - Integration network among the authors. Belo Horizonte, MG, 2025

Regarding the geographical distribution of publications (Figure 5), Spain stood out with the highest number of studies (n=7), followed by Canada (n=5) and the United Kingdom (n=4). Six other countries were represented, including Brazil (n=2). Additionally, two studies were multi-center, involving Switzerland, Argentina, and Colombia in one, and the United Kingdom, United States, and Australia in the other.

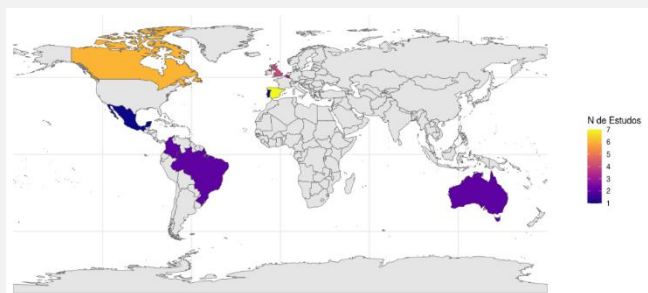


Figure 5 - World map with the number of studies per country. Belo Horizonte, MG, 2025

The analyzed evidence indicates that the actions de-

veloped by compassionate communities vary according to the social, cultural, and economic characteristics and the specific palliative care needs in each context. Interventions occur in different settings—community, home, outpatient, and hospital—and are distributed among cultural and educational practices (34.2%), clinical (26.3%), normative (13.1%), intersectoral articulation (13.1%), and community mobilization (13.1%), as systematized in Chart 3.

DISCUSSION

Across the studies, it is observed that the theoretical foundation of the actions undertaken is anchored in Allan Kellehear⁽³⁾, who stands out as the main conceptual reference adopted by researchers. The author proposes an expansion of the understanding of palliative care, conceiving it as a health promotion strategy, which enables its incorporation into community contexts and not just in institutions.

Considering this, it is noted that a large portion of the mapped interventions (34.2%) focuses on activities aimed at fostering community education in palliative care and on cultural activities about death, dying, and bereavement. Among the identified strategies are educational actions developed in educational institutions, such as schools and universities, and specific training for teachers, aiming to qualify the pedagogical approach to these topics in the school environment^(5,15,19,23-24,30-31,36,38).

Furthermore, there are palliative care education initiatives aimed at the context of sexual and gender diversity⁽²⁵⁾, as well as training actions for professionals from different areas, focusing on qualification for palliative care^(21,28,30-32). In the cultural sphere, noteworthy activities include intergenerational activities between children and the elderly, aimed at addressing social isolation and centered on valuing local memory and traditions⁽²⁹⁾; festivities with the purpose of welcoming new neighborhood residents as a way to strengthen neighborhood bonds⁽¹⁸⁾; and also practices that recover and respect traditional funeral rituals, as in indigenous communities⁽³⁴⁾.

These strategies seek to promote greater public awareness regarding the finitude of life and the shared responsibility in caring for people with weakened support networks. Additionally, they aim to stimulate reflection on inevitable aspects of the human experience, such as aging and death, fostering more receptive and supportive attitudes towards these processes^(11,20-21).

Beyond cultural and educational activities, palliative care practices by multiprofessional health teams were also recorded in home^(13-15,35,37-38), outpatient, and hospital settings⁽³⁸⁾. The distinguishing feature of some of these proposals is the formation of a community support network, in which citizens (neighbors) from the territory itself assist the teams in monitoring patients^(13-14,38).

In this scenario, nurses stand out for their clinical reasoning and ability to manage care. They use standardized instruments for the assessment and management of physical, psychological, and spiritual symptoms, both in face-to-face and telemonitoring consultations. Furthermore, they adapt procedures to the social realities of patients, expanding access to and continuity of palliative care, especially in vulnerable contexts. In this process, they also guide and train informal caregivers to perform basic care, contributing to the safety and quality of care provided at home⁽¹³⁻¹⁴⁾.

Chart 3 - Description of actions carried out in the context of compassionate communities. Belo Horizonte, MG, 2025

Thematic categories	Actions carried out in the context of compassionate communities	Thematic categories
Cultural and educational	Popular education on palliative care for the community	E3; E4; E10; E11; E12; E13; E14; E15; E20; E21; E22; E24; E27; E28
	Educational activities on death and bereavement in schools	E5; E9; E13; E26; E28; E29
	Educational activities on death and bereavement in universities	E9; E14; E20
	Training on death and bereavement for teachers	E21
	Health education for family members of patients with palliative care needs	E7; E8
	Health education on palliative care in the context of diversity	E16
	Professional training actions on palliative care	E11; E18; E20; E21
	Art exhibitions for the celebration of life and understanding of death	E1; E5; E13; E21; E25
	Awareness campaigns on death and bereavement in schools	E21
	Community parties for welcoming new neighbors	E8
	Valuing traditional funeral ritual practices in indigenous communities	E24
Clinical	Death Cafés	E13; E20; E27
	Intergenerational actions involving local memory and tradition	E19
	Bereavement intervention groups led by psychologists and social workers	E14
	Home care by multiprofessional teams for the control of multidimensional symptoms	E3; E4; E25; E27
	Nursing home visits for symptom management and control	E4
	Nursing consultations via telemonitoring for symptom management and control	E4
	Care model based on traditional and scientific knowledge	E24
	Support by psychologists and social workers in the final phase of life and bereavement	E11
	Multiprofessional palliative home care integrated with support from informal caregivers	E3; E4; E28
	Early palliative care approach aimed at symptom prevention	E26
Intersectoral articulation	Hospital palliative care approach for people living with HIV/AIDS	E28
	Outpatient palliative care and rehabilitation approach for people living with HIV/AIDS	E28
	Support in the transition from hospital to home care by informal caregivers	E6
	Care management by nurses for articulation with the local health care network	E4
	Consultations using telemonitoring by external program supporters	E3
Normative	Donations of health care supplies and social support by external program supporters	E3; E19
	Integration of community resources with the local health care network	E1; E3; E4; E9; E12; E13; E16; E18; E20
	Creation of compassionate universities with the development of institutional policies aimed at supporting illness, death, and bereavement for students and workers	E2
	Consultancies for the creation of local public policies aimed at death and bereavement	E5; E15
	Creation of observatories for monitoring and evaluation with criteria for the certification of cities and institutions as "Compassionate Communities"	E21; E22
Community mobilization	Creation of public and institutional policies with funding to foster the development of compassionate communities	E28
	Creation of compassionate companies with the development of institutional policies for workers who care for family members in the final phase of life	E20; E26
	Home visits by informal caregivers to reduce the isolation of people in the final phase of life	E5; E6; E15
	Formation of networks of informal caregivers for palliative care	E3; E4; E1; E15; E21; E22
	Creation of informal care networks that assist in the access of people in palliative care and the socially vulnerable to local health services	E7; E12; E18; E25; E27
Community mobilization	Creation of bereavement support groups led by bereaved individuals for interaction between neighbors	E13
	Integration of volunteers in support and care activities for people with dementia	E28

In addition to this, care in the bereavement process also emerged as a recurring practice within compassionate communities. Studies^(21,24,27) reveal that although the approach to bereavement is aligned with the philosophy of palliative care, many services still lack well-defined structures for its implementation. Moreover, when people are not followed by palliative care teams, they rarely have access to the necessary support for managing grief.

In this sense, the authors adopted the principles of compassionate communities to develop programs aimed at bereavement support in the communities, promoting free and public meetings with spaces for listening, sharing, and psychoeducation. Likewise, they established psychological and social work support at home for patients and families experiencing life-threatening conditions or illnesses, aiming to

prevent complicated grief in places with weaknesses in the health care network^(21,24,27).

In the context of intersectoral articulation activities, it is observed that in many studies, the integration of community resources with the local health care network is one of the premises for implementing compassionate communities^(11,13-14,19,22-23,25,28,30,33,39). This aspect reinforces that this type of approach does not replace the duty of public bodies in ensuring coverage and access to palliative care services but is created to strengthen this network⁽⁴⁰⁾.

Examples of these initiatives include support in the transition of care from the hospital to the home, carried out by previously guided informal caregivers⁽¹⁶⁾, and care management conducted by nurses, who articulate with the different points of the health care network⁽¹⁴⁾. Furthermore, the use

of telemonitoring for consultations with the support of external program supporters is observed, expanding access to care by professionals from various specialties⁽¹³⁾.

Another relevant aspect is community mobilization, which is expressed in initiatives such as donations of supplies and social support, highlighting the engagement of different sectors for the sustainability of compassionate initiatives^(13,29). These actions include home visits by informal caregivers to reduce the isolation of people in the final phase of life^(15-16,26), the formation of support networks for palliative care, the articulation of community groups that assist socially vulnerable people in accessing health services^(11,13-14,26,31-32), the creation of bereavement support spaces led by bereaved individuals^(17,22,28,35,37), and the integration of volunteers in support activities for individuals with dementia⁽³⁸⁾.

Not limited to issues related to culture, education, and health, the philosophy of compassionate communities has been gaining ground in the normative context, in university institutions⁽¹²⁾ and companies^(30,36). In these contexts, the virtue of compassion, defined⁽²⁹⁾ as the human capacity to recognize the suffering of another and act to alleviate it, has been incorporated into the creation of institutional policies that support students and employees during processes of illness and bereavement of family members or close ones.

A qualitative study⁽¹²⁾ conducted at a compassionate university in Belgium explored the experiences and support needs of students and staff facing serious illness, death, and bereavement. Although there are institutional policies that provide for academic flexibility, medical leave, and psychological support, the results indicate that barriers persist, such as the lack of sensitivity of some professors and managers, especially in non-family losses. Difficulties in locating clear information about available services and limitations in the use of technologies, such as the automated chatbot, whose impersonality discourages the search for support, were also pointed out.

In the corporate sphere, compassion has been incorporated as an organizational value, reflected in initiatives that promote mutual support among colleagues and in the institutional recognition that processes such as illness, death,

and bereavement are part of the workers' experience and must be respected⁽³⁰⁾. In this regard, the federal government of Canada has stood out since 2004 by encouraging institutions to support employees responsible for people in palliative care⁽³⁶⁾.

Through the compassionate care benefit, funded by federal employment insurance, workers can request paid leave of up to 26 weeks to accompany loved ones in the final phase of life. However, due to the provincial management of labor codes, job security during this period is not yet guaranteed in all regions of the country⁽³⁶⁾.

Some organizations, such as the New Health Foundation (NHF), have been developing certifications and accreditations for compassionate companies in the corporate sphere, with the definition of criteria to guide the implementation of institutional policies aligned with the philosophy of palliative care. The NHF has created programs such as New-Palex®, All with You®, and iNewCare®, aimed at strengthening organizational practices that integrate health, social support, and end-of-life care, also considering the care of workers. It is a management system that involves the organization, its employees, patients, and the community⁽³¹⁾.

CONCLUSION

The philosophy of compassionate communities promotes the integration of palliative care with social and cultural support in the communities, recognizing the importance of dealing with the finitude of life in a supportive and compassionate manner. The approach focuses on building support networks, raising awareness about death, bereavement, and end-of-life care, and including all social actors involved: patients, families, citizens, and professionals. Although progress is evident, there are still challenges to be overcome, mainly in integrating this philosophy into the culture and institutional agendas.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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All authors are responsible for drafting the manuscript, critically revising its intellectual content for the final published version, and ensuring the study's accuracy and integrity with regard to ethical, legal, and scientific aspects.



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