
Palliative care in the Eastern Mediterranean Region: from challenges to solutions

Executive summary

Palliative care seeks to relieve suffering and enhance the quality of life for individuals with serious illness. It improves patient comfort, satisfaction and health outcomes, while also promoting more efficient resource use and lowering overall health care costs. While global health organizations increasingly recognize its importance, palliative care remains underdeveloped in the WHO Eastern Mediterranean Region. Despite growing demand, a mere 1% of the 2.4 million people estimated to be in need of palliative care, actually receive the service.

The development of palliative care in the Region is constrained by limited integration into health systems, a shortage of trained health care professionals and inadequate availability of opioids. Overly restrictive regulations and prevalent misconceptions hinder pain management. Palliative care is often omitted from medical and nursing curricula, and in many countries the specialty lacks formal recognition or support for intermediate-level training, exacerbating workforce gaps. The absence of national policies, weak health care integration, insufficient funding and cultural barriers, further compound the problem, leaving many without essential care.

To address these challenges, Member States should:

- integrate palliative care into national health policies and universal health coverage frameworks, ensuring inclusion in benefit packages and balanced regulatory support for opioid accessibility;
- invest in training at both the specialist and primary care levels, embedding palliative care into medical, nursing and allied health education;
- develop scalable, cost-effective care models tailored to local contexts, ensuring access to essential medicines, including oral opioids, and expanding hospital and community-level services;
- strengthen research in palliative care and establish robust monitoring mechanisms to track progress and impact.

These actions can reduce avoidable suffering, improve quality of life and advance global commitments towards achieving universal health coverage and the Sustainable Development Goals (SDGs).

Introduction

1. Palliative care is a specialized medical approach that aims to alleviate serious health-related suffering. It manages physical symptoms and addresses psychological, spiritual and practical concerns for patients and their caregivers. Applicable at any illness stage and regardless of treatment goals, palliative care complements curative therapies and becomes central when disease-modifying treatments are no longer beneficial. Multidisciplinary teams – comprising physicians, nurses, mental health professionals, social workers and community providers – deliver this care across diverse settings, from hospitals to homes.
2. Palliative care should be accessible to all individuals experiencing serious health-related suffering, irrespective of age, diagnosis or disease stage. Serious health-related suffering includes physical, psychological, social or spiritual distress that significantly impairs well-being for both the patient and the family. Eligible populations include patients with advanced cancers, organ failure, neurodegenerative conditions and chronic diseases such as HIV and tuberculosis. Humanitarian crises such as conflict and displacement also increase serious health-related suffering, reinforcing the need for universal access to palliative care.
3. Patients who receive palliative care benefit from better symptom management, including reduced pain, anxiety and emotional distress (1). They are more likely to receive care that aligns with their values and preferences through shared decision-making. Early integration into treatment plans has been shown to reduce aggressive interventions at the end of life, improving care quality and satisfaction (2).
4. Integrating palliative care into health systems yields significant benefits: fewer emergency room visits, shorter hospital stays and reduced ICU admissions (3). These outcomes translate into more efficient resource use and cost savings, making palliative care a cornerstone of sustainable and high-quality health systems aligned with the principles of universal health coverage (4).
5. WHO's Public Health Model for Palliative Care (5) outlines a framework for system-wide implementation, comprising policy development, education and access to medications. It advocates early integration alongside disease-modifying treatments to improve outcomes, while aligning care with patient values. Community empowerment, evidence generation and comprehensive service delivery spanning primary to tertiary levels are also key components of the model (6).
6. World Health Assembly Resolution WHA 67.19 (7) urges Member States to incorporate palliative care into health systems by improving access to essential medicines and providing training across all care levels. This is reinforced by the SDGs, particularly SDG 3 (8), and the 2019 Political Declaration of the United Nations High-Level Meeting on Universal Health Coverage, both of which recognize palliative care as integral to achieving health and well-being for all.
7. Palliative care development supports commitments made under the UHC2030 Global Compact. Regional frameworks, such as the Strategic Operational Plan for the Eastern Mediterranean Region 2025–2028, offer guidance for the delivery of comprehensive care packages. Palliative care also aligns with the regional flagship initiatives on investing in a resilient health workforce and expanding equitable access to medical products, as well as with the regional framework for action on cancer prevention and control, which includes palliative care as a core domain (9).
8. This technical paper aims to assess the current state of palliative care in the Eastern Mediterranean Region, identify key barriers to its integration and propose strategic actions to enhance its implementation and accessibility across the Region, in line with global commitments and regional and country-level needs. The identified strategic actions are summarized in the proposed framework for action on palliative care in the Eastern Mediterranean Region, annexed to this technical paper.

Situation analysis

9. The Eastern Mediterranean Region experiences a dual burden of disease, with high rates of both communicable and noncommunicable diseases. Noncommunicable diseases, such as cancer, cardiovascular disease and diabetes, account for more than 60% of deaths and are often diagnosed late, increasing patient suffering. These challenges are compounded by protracted humanitarian emergencies, where armed conflict and displacement disrupt health systems and heighten vulnerability to trauma and infectious disease.

10. Despite the urgent need, less than 1% of the estimated 2.4 million people requiring palliative care in the Region receive it. Almost half a million children in the Region need palliative care annually, a significant proportion linked to injuries and congenital conditions (10), yet paediatric palliative care services are very limited (11). Millions of needy children are left without pain support due to fragmented systems and overly restrictive opioid regulations that limit access to essential pain relief (12, 13).

11. Palliative care in the Region is concentrated in urban tertiary hospitals and primarily serves adults with advanced cancer, excluding children, chronic disease patients and those in early disease stages. A major systems failure is the exclusion of palliative care from primary health care and the inadequate training of physicians, nurses, pharmacists and psychologists. This workforce gap perpetuates limited service delivery and access, particularly for vulnerable groups.

12. Opioid consumption, a proxy for pain relief, remains critically low in the Region. At just 2.4 mg morphine-equivalents per capita, it is just a fraction of the global average (33.24 mg) (14). Regulatory barriers, limited training and persistent stigma contribute to these gaps, leaving pain untreated across the Region.

13. The Region can learn from both low- and high-resource countries. Uganda has authorized nurses who have undergone specialized training to prescribe morphine, while also establishing local production of morphine from raw powder; India's national cancer policy and laws around morphine have expanded access; Bangladesh demonstrates effective task-shifting to nurses (15). In high-income settings, countries such as Australia, Canada and the United Kingdom show how integrating palliative care into primary and home-based services reduces hospital dependence and improves outcomes.

14. Key indicators of progress include integration of palliative care into national strategies and budgets; availability of essential medicines, including oral morphine; comprehensive educational programmes; service models for both adult and paediatric patients; and monitoring and research systems to track outcomes.

Challenges to the implementation of palliative care in the Region

15. The Region faces major barriers to scaling up palliative care, including a lack of comprehensive national strategies and limited inclusion in health benefit packages (15, 16). Funding remains inadequate and services are fragmented, mostly limited to tertiary facilities. Health workforce education lacks core palliative care competencies, especially at the primary level. Other challenges include restrictive opioid policies, poor monitoring systems, low public awareness and limited access in conflict zones.

16. Restrictive opioid regulations and inefficient supply chains limit access to essential pain management medications. Service delivery fragmentation is evident, with palliative care rarely integrated into primary health care systems and concentrated in urban tertiary facilities, namely those providing cancer services.

17. The absence of palliative care competencies in the core education curricula of health professionals creates acute human resource constraints, including lack of recognition for the profession. These systemic gaps are compounded by inadequate monitoring systems, limited public awareness and particular challenges in conflict-affected areas.

18. Addressing these interconnected barriers requires coordinated policy action across health system pillars to reduce preventable health-related suffering and ensure equitable access to holistic person-centred care throughout the disease course.

Proposed actions for palliative care integration in the Eastern Mediterranean Region

19. Governance for palliative care integration should be strengthened by:

- developing national roadmaps for implementation, with measurable goals;
- formally recognizing palliative care as an essential service aligned with the right to health;
- creating dedicated funding mechanisms, such as health insurance coverage and public financing streams, to ensure sustainable service delivery;
- including palliative care in humanitarian response frameworks for displaced and crisis-affected communities.

20. Health workforce capacity should be strengthened through education and training by

- mandating basic palliative care education in pre-licensure medical, nursing and allied health professional curricula;
- implementing tiered palliative care training programmes (basic, intermediate and specialist);
- promoting task-shifting to nurses and community health workers, supported by supervision and mentorship, to expand services;
- creating career pathways in palliative care in terms of certification, experience and research.

21. Equitable access to palliative care essential medications (17), including opioids, should be ensured by:

- reviewing and reforming national opioid regulations in line with WHO guidelines, ensuring medical access, while preventing misuse;
- training prescribers in safe opioid use and addressing stigma through professional and public education;
- implementing short-term strategies to reinforce the strengthening of supply chains and pooled procurement mechanisms, while institutionalizing longer-term strategies for local production.

22. Service delivery should be expanded through integrated care models by:

- embedding palliative care in primary health care and home-based settings, especially in underserved and remote areas;
- developing hospital-based palliative care teams and linking them to specialized services such as oncology, geriatrics, disability, paediatrics and mental health;
- using telehealth and digital platforms to enhance reach and continuity of care;
- including palliative care services in humanitarian response plans for displaced and crisis-affected communities.

23. Monitoring and accountability frameworks should be established by:

- defining and adopting standardized indicators to monitor service integration and outcomes, as reflected in the regional framework;
- developing national reporting systems for medicine availability, workforce deployment and equity;
- encouraging research to build Region-specific evidence, especially on cost-effectiveness, to inform policy and guide implementation.

24. Health promotion principles and actions for supporting the seriously ill, the caregivers and the bereaved should be implemented through the development of compassionate communities by (18):

- promoting death and grief literacy (knowing how to support people experiencing death and loss) across the different public and civic sectors and entities (such as schools, universities, workplaces, cultural centres, social clubs and faith-based institutions);
- developing and promoting inclusive civic policies and practices that enable compassionate support and connectedness across the different public and civic sectors and entities;
- fostering collaboration with civil society organizations and community groups to raise awareness, mobilize resources and ensure seamless and culturally-sensitive delivery of palliative care.

Conclusion

25. Integrating palliative care strengthens the resilience, equity and sustainability of health systems. Member States are urged to prioritize palliative care in national health planning, allocate the necessary resources and foster vital partnerships to ensure no patient is left to suffer needlessly. Member States are kindly requested to endorse the resolution and framework.

References¹

1. Henson LA, Maddocks M, Evans C, Davidson M, Hicks S, Higginson IJ. Palliative care and the management of common distressing symptoms in advanced cancer: pain, breathlessness, nausea and vomiting, and fatigue. *J Clin Oncol*. 2020;38(9):905–14. doi:10.1200/JCO.19.00470.
2. Abernethy AP, Currow DC, Shelby-James T, Rowett D, May F, Samsa GP, et al. Delivery strategies to optimize resource utilization and performance status for patients with advanced life-limiting illness: results from the “palliative care trial” [ISRCTN 81117481]. *J Pain Symptom Manage*. 2013;45(3):488–505. doi:10.1016/j.jpainsymman.2012.02.024.
3. Delgado-Guay MO, Kim YJ, Shin SH, Chisholm G, Williams J, Allo J, et al. Avoidable and unavoidable visits to the emergency department among patients with advanced cancer receiving outpatient palliative care. *J Pain Symptom Manage*. 2015;49(3):497–504. doi:10.1016/j.jpainsymman.2014.07.007.
4. National cancer control programmes: policies and managerial guidelines, 2nd edition. Geneva: World Health Organization; 2002 (<https://iris.who.int/handle/10665/42494>).
5. Callaway MV, Connor SR, Foley KM. World Health Organization public health model: a roadmap for palliative care development. *J Pain Symptom Manage*. 2018;55(2):S6–S13. doi:10.1016/j.jpainsymman.2017.03.030.
6. Assessing the development of palliative care worldwide: a set of actionable indicators. Geneva: World Health Organization; 2021 (<https://iris.who.int/bitstream/handle/10665/345532/9789240033351-eng.pdf>). License: CC BY-NC-SA 3.0 IGO.
7. Seventy-sixth World Health Assembly, agenda item 15.5., 25 May 2014: Strengthening of palliative care as a component of comprehensive care throughout the life course. Geneva: World Health Organization; 2014 (WHA67.19, https://iris.who.int/bitstream/handle/10665/162863/A67_R19-en.pdf).
8. Transforming our world: The 2030 agenda for sustainable development [website]. New York: United Nations; 2015 (<https://sdgs.un.org/2030agenda>).
9. Regional framework for action on cancer prevention and control. Cairo: WHO Regional Office for the Eastern Mediterranean; 2017 (https://applications.emro.who.int/docs/EMROPUB_2019_NCD_EN_23548.pdf).
10. Connor SR, editor. Global atlas of palliative care at the end of life, 2nd edition. London: Worldwide Palliative Care Alliance; 2020 ([https://cdn.who.int/media/docs/default-source/integrated-health-services-\(ihs\)/csy/palliative-care/whpca_global_atlas_p5_digital_final.pdf?sfvrsn=1b54423a_3](https://cdn.who.int/media/docs/default-source/integrated-health-services-(ihs)/csy/palliative-care/whpca_global_atlas_p5_digital_final.pdf?sfvrsn=1b54423a_3)).
11. Mojen LK, Rassouli M, Eshghi P, Sari AA, Karimooi MH. Palliative care for children with cancer in the Middle East: a comparative study. *Indian J Palliat Care*. 2017 Oct–Dec;23(4):379–386. doi:10.4103/IJPC.IJPC_69_17.
12. International Narcotics Control Board. Availability of internationally controlled drugs: ensuring adequate access for medical and scientific purposes. New York: United Nations; 2016 (https://www.drugsandalcohol.ie/25258/1/INCB_Supplement-AR15_availability.pdf).
13. Downing J, Birtar D, Chambers L, Gelb B, Drake R, Kiman R. Children’s palliative care: a global concern. *Int J Palliat Nurs*. 2012;18(3):109–114. doi:10.12968/ijpn.2012.18.3.109.
14. Downing J, Boucher S, Daniels A, Nkosi B. Paediatric palliative care in resource-poor countries. *Children (Basel)*. 2018;5(2):27. doi:10.3390/children5020027.

¹ References accessed on 7 September 2025.

15. Knaul FM, Farmer PE, Krakauer EL, De Lima L, Bhadelia A, Jiang Kwete X et al. Alleviating the access abyss in palliative care and pain relief – an imperative of universal health coverage: the Lancet Commission report. *Lancet*. 2018; 391(10128):1391–1454. doi:10.1016/S0140-6736(17)32513-8.
16. Political declaration of the high-level meeting on universal health coverage. New York: United Nations; 2019 (<https://www.un.org/pga/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf>).
17. The selection and use of essential medicines: report of the WHO Expert Committee on Selection and Use of Essential Medicines, 2023 (including the 23rd WHO Model List of Essential Medicines and the 9th WHO Model List of Essential Medicines for Children). Geneva: World Health Organization; 2024 (<https://iris.who.int/handle/10665/376570>). License: CC BY-NC-SA 3.0 IGO.
18. The Bern Declaration. Public Health Palliative Care International; 2024 (<https://www.phpci.org/berndeclaration>).

Annex

Framework for action on palliative care in the Eastern Mediterranean Region

Strategic intervention	Indicator
Governance	
Developing national roadmaps for implementation, with measurable goals	Existence of a current national palliative care plan, programme, policy or strategy with defined implementation framework (5)
Formally recognizing palliative care as an essential service aligned with the right to health	Existence of national standards and norms for the provision of palliative care services (8)
Creating dedicated funding mechanisms, such as health insurance coverage and public financing streams, to ensure sustainable service delivery	Existence of national coordinating authority for palliative care (called a unit, branch, or department) in the Ministry of Health (or equivalent) responsible for palliative care (9)
Including palliative care in humanitarian response frameworks for displaced and crisis-affected communities	Palliative care is integrated into national emergency preparedness and response plans (*)
Service delivery	
Embedding palliative care in primary health care and home-based settings, especially in underserved and remote areas	Number/% of primary health care facilities with palliative care teams/units (m1)
Developing hospital-based palliative care teams and linking them to specialized services such as oncology, geriatrics, disability, paediatrics and mental health	Number/% of referral hospitals with palliative care teams/units (m1) Number/% of paediatric departments with specialized palliative care teams/units (m2)
Using telehealth and digital platforms to enhance reach and continuity of care	Number of networks providing remote palliative care services (*)
Including palliative care services in humanitarian response plans for displaced and crisis-affected communities	Existence of adaptable models for palliative care delivery in humanitarian settings, with trained staff and access to essential medications (*)
Essential medications	
Reviewing and reforming national opioid regulations in line with WHO guidelines, ensuring medical access while preventing misuse	Reported annual opioid consumption, excluding methadone, in oral morphine equivalents (OME) per capita (10)
Training prescribers in safe opioid use and addressing stigma through professional and public education	Availability of essential medicines for pain and palliative care at all levels of care (11)
Implementing short-term strategies to reinforce the strengthening of supply chains and pooled procurement mechanisms, while institutionalizing longer-term strategies for local production	General availability of immediate-release oral morphine (liquid or tablet) at the primary care level (12)
Health workforce capacity	
Mandating basic palliative care education in pre-licensure medical, nursing and allied health professional curricula	Proportion of medical and nursing schools with formal education in palliative care in undergraduate curricula (13)
Implementing tiered training programmes (basic, intermediate and specialist)	Recognizing intermediate level training and specialization in palliative medicine for physicians and nurses (m14)
Promoting task-shifting to nurses and community health workers, supported by supervision and mentorship to expand services	
Creating career pathways in palliative care in terms of certification, experience and research	

Strategic intervention	Indicator
Compassionate communities	
Promoting death and grief literacy across the different public and civic sectors and entities	Existence of groups dedicated to promoting the rights of patients in need of palliative care, their families, their caregivers and disease survivors (16)
Developing and promoting inclusive civic policies and practices that enable compassionate support and connectedness across the different public and civic sectors and entities	
Fostering collaboration with civil society organizations and community groups to raise awareness, mobilize resources and ensure seamless and culturally sensitive delivery of palliative care	Number of stakeholders involved in the provision of specialist home palliative care services (*)
Research and surveillance	
Defining and adopting standardized indicators to monitor service integration and outcomes	Availability of monitoring systems to evaluate the quality of palliative care programmes (3) Estimated number of patients receiving specialized palliative care at the national level (4)
Developing national reporting systems for medicine availability, workforce deployment and equity.	Number/% of palliative care units reporting timely and complete data (*)
Encouraging research to build Region-specific evidence, especially on cost-effectiveness, to inform policy and guide implementation	Existence of congresses or scientific meetings at the national level specifically related to palliative care (17) Palliative care research on the country estimated by peer reviewed articles (18)

Indicators with numbering are taken from the global set of actionable indicators, while those with an “m” preceding the number have been slightly modified. See page 16, Table 3, in: Assessing the development of palliative care worldwide: a set of actionable indicators. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/item/9789240033351>). License: CC BY-NC-SA 3.0 IGO.

Indicators with an asterisk (*) are tailored indicators developed for the Eastern Mediterranean Region.