Atlas of Palliative Care Developments in the Eastern Mediterranean Countries 2025

Daniela Suárez, Vilma A. Tripodoro, Nahla Gafer, Álvaro Montero, Eduardo Garralda, Fernanda Bastos, Laura Monzón Llamas, Julen Herrero, Juan José Pons and Carlos Centeno.

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AUTHORS
Daniela Suárez, Vilma A. Tripodoro, Nahla Gafer, Álvaro Montero, Eduardo Garralda, Fernanda Bastos, Laura Monzón Llamas, Julen Herrero, Juan José Pons and Carlos Centeno.

EDITORS
Daniela Suárez, Álvaro Montero, and Carlos Centeno
University of Navarra
ATLANTES Global Observatory of Palliative Care
Institute for Culture and Society (ICS)
Campus Universitario
31009 Pamplona, Spain

CARTOGRAPHY
Álvaro Montero Calero, Julen Herrero
and Juan José Pons
University of Navarra
Department of Geography
Campus Universitario
31009 Pamplona, Spain

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EDITORIAL
Ediciones Universidad de Navarra, S.A. (EUNSA)
Campus Universitario
University of Navarra
31009 Pamplona, Spain
T 34 948 256 850
eunsa@eunsa.es
www.eunsa.es

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The study included 22 countries and territories from the Eastern Mediterranean Region according to the World Health Organization: Afghanistan, Arabia Saudi, Bahrain, Djibouti, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Occupied Palestinian Territory (oPt), Oman, Pakistan, Qatar, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates (UAE), and Yemen.

Authors

Daniela Suárez
University of Navarra
Institute for Culture and Society (ICS)
ATLANTES Global Observatory of Palliative Care
Pamplona (Navarra), Spain

Vilma A. Tripodoro
University of Navarra
Institute for Culture and Society (ICS)
ATLANTES Global Observatory of Palliative Care
Pamplona (Navarra), Spain

Nahla Gafer
MD, MSc Palliative Care
PhD Research Fellow
King's College London, United Kingdom

Álvaro Montero
University of Navarra
Institute for Culture and Society (ICS)
ATLANTES Global Observatory of Palliative Care
Pamplona (Navarra), Spain

Eduardo Garralda
University of Navarra
Institute for Culture and Society (ICS)
ATLANTES Global Observatory of Palliative Care
Pamplona (Navarra), Spain

Fernanda Bastos
University of Navarra
Institute for Culture and Society (ICS)
ATLANTES Global Observatory of Palliative Care
Pamplona (Navarra), Spain

Laura Monzón Llamas
University of Navarra
Institute for Culture and Society (ICS)
ATLANTES Global Observatory of Palliative Care
Pamplona (Navarra), Spain

Julen Herrero
University of Navarra
Institute for Culture and Society (ICS)
ATLANTES Global Observatory of Palliative Care
Pamplona (Navarra), Spain

Juan José Pons
University of Navarra
Department of Geography
Pamplona (Navarra), Spain

Carlos Centeno
University of Navarra
Institute for Culture and Society (ICS)
ATLANTES Global Observatory of Palliative Care
Pamplona (Navarra), Spain

Abstract

Introduction

Palliative care (PC) is a cornerstone of universal health coverage (UHC), essential for alleviating serious health-related suffering and improving quality of life. In the Eastern Mediterranean Region, an estimated 3.2 million people experience serious health-related suffering (SHS) each year and would benefit from PC. This figure includes both adults and children living with life-limiting conditions, not only those at the end of life, yet most lack adequate access. Using the updated WHO public health framework, this third Atlas identifies advances, opportunities, and gaps to guide action, reaffirming the region's commitment to equitable access for all.

Objectives

This Atlas aims to present a comprehensive picture of the current state of PC in terms of health policies, service provision, and their integration into health systems. It covers pediatric palliative care (PPC), professional training, access to opioids and other essential medicines, research, and community empowerment. The ultimate goal is to identify gaps, strengthen advocacy, and promote the inclusion of PC within UHC frameworks and benefit packages.

Methodology

The methodology for this project was refined from previous editions and organized into four phases.

The first phase, *Building Networks of National Informants*, involved forming a network of consultants from key organizations, such as national PC associations, together with experienced in-country informants. Consultants were selected based on their expertise in PC.

The second phase, *Data Collection through the E-Course*, was conducted via a free online course accredited by the University of Navarra. Consultants completed modules introducing PC development dimensions and indicators, and provided figures, narrative justifications, and supporting documents for their responses.

The third phase, *Country Report Review*, comprised three steps: (a) conciliation —the ATLANTES team compiled and harmonized data from consultants with available literature to build the country reports; (b) validation— incorporating quantitative and qualitative data reviewed by the consultants into a single report per country; and (c) final review — conducted by national PC associations or by other recognized health-related institutions.

The fourth and final phase was the comparative analysis of indicators and the preparation of the resulting country reports, which are presented in this *Atlas of Palliative Care Developments in the Eastern Mediterranean Countries 2025*.

Results

The Atlas provides the most comprehensive assessment to date of PC development across the 22 countries of the Eastern Mediterranean Region, using 14 context-specific indicators. A total of 123 informants were initially identified, of whom 38 from 19 countries actively contributed—35 by completing an accredited e-course and 3 via the e-survey. In countries where it was not possible to connect with national experts at the initial stage, information was compiled through a structured bibliographic review of publicly available sources, including scientific databases, official government websites, and national institutional documents. The data were validated by national experts or, where available, by the national PC association or another recognized health-related institution.

A total of 258 specialized PC services were identified (median = 3.5), equating to a median of 0.04 services per 100,000 inhabitants across the 22 countries of the region. PPC services were reported in 38 instances, present in a majority of countries. Availability of essential medicines, including immediate-release oral morphine, remains critically low in both urban and rural settings. Opioid consumption rates are consistently well below global averages in most countries.

Policy development shows marked variability: only one country (5%) reports a comprehensive stand-alone national PC strategy (Level 4). Four countries (18%) have more established though incomplete frameworks (Level 3). Five countries (23%) are at a progressing stage with partial policies (Level 2), while the majority, eleven countries (50%), remain at an emerging stage without a national plan (Level 1).

Research production, public engagement, and advocacy structures remain limited, with only a few countries organizing national conferences on PC and a small number maintaining active national associations. Overall, civil society participation is weak, and research output is relatively low. Despite these challenges, several countries, including Iran, Lebanon, Egypt, Jordan, Kuwait, Qatar, and Saudi Arabia, demonstrate promising progress, offering models for regional development. The findings highlight critical gaps but also reveal emerging opportunities to advance equitable and integrated PC across the Eastern Mediterranean Region.

Conclusion

This edition of the Atlas of Palliative Care Developments in the Eastern Mediterranean Countries 2025 reveals a landscape of uneven progress. While some countries show promising advancements in policy, education, and service provision, the region as a whole continues to face significant limitations in the availability of specialized services, access to essential medicines, and formal PC training. Development remains closely linked to national income levels, with disparities across subregions and fragile health systems

Abstract

exacerbating gaps. Despite these challenges, the consolidation of a regional network of experts and the application of WHO indicators have enabled the generation of the most comprehensive and validated data set to date.

The findings of this Atlas highlight key priorities and opportunities to strengthen PC developments across the Eastern Mediterranean Region. These include consolidating national policies and implementation frameworks, improving access to essential medicines—particularly opioids—and ensuring the integration of PC into UHC benefit packages. Future progress will rely on advancing standalone national strategies, incorporating PC into undergraduate and professional curricula, and formally recognizing the discipline as a medical specialty where possible. Expanding service provision through home-based and primary care models, establishing dedicated coordination units within Ministries of Health, and fostering regional collaboration in research, knowledge exchange, and advocacy will be essential. Finally, empowering communities and engaging civil society will help build sustainable, people-centered systems, ensuring that equitable and integrated PC becomes accessible to all who need it. ●

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Presentation

Foreword

Nahla Gafer
Khartoum Oncology
Hospital & King's College
London

Advancing Palliative Care: A Shared Responsibility for the Eastern Mediterranean Region

The *Atlas of Palliative Care Developments in the Eastern Mediterranean Countries 2025* is more than a technical report – it is a reflection of how much remains to be done. It recognizes and aligns with ongoing efforts, including the WHA Resolution 67.19, the WISH Report (Qatar, 2024), and the Regional Committee 72 technical paper on palliative care, all of which underscore the urgent need to integrate palliative care into health systems, including within humanitarian preparedness and response.

Palliative care is not high-tech —it is high-impact. It centers on the person, not just the disease, addressing physical, emotional, social, and spiritual needs across the illness trajectory. From hospitals to homes, palliative care improves outcomes, reduces unnecessary interventions, and restores dignity. The principles of palliative care —placing the patient at the center of care, holistic assessment and management, empowering families, teamwork, ethical practice, and continuity of care —should be embraced by all health professionals. It must also extend to children living with a wide range of conditions, both progressive and non-progressive.

Across the Eastern Mediterranean Region, we see promising models: home-based palliative care, academic research, and hospital-integrated teams. Yet gaps remain. Training is key. WHO's tiered model – basic, intermediate, and specialist —must be scaled, accredited, and adequately supported, with healthcare professionals fairly reimbursed. Only then can services expand and reach all those in need.

Let this Atlas be a tool for advocacy and planning. It is unacceptable that a child can receive advanced interventions but not basic pain relief. Equally concerning is when patients are prescribed costly medications without proper explanation of side effects, how to manage them, or reassurance about the nature of their illness. Patients and families deserve clear information and the opportunity to be part of decision-making from the moment of diagnosis. We must treat patients as we would want to be treated ourselves, addressing not only medical but also social and psychological implications of disease. Palliative care must be embedded as a foundation of care, not an afterthought. It is simple, cost-effective, and rewarding; yet it requires continuous skill development, sustained change in practice, and joint efforts.

Contributing as an informant to a previous edition of the Atlas reminded me of the importance of the work we, as palliative care providers, do and deepened my commitment. I hope this edition inspires other contributors in the same way.

My sincere thanks to the Atlantes team for their dedication —this publication reflects hard work and precision. I look forward to future editions reflecting significant, measurable progress across the region, and I hope this goal becomes the shared responsibility of all who engage with and read this report. ●

"Palliative care must be embedded as a foundation of care, not an afterthought. It is simple, cost-effective, and rewarding; yet it requires continuous skill development, sustained change in practice, and joint efforts"

Foreword

Hibah Osman
President, Balsam–Lebanese Center
for Palliative Care
Dana-Farber Cancer Institute
Harvard Medical School

Palliative Care Development in the Eastern Mediterranean: From Evidence to Regional Action

Over a decade has passed since the World Health Assembly Resolution 67.19 called for the integration of palliative care into health systems as a critical component of universal health coverage. Yet, despite the documented benefits of palliative care to patients and the health system and endorsement of nation states, many countries still struggle to make palliative care accessible to patients who need it.

An estimated 3.2 million people in the Eastern Mediterranean experience SHS due to life-limiting illnesses each year. This burden includes both those living with advanced illness and the 2.2 million people who die annually with SHS—approximately 1.9 million adults and 300,000 children—all of whom could benefit from palliative care. Yet, only 10–20% currently have access to it. Misconceptions, resource constraints, underdeveloped healthcare infrastructure, and political instability are just some of the barriers to development of palliative care in the region. In this complex landscape, reliable data, informed advocacy and evidence-based policy guidance are essential to advancing palliative care.

The Atlas of Palliative Care in the Eastern Mediterranean has become an indispensable resource for the people working to advance this field. Clinicians use it to identify available services, assess opioid accessibility, and connect with local networks. Advocates leverage its findings to shape national strategies, while policymakers rely on the clear and actionable insights it offers to guide health system planning.

This third edition aligns with the World Health Organization's 2021 framework, Assessing the Development of Palliative Care Worldwide: A Set of Actionable Indicators, also developed by the ATLANTES Global Palliative Care Observatory in collaboration with clinicians, researchers, and palliative care leaders worldwide. These standardized indicators enable countries to evaluate their progress, identify gaps, and prioritize steps toward achieving equitable access. By mapping regional and national data against global benchmarks, the Atlas highlights the current state of palliative care and provides a roadmap for its future development. Information is presented simply and clearly using of graphics and illustrative maps making it accessible to all stakeholders regardless of professional background.

With aging populations, rising chronic disease burdens, and the health consequences of conflict and humanitarian crises, the need for palliative care in the Eastern Mediterranean will grow. The urgency of developing palliative care to meet the needs of the population will continue to increase.

Palliative care development remains an iterative process requiring sustained knowledge-sharing and multisectoral collaboration. The data presented in this Atlas highlights persistent inequities which underscores the need for continued regional cooperation around:

- Standardized monitoring and evaluation
- Cross-border capacity building initiatives
- Adaptation of existing models to culture and context
- Translational research partnerships

The findings from the Atlas can drive our individual and collective efforts to advance palliative care in our countries whether we are early in the trajectory or at more advanced stages of palliative care development. It provides both opportunity and incentive to identify and pursue achievable goals and will hopeful inspire those who are working in the field generate contextually relevant research that may address barriers to the development of palliative care and contribute to advancing models of care that are appropriate for the Eastern Mediterranean. ●

"In this complex landscape, reliable data, informed advocacy and evidence-based policy guidance are essential to advancing palliative care"

Note from the authors

Evaluating the development of PC in countries provides a vital lens through which to assess the capacity of health systems to address the multifaceted needs of individuals experiencing SHS. PC represents a cornerstone of UHC by alleviating suffering and improving quality of life, yet its integration and accessibility remain uneven across regions.

In this Atlas we deliberately use the term "Developments" in plural. Our intention is to highlight that this work does not merely describe an abstract process of development, but rather documents new advances, concrete milestones, and innovations that are emerging across the different dimensions of PC. These developments reflect the variety of ways in which health systems are evolving — through new services, policies, training programs, professional associations, and improved access to medicines — and they illustrate the sum of changes and achievements taking place in each country.

To accomplish a thorough evaluation of these developments, it was imperative to identify reliable indicators and methodologies capable of monitoring the breadth and impact of health policies on PC service provision. This included measuring the integration of PC services into broader health systems, the availability of pediatric palliative care, the incorporation of undergraduate training programs, the accessibility and appropriate use of opioids and essential medicines, and the empowerment of individuals and communities who benefit from these resources. These indicators serve as tools for analysis and reflect health systems' commitment to equity and inclusivity in care delivery.

This publication is the third edition of an Eastern Mediterranean Region Atlas, providing an updated picture of the current state and historical evolution of palliative care across the region. The project was coordinated by the ATLANTES Global Observatory of Palliative Care, in close collaboration with WHO's Regional Office for the Eastern Mediterranean and a wide network of stakeholders. The comprehensive data collection process was designed to generate actionable insights and evidence-based strategies, strengthening advocacy for the full integration of PC within UHC frameworks and national health benefit packages.

The ATLANTES Global Observatory of Palliative Care, based at the University of Navarra, played a pivotal role in designing the evaluation process and compiling this report. This Atlas offers a unique and indispensable tool for understanding PC developments in the Eastern Mediterranean Region by systematically assessing resources, strengths, and opportunities. The insights from the selected indicators provide decision-makers with essential information to prioritize healthcare needs, address policy gaps, allocate resources effectively, and strengthen healthcare activities.

Beyond supporting decision-making, measurement also drives improvement. By standardizing and tracking indicators, we can elevate the quality of PC services, raise awareness of their importance, mobilize essential resources, and foster greater transparency. All these efforts align with global UHC objectives, reducing inequities and improving access to care for vulnerable populations. Importantly, in countries and territories facing humanitarian emergencies, systematic measurement provides critical evidence to sustain essential PC services, guide resource allocation, and ensure that no population is left behind. The indicators proposed in this report not only serve as benchmarks for progress but also have the potential to align with global Primary Health Care (PHC) measurement frameworks, enriching national and regional health planning efforts.

"This publication is the third edition of an Eastern Mediterranean Region Atlas, providing an updated picture of the current state and historical evolution of palliative care across the region"

Note from the authors

The report is structured to provide a detailed analysis and practical tools for action. The first section offers a comprehensive overview of each PC component, presenting comparative data to highlight existing gaps and opportunities for improvement in the short term. Country comparisons facilitate benchmarking, helping policymakers and stakeholders draw meaningful conclusions to guide future initiatives. In the second section, infographics are featured for each country and area, serving as visually engaging tools to support decision-making, promote innovative approaches, and strengthen advocacy for PC integration.

The work encapsulated in this Atlas reflects a collaborative and multidisciplinary effort. It establishes a baseline for developing a regional PC monitoring system, enabling periodic evaluations to track progress. The country-specific data in this publication result from meticulous data collection, drawing from available literature, contributions from national leaders and consultants, and consultations with International, Regional and National Associations of Palliative Care. These efforts ensured depth and contextual accuracy, with findings reviewed and endorsed by key stakeholders. ●

ATLANTES Global Observatory of Palliative Care: Juan José Pons, Álvaro Montero, Fernanda Bastos, Daniela Suárez, Vilma Tripodoro, Laura Monzón Llamas, Carlos Centeno, Eduardo Garralda, and Jesús López Fidalgo (from left to right).

Network of collaborators

On behalf of the project team and their supporting institutions, we express our gratitude to the organizations, institutions, associations, and professionals who made this project possible by contributing valuable time to provide information, feedback, and support. The following individuals participated in the training process and completed the survey as consultants, providing essential information on the development of PC in their respective countries and territories. A total of 123 palliative care professionals were initially identified across the 22 countries of the WHO Eastern Mediterranean Region. From this group, a network of 42 in-country experts was consolidated, many of whom had participated in previous regional reports or were members of the Regional Palliative Care Expert Network established in 2019. In the end, 38 experts from 19 countries actively contributed to this study: 35 completed the accredited online course and 3 the e-survey. This collaborative effort represents the most up-to-date and regionally grounded overview of palliative care development in the Eastern Mediterranean Region to date. ●

TABLE 1. **Collaborators who participated as key informants for their respective countries/territories and country's representatives**

Country	Name	Organisation
Afghanistan	Mohammed Qais Niazai	The Cancer Center at Jumhuriat Hospital, National Cancer Control Program, Ministry of Public Health, Kabul, Afghanistan
Bahrain	Husain Ismaeel	Governmental Hospitals
	Waleed Hamouda	Salmania Hospital
Djibouti	Awaleh Ahmed	Ministère de la Santé
Egypt, Arab Rep.	Maged El-Ansary	Al Azhar University; Egyptian Society for Regional Anesthesia and Pain Medicine
	Tandiar Samir Mosaad Ghattas	Josaab Foundation for social development - Hospice Egypt
Iran	Mamak Tahmasebi	Cancer Institute/ Tehran University of Medical Sciences
	Maryam Rassouli	Shahid Beheshti University of Medical Sciences
Iraq	Samaher Fadhil Razaq	Children Welfare Teaching Hospital
	Mazin Faisal Al-Jadiry	University of Baghdad, Children Welfare Teaching Hospital
Jordan	Anwar Al-Nassan	King Hussein Cancer Center
Kuwait	Abdel Rahman Alkandri	Palliative Care Specialist, Head Department
	Qutaibah Alotaibi	Paediatric palliative care specialist
Lebanon	Farah Demachkieh	SANAD
	Hibah Osman	Balsam, Lebanese Center for Palliative Care
	Michel Daher	Saint Georges Hospital- UMC-Beirut- Lebanon
	Rana Yamout	American University of Beirut
Libya	Masaud Waled	National Cancer Control Program
Morocco	Awatef Belakhel	Ministère de la Santé et de la Protection Sociale
	Berraho Mohamed	Faculté de Médecine, de Médecine Dentaire et de Pharmacie Fès
	Elazhari Asmaa	Association Marocaine des Soins Palliatifs (AMSP)
	Loubna Abousselham	Ministère de la Santé et de la Protection Sociale
Occupied Palestinian Territory	Abu-Odah Hammoda	European Gaza Hospital
	Khamis Elessi	Faculty of Medicine at IUG and Turkish Palestinian Friendship Hospital
	Wasim Sharbati	-
	Mhoira Leng	Makerere University, Cairdeas International Palliative Care Trust
	Khadija Abu Khader	National Health Professional, Health Systems, Cancer Control, World Health Organization, oPt

Network of collaborators

Country	Name	Organisation
Oman	Atika Al Musalami	Royal Hospital Oman
Pakistan	Atif Waqar	The Aga Khan University
Qatar	Amrita Sarpal	Sidra Medicine
Saudi Arabia	Mohammad Zafir Al-Shahri	
	Sami Alshammary	KFMC, Ministry of Health
Syrian Arab Republic	Maha	BCPC
Somalia	Confidential	
Sudan	Confidential	
	Halima Ibrahim Malik Ali	National Cancer Institute, Comboni College
	Nahla Gafer	MD, MSc Palliative Care, PhD Research Fellow, King's College London
Tunisia	Henda Rais	Association Tunisienne de Soins Palliatifs (ATSP)
	Nesrine Mejri	Department of Medical Oncology, University Hospital Abderrahman Mami
United Arab Emirates	Neil Nijhawan	Burjeel Medical City
Yemen	Anghma Al-Akwaa	National Oncology Center, Aden
	Confidential	

The Atlas project

The Atlas of Palliative Care Developments in the Eastern Mediterranean Countries 2025 is an initiative of the ATLANTES Global Observatory of Palliative Care at the Institute for Culture and Society, University of Navarra (Spain), carried out in close collaboration with the WHO Regional Office for the Eastern Mediterranean (EMRO). Since 2022, ATLANTES has been designated as a WHO Collaborating Centre for the Global Monitoring of Palliative Care Development, and this Atlas forms part of its official work plan as a Collaborating Centre.

Since 2022, ATLANTES—under the leadership and coordination of international PC associations—has conducted the Global Study on the Development of Palliative Care in every country of the world, using the methodology based on the WHO's 2021 technical report *Assessing the Development of Palliative Care Worldwide: A Set of Actionable Indicators.*

The project benefits from the collaboration and scientific guidance of the International Association for Hospice and Palliative Care (IAHPC) and the Worldwide Hospice Palliative Care Alliance (WHPCA).

The ATLANTES Global Observatory of Palliative Care at the University of Navarra coordinated the development of this project, with Daniela Suárez and Vilma Tripodoro serving as project leads. The core technical team was composed of Álvaro Montero, Fernanda Bastos, Eduardo Garralda, Juan José Pons, Julen Herrero and Carlos Centeno. We gratefully acknowledge the invaluable contribution of Dr. Nahla Gafer, Research Fellow at King's College London (UK), whose expertise and dedication significantly enriched the development of this Atlas.

The project was carried out under the supervision and guidance of key collaborators from the World Health Organization, including Julie Ling (WHO Europe), and Megan Doherty (WHO Headquarters, Geneva, Department of Service Delivery and Safety).

We are deeply grateful to the members of our Advisory Board for their invaluable guidance throughout the development of this Atlas. Their expertise and insight were instrumental in shaping this project.

Our sincere thanks go to:

- Megan Doherty and Marie-Charlotte Bouësseau (WHO Geneva)
- Julie Ling (WHO EURO)
- Issimouha Dille Mahamadou (WHO AFRO)
- Lamia Mahmoud (WHO EMRO)
- Mark Stoltenberg (Massachusetts General Hospital)
- Liliana De Lima, Katherine Pettus, and Hibah Osman (IAHPC)
- Emmanuel Luyirika and Eve Namisango (APCA)
- Stephen Connor (WHPCA)
- Joanne Brennan (EAPC)
- Julia Downing (ICPCN)
- José Luis Pereira (ICS–University of Navarra)
- Daniel Cobos Muñoz (Swiss Tropical and Public Health Institute Basel, Switzerland). ●

The institutions involved

ATLANTES GLOBAL OBSERVATORY OF PALLIATIVE CARE
WHO Collaborating Centre for the Global Monitoring of Palliative Care Development

Prof. Carlos Centeno, Director

The ATLANTES Global Observatory of Palliative Care is committed to promoting the global development of palliative care (PC) with the aim of improving the quality of life of individuals facing serious and life-limiting illnesses. Through a combination of scientific research, international collaboration, and knowledge dissemination, ATLANTES seeks to integrate palliative care into health systems worldwide, ensuring its accessibility and sustainability.

As part of the Institute for Culture and Society at the University of Navarra (Spain), ATLANTES brings together a multidisciplinary team of researchers and professionals specialising in medicine, social sciences, public health, bioethics, and policy analysis. The observatory works closely with international experts, professional organisations, and policymakers to generate and translate evidence into actionable strategies.

A central aspect of ATLANTES' work is fostering a positive perception of palliative care in both society and the medical profession. The observatory promotes a patient-centred approach based on the principles of human dignity, holistic support, and respect for the natural course of life. This includes not only medical care but also the psychosocial, emotional, and spiritual dimensions of well-being.

Since 2022, ATLANTES has been designated as a WHO Collaborating Centre for the Global Monitoring of Palliative Care Development, taking on specific commitments aligned with the World Health Organization's mission. These responsibilities include:

1. Evaluating and monitoring the development of palliative care services globally, using evidence-based methodologies to track progress and identify gaps in access and quality. This is carried out through regional and global Atlases, offering a comprehensive analysis of palliative care integration in different health systems.
2. Disseminating key findings and data to inform policymakers, health authorities, and stakeholders, ensuring that palliative care becomes an integral part of national and international health planning.
3. Providing strategic guidance for the advancement of palliative care, by assessing trends, challenges, and policy frameworks that influence its implementation and sustainability.

As part of these efforts, ATLANTES collaborates closely with leading global institutions, including the World Health Organization (WHO), the International Association for Hospice and Palliative Care (IAHPC), the Worldwide Hospice Palliative Care Alliance (WHPCA), and regional palliative care networks.

By fulfilling these commitments, ATLANTES contributes to WHO's overarching goal of ensuring that palliative care is recognised as a fundamental component of health services worldwide. A particular focus is placed on low- and middle-income countries where palliative care remains scarce, and on fostering capacity-building initiatives that empower local healthcare providers.

Through its continued research, advocacy, and collaboration, the ATLANTES Global Observatory of Palliative Care remains dedicated to advancing the field, shaping global policy, and reinforcing the importance of compassionate, high-quality care for all individuals facing serious illnesses.

THE INTERNATIONAL ASSOCIATION FOR HOSPICE AND PALLIATIVE CARE (IAHPC)
Katherine Pettus

The International Association for Hospice and Palliative Care (IAHPC) is a global membership organisation officially chartered in the US since 2000. It is a non-state actor in official relations with the World Health Organization (WHO) and a civil society organisation in consultative status with the UN Economic and Social Council (ECOSOC). These official accreditations entitle the IAHPC to participate, by invitation, in official meetings of the multilateral organisations and specialised agencies of the UN, and in technical consultations on specific projects executed by Secretariat staff.

The IAHPC's vision is "a world free from health-related suffering," and its mission is to "serve as a global platform to inspire, inform, and empower individuals, governments, and organisations to increase access to, and optimise the practice of, palliative care." The global board of directors supervises the organisation's four pillars of work: education, advocacy, research, and communications.

The IAHPC has collaborated closely with regional palliative care organisations and has recently focused on strengthening national associations and partnering with academic institutions to advance global palliative care integration and quality care provision at the national level.

IAHPC members are regularly invited to participate in research projects such as the GAP Project to develop Essential and Expanded Palliative Care Packages and a Manual on the Use of Essential Medicines. Forthcoming projects will be associated with work plans agreed under its accreditation relationships with WHO and UN ECOSOC organisations, as well as the International Narcotics Control Board.

Pallipedia, the IAHPC Calendar of Events, and the Directory of Services—regularly updated by IAHPC staff—provide palliative care workers, professional associations, and the global public with valuable resources at no charge. This includes information published by institutional partners, including the dissemination of the ATLANTES Atlases through institutional websites, social and traditional media, and regularly scheduled webinars, courses, or conferences.

The IAHPC has played a key role in building the network of contributors who made the Global Survey possible by:

- Refining the indicators and consulting on the ATLANTES survey methodology.
- Sharing membership lists by region to facilitate member participation in ATLANTES surveys.
- Extending membership benefits to all individuals who participated in the ATLANTES surveys.

The IAHPC collaborates with ATLANTES by supporting national-level palliative care planning based on the GAP Essential and Expanded Palliative Care Packages and the ATLANTES Global Survey indicators and baseline assessment. The ATLANTES Regional Atlases will serve as a key resource for individual and academic researchers, advocates, and national palliative care organisations whose members will take the forthcoming six-module IAHPC/PROESA course on the GAP Essential Packages.

THE WORLDWIDE HOSPICE PALLIATIVE CARE ALLIANCE (WHPCA)
Dr. Stephen R. Connor, Executive Director

The Worldwide Hospice Palliative Care Alliance (WHPCA) is an international non-governmental organisation focusing exclusively on hospice and palliative care development worldwide. We are a network of national and regional hospice and palliative care associations and affiliate organisations.

The WHPCA was formed in 2008 as a global voice for palliative care provider organisations through a series of global summits at regional conferences starting in 2005. The WHPCA is in official relations with the World Health Organization (WHO) and holds consultative status with the United Nations through its Economic and Social Council (ECOSOC). This enables us to influence global health policy at WHO and UN meetings.

Our primary advocacy focus is on ensuring the inclusion of palliative care within the UN Sustainable Development Goals, particularly Goal 3: Improving Health and Well-Being, specifically under target 3.8, achieving Universal Health Coverage (UHC). WHPCA played a key role in ensuring palliative care was recognised as an essential component of the UHC continuum (Promotion–Prevention–Treatment–Rehabilitation–Palliative Care).

Today, the WHPCA has over 500 organisational members across 103 countries. Organisational membership is free, and all WHPCA resources are accessible on our website: https://thewhpca.org.

Mission

To improve access to timely, quality palliative care globally and reduce serious health-related suffering through impactful collaboration with the global health community. We believe that no one with a life-limiting condition, such as cancer, organ failure, or HIV, should endure unnecessary pain and distress.

Vision

A world with universal access to hospice and palliative care.

Key Facts

- The WHPCA is a registered charity in the UK, where our secretariat is based.

The institutions involved

- Over 70 million people require palliative care annually, including more than 27 million at the end of life. Over 20 million of these individuals die in avoidable pain and distress.
- Pain management is fundamental to hospice and palliative care. The WHPCA actively works to improve access to essential medications. Currently, about 80% of the world's population lacks adequate access to the medications required to manage pain and other symptoms.
- The WHPCA upholds a patient-centred approach, addressing the physical, psychological, social, practical, legal, and spiritual needs of patients and their families.
- The WHPCA advocates for the integration of hospice and palliative care into national and regional health systems and supports organisations in achieving this goal.
- We collaborate with partner organisations to support patients, families, and caregivers in alleviating pain and distress while promoting quality of life.

Strategic Plan Goals 2024-2025

- **Strategic Goal 1:** Advocate for the inclusion of palliative care services under universal health coverage at all levels, including primary care.
- **Strategic Goal 2:** Work with member organisations to build leadership and management capacity, enhance evidence-based advocacy and policy skills, provide technical assistance, and strengthen communication capabilities. ●

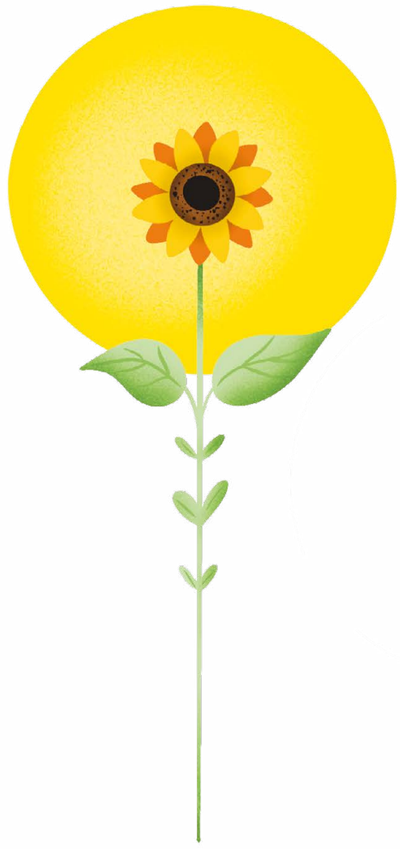
Aim and objectives

For the third time in this region, this work aimed to implement a set of actionable indicators for evaluating PC development in the Eastern Mediterranean Countries. The goal was to consolidate the monitoring of the development of palliative care in the Member States.

The objectives were to:

- Implement a set of WHO quantitative and qualitative indicators to monitor PC development in the Eastern Mediterranean Region.
- Identify areas for improvement in the development of PC in the regions.
- Present updated, reliable, evidence-based information and comprehensive analysis on PC development regionally.
- Provide open-access data on PC development in each of the 22 countries of the WHO Eastern Mediterranean Region to facilitate discussion and benchmarking. ●

This Atlas presents the most relevant information to palliative care development in a way that is clear, accessible, and easy to interpret for professionals, policymakers, and the general public.

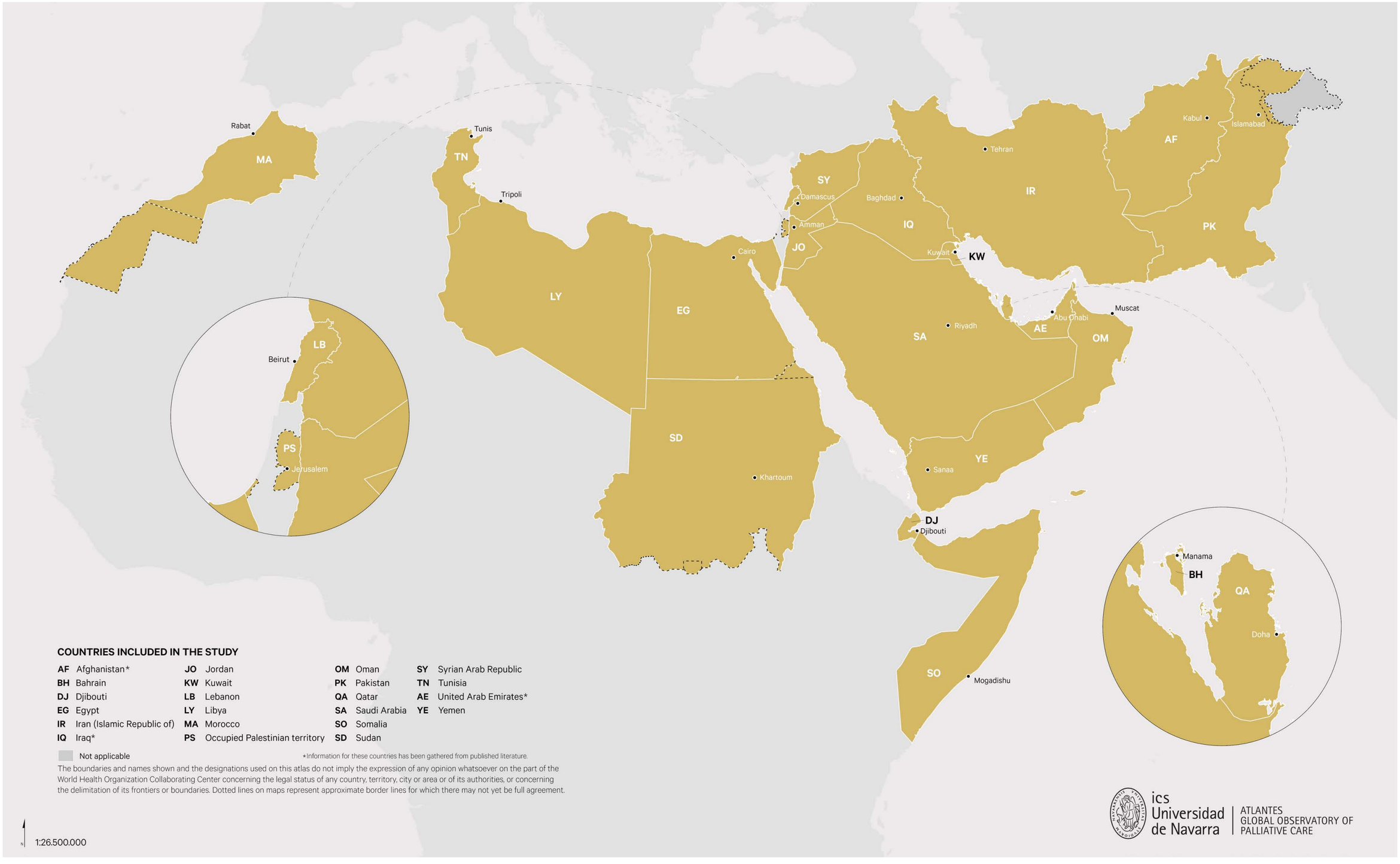


Population and methods

Geopolitical context

POPULATION AND METHODS

Geopolitical context

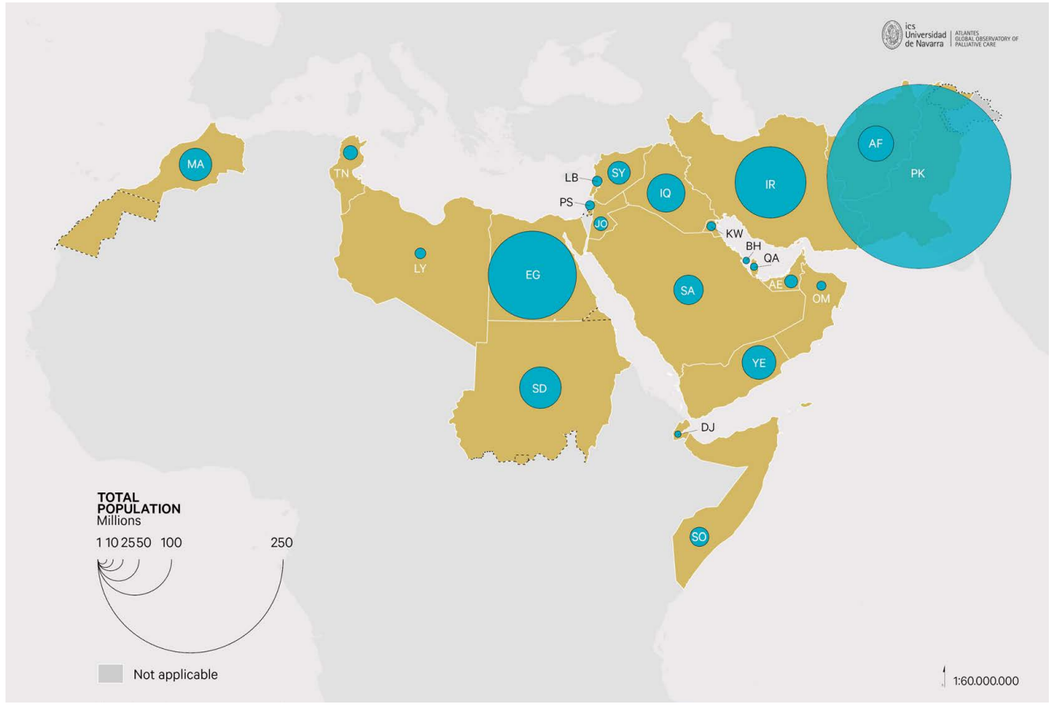


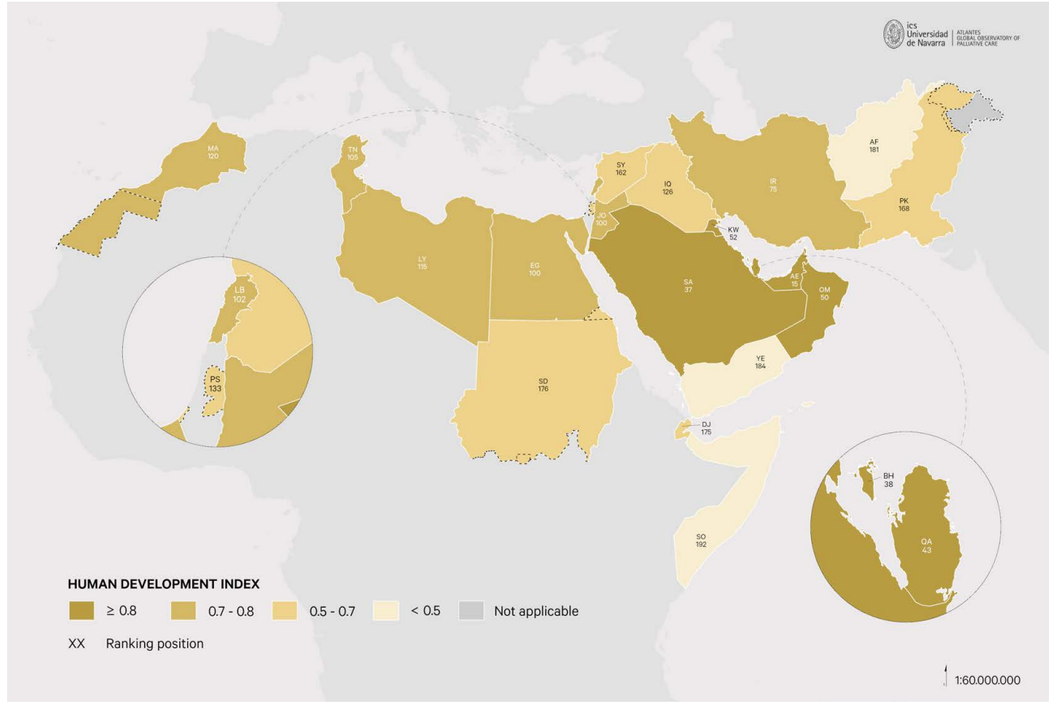
Socioeconomic context

TABLE 2. **Demographic and economic overview of the Eastern Mediterranean Region**

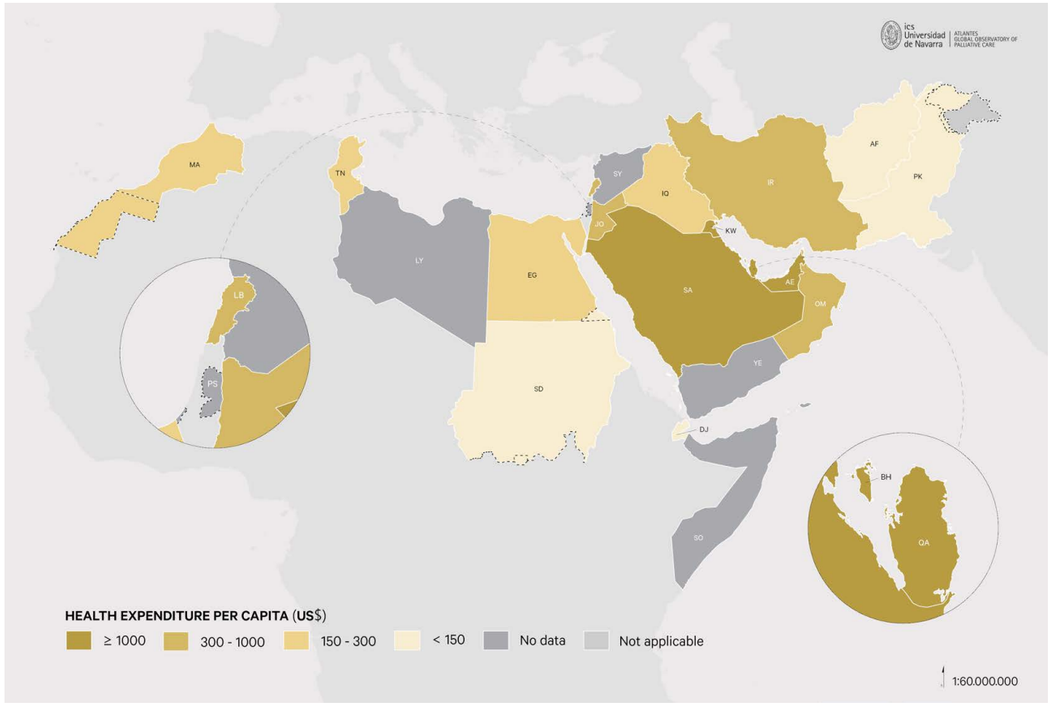
Country or Area	Population 2024	Health expenditure (per capita) 2021	Income Level	Human development index rank	Physicians per 1000 inhabitants
Afghanistan	42,647,492	81.32	Low income	181	0.21
Bahrain	1,588,670	1,146.47	High income	38	-
Djibouti	1,168,722	87.75	Lower middle	175	-
Egypt, Arab Rep.	116,538,258	179.68	Lower middle	100	0.71
Iran, Islamic Republic	90,608,707	392.54	Upper middle	75	-
Iraq	46,042,015	248.92	Upper middle	126	0.87
Jordan	11,552,876	299.07	Lower middle	100	2.51
Kuwait	4,973,861	1,860.78	High income	52	-
Lebanon	5,805,962	307.13	Lower middle	102	2.62
Libya	7,381,023	-	Upper middle	115	-
Morocco	38,081,173	221.11	Lower middle	120	-
Occupied Palestinian Territory	5,289,152	-	Lower middle	133	-
Oman	5,281,538	852.62	High income	50	2.09
Pakistan	251,269,164	43.09	Lower middle	168	1.08
Qatar	2,857,822	1,934.08	High income	43	-
Saudi Arabia	35,300,280	1,442	High income	37	2.63
Somalia	19,009,151	-	Low income	192	-
Sudan	50,448,963	21.58	Low income	176	-
Syrian Arab Republic	24,672,760	-	Low income	162	-
Tunisia	12,277,109	265.46	Lower middle	105	1.28
United Arab Emirates	10,876,981	2,351.81	High income	15	2.76
Yemen	40,583,164	-	Low income	184	-

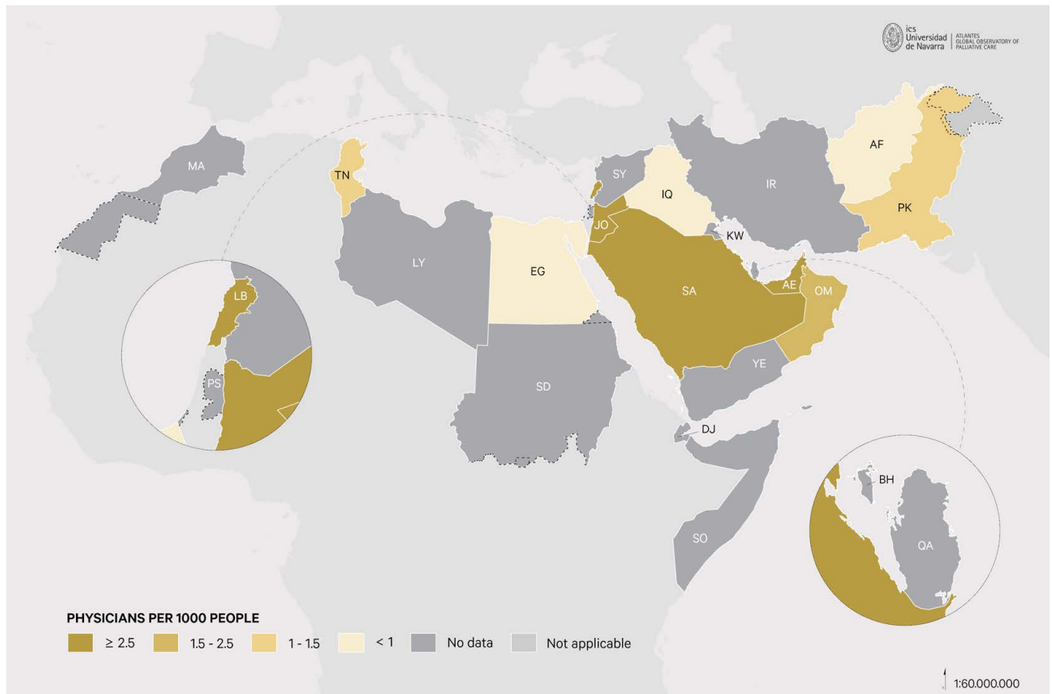
Socioeconomic context





Socioeconomic context





PC needs across the WHO EMRO

Estimates of PC needs at global level have been lately studied as world´s population is increasingly aging and, therefore, an increased prevalence of NCDs and the persistence of other chronic and infectious diseases is happening. This population needing PC is estimated to rise significantly in the future, and the Eastern Mediterranean Region is not an exception.

For this edition of the ATLAS, we estimate the people affected by SHS every year in the Eastern Mediterranean Region and each country by estimating decedents with life threatening or life-limiting health conditions. We used the 2015 data of the database as for being the most complete and recent one, from the IAHPC Global Data Platform to calculate SHS, based on the Lancet Commission Report on Palliative Care and Pain Relief (Knaul FM, et al 2018). SHS was defined as suffering associated with a need for PC. The work of the Commission estimated the global burden using mortality data for 20 conditions, adjusted for the prevalence of both physical and psychosocial symptoms that cause most of the burden of SHS. Based on this burden of symptoms they calculate a multiplier for each condition to estimate the proportion of patients who can benefit from palliative care.

The need for palliative care in the Eastern Mediterranean Region can be estimated at two levels. First, it is calculated that around 1.56 million people die each year with conditions associated with SHS, representing a substantial share of annual deaths. Second, when including individuals who live with life-limiting illnesses and experience SHS before the final stage of life, the estimated annual need for palliative care increases to approximately 3.2 million people. Together, these figures underscore both the mortality-related and the prevalent needs for PC across the region. ●

FIGURE 1. **Main health conditions requiring palliative care**

Main health conditions requiring PC[1]	TOTAL SHS (people died in 2015 needing PC across participating countries
Cancer	**334,695** (21.41%)
Cerebrovascular diseases	**232,983** (14.91%)
Low Birth weight & prematurity	**178,644** (11.43%)
Injury	**147,860** (9.46%)
Liver disease	**103,646** (6.63%)
Lung diseases	**93,270** (5.97%)
Tuberculosis	**81,881** (5.24%)
Dementia	**73,521** (4.70%)
Non-ischemic heart disease	**69,906** (4.47%)
Congenital malformations	**52,181** (3.34%)
Inflammatory disease of the CNS	**40,482** (2.59%)
Chronic ischemic heart disease	**37,664** (2.41%)
Renal Failure	**30,421** (1.95%)
Atherosclerosis	**23,732** (1.52%)
Leukemia	**18,969** (1.21%)
HIV	**15,289** (0.98%)
Malnutrition	**15,014** (0.96%)
CNS Degenerative disease	**9,846** (0.63%)
Musculoskeletal disorders	**1,807** (0.12%)
Heart Failure	**1,191** (0.08%)
TOTAL	**1,563,002** (100%)

[1] Source: The Lancet Commission on Global Access to Palliative Care and Pain Relief. Serious health-related suffering database, 2015.

PC needs across the WHO EMRO

TABLE 4. **Palliative care needs of people who die each year with serious health-related suffering (SHS) in selected countries of the PAHO region** (in thousands)

Country	Heart Failure	Tuberculosis	HIV	Cancer	Leukemia	Dementia	Inflamatory disease of the CNS	CNS degenerative diseases	Cerebro-vascular diseases	Non-ischemic heart disease
Afghanistan	0.05	13.38	0.35	15.27	0.72	1.66	4.21	0.81	11.83	2.26
Bahrain	0.00	0.01	0.01	0.31	0.02	0.12	0.00	0.02	0.12	0.04
Djibouti	0.00	0.35	0.57	0.40	0.03	0.05	0.15	0.04	0.30	0.11
Egypt	0.07	0.32	0.33	65.29	3.62	11.78	1.67	1.01	36.86	13.55
Iran (Islamic Rep. of)	0.01	1.34	3.89	48.99	2.92	13.74	0.33	0.73	27.53	12.65
Iraq	0.02	0.97	0.00	16.04	1.56	2.75	0.61	0.31	9.30	2.49
Jordan	0.00	0.03	0.00	3.60	0.24	1.07	0.04	0.11	1.86	1.00
Kuwait	0.00	0.01	0.00	0.76	0.07	0.37	0.01	0.04	0.58	0.25
Lebanon	0.00	0.06	0.07	4.87	0.23	1.98	0.02	0.09	2.14	0.47
Libya	0.00	0.64	0.00	3.34	0.19	1.28	0.03	0.09	2.22	0.45
Morocco	0.02	3.23	0.91	21.86	0.76	7.88	0.64	0.54	13.98	3.64
Oman	0.00	0.03	0.07	0.92	0.10	0.28	0.02	0.04	0.53	0.11
Pakistan	0.78	44.67	3.57	96.49	4.31	12.34	16.03	3.09	70.96	22.21
Qatar	0.00	0.01	0.00	0.47	0.04	0.08	0.00	0.02	0.11	0.02
Saudi Arabia	0.01	0.71	0.00	9.08	0.65	4.36	0.10	0.33	7.42	1.16
Somalia	0.06	6.66	2.07	5.01	0.28	0.30	9.21	0.40	2.55	0.99
Sudan	0.09	8.04	2.99	14.25	0.97	3.80	5.43	1.02	17.69	3.93
Syrian Arab Republic	0.01	0.03	0.03	11.85	0.80	3.10	0.25	0.15	7.17	0.97
Tunisia	0.00	0.24	0.08	6.94	0.31	4.07	0.08	0.36	7.01	1.00
United Arab Emirates	0.00	0.04	0.00	1.37	0.10	0.24	0.06	0.09	1.10	0.26
Yemen	0.04	1.12	0.34	7.56	1.03	2.26	1.58	0.55	11.72	2.34
TOTAL	**1,191**	**81,881**	**15,289**	**334,695**	**18,969**	**73,521**	**40,482**	**9,846**	**232,983**	**69,906**

Chronic ischemic heart disease	Lung diseases	Liver disease	Renal Failure	Low birth weight & prematurity	Congenital malformations	Injury	Athero-sclerosis	Musculo-skeletal disorders	Mal-nutrition	Total children with SHS in thousands	Total people with SHS (all ages) in thousands
1.50	3.75	3.86	1.70	14.44	3.66	14.11	1.03	0.10	1.60	**96,275.44**	**33770.18**
0.04	0.08	0.06	0.06	0.02	0.04	0.09	0.02	0.01	0.00	**1,074.81**	**82.46**
0.02	0.08	0.16	0.02	0.29	0.10	0.22	0.07	0.01	0.12	**3,105.04**	**734.42**
6.32	11.94	51.95	9.03	14.63	9.43	9.49	6.24	0.22	0.67	**254,422.21**	**32059.85**
4.46	7.99	3.93	2.50	4.57	2.54	11.95	4.33	0.18	0.23	**154,818.11**	**9472.09**
1.63	1.33	1.15	1.89	8.40	3.76	17.06	1.54	0.07	0.31	**71,205.57**	**18428.24**
0.26	0.51	0.48	0.40	0.90	0.59	0.94	0.18	0.06	0.01	**12,291.26**	**1868.17**
0.14	0.13	0.20	0.12	0.13	0.18	0.39	0.07	0.01	0.00	**3,464.78**	**351.20**
0.62	0.91	0.67	0.35	0.20	0.20	0.85	0.30	0.03	0.02	**14,106.90**	**528.72**
0.37	0.74	0.76	0.51	0.33	0.35	1.40	0.24	0.03	0.02	**13,005.57**	**1000.90**
1.72	2.82	4.19	2.07	4.58	1.88	3.99	1.71	0.15	0.23	**76,817.54**	**8475.15**
0.12	0.16	0.23	0.11	0.18	0.18	0.63	0.34	0.01	0.02	**4,085.32**	**479.34**
13.25	47.41	19.14	5.66	98.62	15.90	35.56	2.12	0.31	5.50	**517,908.30**	**159226.78**
0.03	0.03	0.07	0.04	0.05	0.05	0.27	0.02	0.00	0.00	**1,321.25**	**133.30**
1.18	1.50	1.99	0.93	2.05	1.99	5.13	0.85	0.10	0.04	**39,579.09**	**5429.04**
0.14	0.67	1.54	0.17	6.74	1.94	4.01	0.56	0.04	4.21	**47,551.64**	**23643.75**
2.17	5.70	6.37	2.14	13.97	5.30	12.09	1.68	0.21	1.45	**109,297.19**	**34611.28**
1.32	1.16	1.35	0.37	1.04	0.85	20.44	0.47	0.03	0.13	**51,501.99**	**5860.47**
0.59	2.35	1.56	0.64	0.69	0.55	1.53	0.76	0.12	0.09	**28,987.18**	**1547.45**
0.19	0.50	0.28	0.21	0.16	0.15	0.76	0.06	0.02	0.01	**5,603.33**	**406.91**
1.60	3.50	3.67	1.50	6.64	2.53	6.96	1.15	0.11	0.37	**56,579.39**	**14779.23**
37,664	93,270	103,646	30,421	178,644	52,181	147,860	23,732	1,807	15,014	**1,563,002**	**352,889**

Source: https://iahpc.org/what-we-do/research/global-data-platform-to-calculate-shs-and-palliative-care-need/database/

PC needs across the WHO EMRO

Knaul FM, Farmer PE, Krakauer EL, 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): 1391-454 http://www.thelancet.com/commissions/palliative-care
Knaul FM, Farmer PE, Krakauer EL, De Lima L, Bhadelia A, Jiang Kwete X, Arreola-Ornelas H, et. al. Technical Note and Data Appendix for "Alleviating the access abyss in palliative care and pain relief—an imperative of universal health coverage: The Lancet Commission report". Background Document. Miami: University of **Miami** Institute for Advanced Study of the Americas. Available at: https://miami.edu/lancet

Methods of the project

In 2021, a consensus-building process led by ATLANTES and coordinated by WHO was conducted to identify a refined set of indicators to monitor the development of PC programs in different contexts, especially in coun¬tries where PC is at an initial stage of development. The straight set was chosen from a long list of validated indi¬cators used in different settings worldwide. The consen¬sus was reached by a panel of international experts rep¬resenting all WHO regions through a series of meetings, group work, and a two-round Delphi process. The group agreed upon a working concept of PC development and fed it into an updated conceptual model. The technical report titled *Assessing the Development of Palliative Care Worldwide: A Set of Actionable Indicators* presents a set of palliative care indicators that Member States can universally apply to monitor and evaluate the provision of PC services[1].

The proposed model highlights six essential components required to provide an optimal PC for those people with severe health-related suffering (*Figure 2*)**:**

1. Empowerment of people and communities.
2. Robust health policies related to PC.
3. PC-related research.
4. Use of essential PC medicines.
5. Education and training for health workers and volunteers providing PC.
6. Provision of PC within integrated health services.

The WHO established a set of 14 PC indicators using the updated PC development conceptual model (Table 4). These indicators were applied to each country by gather¬ing information from participants known as experts. The project for each country involved a national cross-sec¬tional observational study. Each country was profiled individually and presented in this final report. The data included quantitative outcomes along with supplemen-tary qualitative information. Each country produced and validated its national report. In the case of the Eastern Mediterranean Region, some reports also received endorsement from national palliative care associations or another recognized health-related institution.

Figure 2. The WHO's new framework for Palliative care Development: The House of Palliative Care.

Methods of the project

TABLE 5. **WHO indicators**

Indicator	Core	Estrategic
Empowerment of peoples and communities		
1 Existence of groups dedicated to promote the rights of patients in need of palliative care, their families, their caregivers and disease survivors	✔	✔
2 Existence of national policy or guideline addressing advance care planning of medical decisions for use of life-sustaining treatment or end-of-life care	✔	
Health policies		
3 Existence of a current national palliative care plan, programme, policy or strategy with defined implementation framework	✔	✔
4 Inclusion of palliative care in the list of health services provided at the primary care level in the national health system		✔
5 Existence of national coordinating authority for palliative care (labelled as unit, branch, department) in the Ministry of Health (or equivalent) responsible for palliative care		✔
Research		
6 Existence of congresses or scientific meetings at the national level specifically related to palliative care	✔	
7 Palliative care research on the country estimated by peer reviewed articles	✔	
Use of essential medicines		
8 Reported annual opioid consumption —excluding methadone— in Defined Daily dosis for statistical purposes (S-DDD)	✔	✔
9 Availability of essential medicines for pain and palliative care at all levels of care		✔
10 General availability of immediate-release oral morphine (liquid or tablet) at the primary care level		✔
Education and training		
11 Proportion of medical and nursing schools with palliative care formal education in undergraduate curricula	✔	✔
12 Specialization in palliative medicine for physicians	✔	
Integrated palliative care services		
13 Number of specialized palliative care programmes in the country per population	✔	✔
14 Number of specialized palliative care programmes for paediatric population in the country	✔	

Source: Assessing the development of palliative care worldwide: a set of actionable indicators. WHO, 2021.

Methods of the project

ATLANTES structured the research process in four steps (*Figure 3*):

1. Building an informant network
2. Data collection through the E-Course
3. Analysis: conciliation, validation and endorsement of National associations
4. Results dissemination

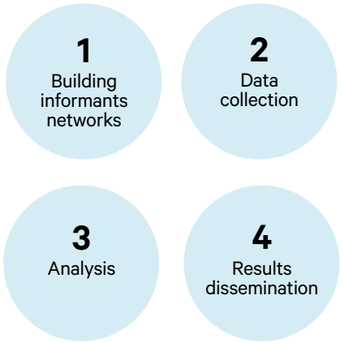


Figure 3. Methodology scheme in four steps

1. BUILDING NETWORKS OF NATIONAL INFORMANTS

Since June 2024, ATLANTES built a network of consultants among the following organizations: the IAHPC, the WHPCA, the National PC associations, and ATLANTES previous collaborators. In each country, data were agreed upon by at least two con¬sultants who met two or more of the selection criteria:

1. More than 5 years of PC professional experience
2. Identified as PC National Champion for an International or National Association
3. Participation in previous Atlas studies
4. Publications on PC development
5. Member of a PC organisation
6. High interest in PC development

Experts were asked whether they consented to having their data made public in upcoming publications.

2. DATA COLLECTION THROUGH THE E-COURSE

A free, asynchronous, tutored online course accredited by the University of Navarra was created. This e-course car¬ries one European Credit Transfer and Accumulation Sys¬tem (ECTS) credit (25 hours) and comprises seven units. The first unit includes a didactic guide with general infor¬mation such as overall objectives, course modules, meth¬odology, resources, and critical dates. The second unit gathers the socio-demographic information of the partic¬ipants necessary for granting official certification. Units three to six feature short videos introducing PC develop¬ment dimensions, a measurement framework, support¬ing PDF documents, and a questionnaire. Each question corresponds to a WHO indicator within its dimension and includes a multiple-choice option to determine the country's level of development in that indicator. After selecting the level, participants were prompted to pro¬vide a narrative justification and uploaded supporting documents to validate their responses. The final unit con¬tains Benin´s country report, the outcome of the first pilot project validating the WHO conceptual framework. The course was available in English.

The PC experts were invited via official email based on detailed criteria. By December 2024, invitations were shared via social media and international PC associa¬¬tion websites to expand the reach and capacity-building potential. Additional incentives, like free International IAHPC membership, were offered upon course comple¬¬tion (*Figure 4*).

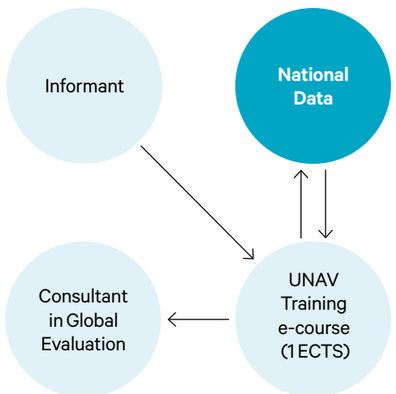


Figure 4. Data Collection through the E-Course with experts from each country.

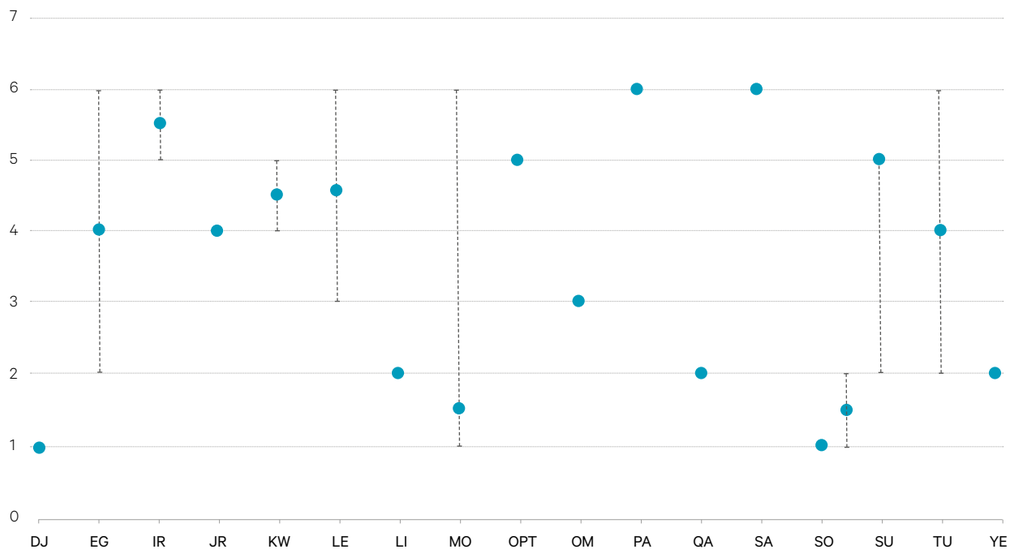
Methods of the project

A total of 123 palliative care professionals were initially identified across the 22 countries of the WHO Eastern Mediterranean Region. From this group, a regional network of 42 national consultants was consolidated, many of whom had contributed to previous assessments or were part of the Eastern Mediterranean Regional Palliative Care Expert Network. Ultimately, 38 key informants from 19 countries actively participated in this study: 35 completed the accredited online course and full data collection process, while 3 contributed through the completion of the e-survey. The network of consultants represented a wide range of disciplines and professional backgrounds in PC ensuring a multidisciplinary and comprehensive perspective that supports the rigor and credibility of the study.

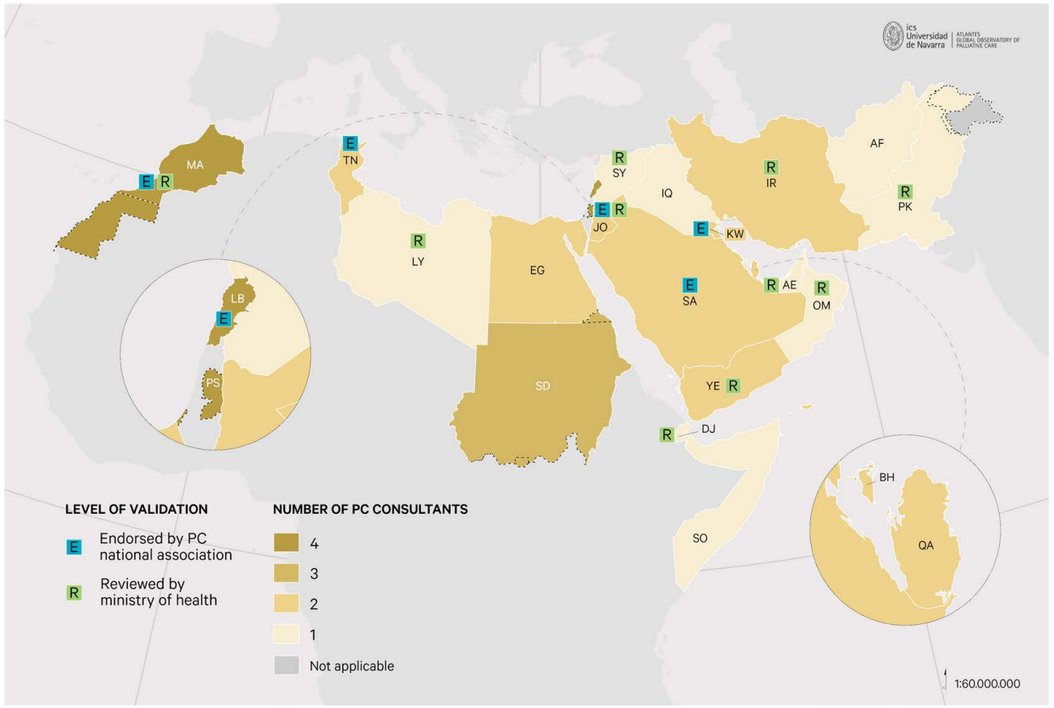
Each of the 19 participating countries included at least one key informant who met two or more of the following selection criteria:

1. Over 5 years of professional experience in PC
2. Identified as a National PC Champion by international or national associations
3. Participant in previous studies
4. Member of a National or Regional Association
5. Publications on national development
6. High interest in PC development

Consultants' Palliative Care Expertise Profile



Methods of the project



Network of collaborators.

Methods of the project

3. ANALYSIS: CONCILIATION, VALIDATION AND ENDORSEMENT OF NATIONAL ASSOCIATIONS

Data has been collected through online questionnaires and compiled into a structured country-wise database. A total of 22 country reports have been produced, including 19 reports with conciliated information from key informants and three reports based on a literature review. The path of the collected data is shown in in *figure 6*.

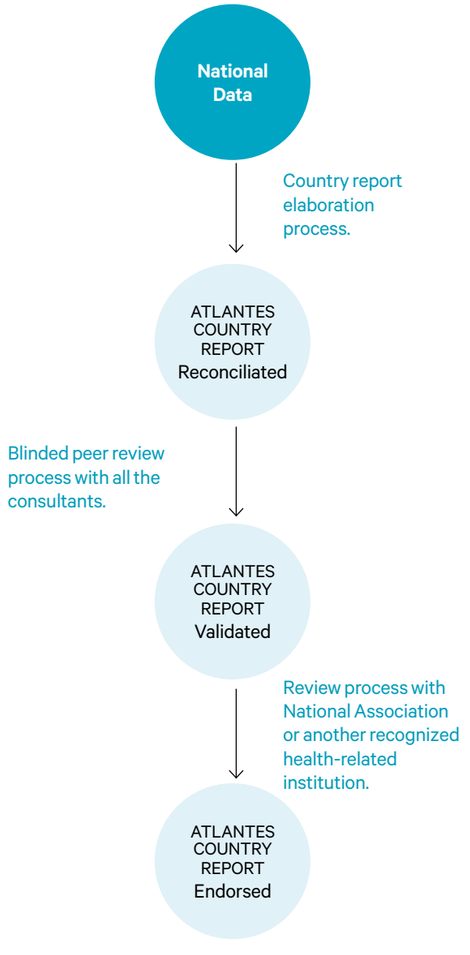


Figure 6. The path of the collected data.

All consultant inputs were first conciliated for each indicator to ensure consistency. The information was then supplemented with available literature, and each indicator was assigned a level with a corresponding justification. On this basis, structured Country Reports were developed, incorporating the assigned levels of PC development together with a narrative contextualization for each indicator. These reports were validated by the consultants (and, where necessary, by additional experts) and, when possible, underwent further review by national PC associations or other recognized health-related institutions. Each report specifies the review process, together with the names of the consultants and, where applicable, the organizations involved.

Statistical analysis

The 14 indicators were obtained from the different scores collected for each country. In particular, indi¬cators 1 (Groups promoting the rights of patients), 2 (Advance care planning-related policies), 4 (Inclusion of PC in the basic health package at the primary care level), 6 (Existence of congresses or scientific meetings) , 7 (PC-re¬lated research articles and 12 (Recognition of PC special¬ty) had just one integer score between 1 and 4. Indicators 3 (National PC plan or strategy), 5 (Responsible authority for PC in the Ministry of Health), 9 (Overall availability of essential medicines for pain and PC at the primary level), 10 (General availability of immediate-release oral mor¬phine at the primary level), 10.1 (General availability of different opioids in different formulations) and 13 (Provision of PC (Specialized Services) were obtained as each median score. It means values between 1 and 4 eventually with decimals.

Indicator 8 comes from the consumption of opioids in defined daily doses for statistical purposes per million inhabitants per day (S-DDD). Average consumption of nar¬cotic drugs (excluding methadone) 2020–2022.

Source: Narcotic Drugs 2022: Estimated World Requirements for 2023 – Statistics for 2021 International Narcotics Control Board https://digitallibrary.un.org/record/4061663/files/E_INB_2023_2-EN.pdf

Cartography

Alvaro Montero and Julen Herrero developed the cartography under the supervision of Professor Juan José Pons from the Department of History, History of Art, and Geography at the University of Navarra. The software used for map construction was ArcGIS Pro 3.3.2. The digital coverage for country boundaries was adapted to a small scale and obtained from the ESRI ArcGIS Online repository, while the disputed borders and areas were obtained from the WHO ArcGIS Hub repository. For the cities, a point map from Esri ArcGIS Online was used. The projection applied to all the maps is Africa Lambert Conformal Conic, with the central meridian at 30°. The scale is 1:25,000,000 for the

Methods of the project

Geopolitical Map and 1:60,000,000 for the thematic maps. All maps include two zoom levels to facilitate visualization at 1:16,000,000, 1:8,000,000, and 1:4,000,000. Choropleth and symbol maps are used for categorical and quantitative variables, while proportional symbol maps and chart maps are employed for quantitative data. In terms of stylistic representation, consistent color ranges have been adopted and used throughout this publication: beige for choropleths, and turquoise or green for symbols and charts.

Boundaries and geopolitical designations

The boundaries, names, and designations used in this palliative care atlas for the Eastern Mediterranean Region follow the cartographic guidelines of the World Health Organization (WHO). Their inclusion does not imply any judgment on the part of the authors or editors concerning the legal status of any country, territory, city, or area, or of its authorities, or concerning the delimitation of its frontiers or boundaries.

Dotted lines on maps represent approximate borderlines for which there may not yet be full agreement. This atlas is intended solely to provide information on PC in the Eastern Mediterranean Region and does not aim to make statements on geopolitical matters.

Commercial mentions and responsibility

The mention of specific companies or certain manufacturers' products does not imply that they are endorsed or recommended in preference to others of a similar nature that are not mentioned.

The authors have taken all reasonable precautions to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the authors or the publishing institution be liable for damages arising from its use.

4. RESULTS DISSEMINATION

The upcoming release of the new Atlas of Palliative Care Developments in the Eastern Mediterranean Countries 2025, marks a new milestone in advancing PC across the region. This comprehensive Atlas, officially launched on October 20th, 2025, at the webinar *Advancing Palliative Care in the Eastern Mediterranean*, is the result of a collaborative effort involving healthcare professionals, policymakers, and key stakeholders.It provides critical insights and data to support us all in improving PC services. By disseminating this valuable resource, the atlas seeks to enhance awareness, inform policy development, and foster collaboration among countries to ensure accessible, high-quality PC for all needy individuals. The presentation at the webinar *Advancing Palliative Care in the Eastern Mediterranean* served as a platform to engage the regional and global palliative care community and highlight the ongoing collaborative efforts to address challenges across the Eastern Mediterranean Region.

Limitations and constraints

All 22 countries have had information either provided by both key informants and available literature or at least revised and amended by one in-country expert. The lack of engagement has been attributed to the selection criteria for key informants, as well as the limited or non-existent PC activity in some countries.

This study is based on official documents, perspectives, and knowledge from national experts, regional PC key persons, and trained consultants. Although this methodology is widely accepted for data collection, the data are still considered estimates. Consequently, the accuracy and precision of the data can be challenging to verify on occasion. However, it remains the best and most up-to-date information available in the region.

Based in Spain, the ATLANTES Global Observatory of Palliative Care contributed its experience and knowledge from previous international atlas studies (overall previous editions of the Eastern Mediterranean Region Atlas). Nevertheless, the implementation of the WHO's new indicators and the limited evidence regarding exploring PC activity within national health systems should be considered.

Source:
1. Assessing the development of palliative care worldwide: a set of actionable indicators. Geneva: World Health Organization, 2021. https://www.who.int/publications/i/item/9789240033351
2. Tripodoro VA, Ray A, Garralda E, Bastos F, Montero Á, Béjar AC, Pons JJ, Bouësseau MC, Centeno C. Implementing the WHO Indicators for Assessing Palliative Care Development in Three Countries: A Do-It-Yourself Approach. J Pain Symptom Manage. 2025 Jan;69(1):e61-e69. doi: 10.1016/j.jpainsymman.2024.09.017. https://pubmed.ncbi.nlm.nih.gov/39326467/

Methods of the project

INTEGRATING PC INTO RESPONSES TO HEALTH EMERGENCIES IN THE EASTERN MEDITERRANEAN REGION

Following lessons from the COVID 19 pandemic, the WHO's Fourteenth General Programme of Work (GPW 14, 2025–2028) sets a bold agenda to reinvigorate progress toward health related Sustainable Development Goals (SDGs), emphasizing health equity and system resilience in an increasingly turbulent global context. Grounded in WHO's mission to promote, provide and protect health and well being for all people, GPW 14 defines six strategic objectives including advancing PHC, achieving UHC, and strengthening preparedness for health emergencies.

To achieve these goals in the Eastern Mediterranean Region, PC, focused on preventing and relieving pain, other physical and psychological symptoms, and social and spiritual suffering, must be recognized as a vital component of emergency preparedness, response, and recovery efforts.

The WHO's 2018 guide Integrating palliative care and symptom relief into the response to humanitarian emergencies and crises establishes the medical and moral imperative to include PC in emergency responses of all kinds, and introduces the Essential Package of Palliative Care for Humanitarian Emergencies and Crises (EP PCHEC).

The Eastern Mediterranean Region faces recurrent humanitarian crises, from prolonged armed conflict, mass displacement, and refugee flows to outbreaks, natural disasters, and health system disruptions. These crises inflict severe physical and psychological trauma, fueling the suffering of children, women, refugees, persons with chronic conditions, and underserved populations. Such reality highlights the urgent need for Ministries of Health, public and private institutions, and humanitarian actors to integrate PC across all levels of crisis response.

To operationalize this integration, the following actions are recommended for the Eastern Mediterranean Region:

- **Ensure national policies explicitly include PC** as part of essential, universally accessible health services, including during emergencies.
- **Mandate PC inclusion** in protocols of both domestic and international humanitarian response, in alignment with the WHO EP PCHEC.
- **Facilitate timely access to essential palliative medicines,** including controlled substances, by local systems and humanitarian providers.
- **Train emergency health teams** in PC principles, emphasizing both life saving and suffering relief imperatives.
- **Equip response teams with the WHO EP PCHEC,** adapted to the cultural and logistical realities of the Region.
- **Engage local health and mental health professionals** to deliver culturally appropriate psychosocial support for affected individuals, families, and responders.

In summary, the WHO EP PCHEC offers a structured yet adaptable framework to deliver essential palliative services in complex humanitarian settings. In the Eastern Mediterranean region, where crises are both frequent and protracted, embedding PC into emergency health strategies is not only an ethical necessity but also fundamental to building equitable, resilient, and people centered systems. ●

Source:
1. A Global Health Strategy for 2025-2028 - advancing equity and resilience in a turbulent world: fourteenth General Programme of Work A Global Health Strategy for 2025–2028
2. Integrating palliative care and symptom relief into the response to humanitarian emergencies and crises: a WHO guide. Geneva: World Health Organization; 2018. https://iris.who.int/bitstream/handle/10665/274565/9789241514460-eng.pdf?sequence=1

Abbreviations

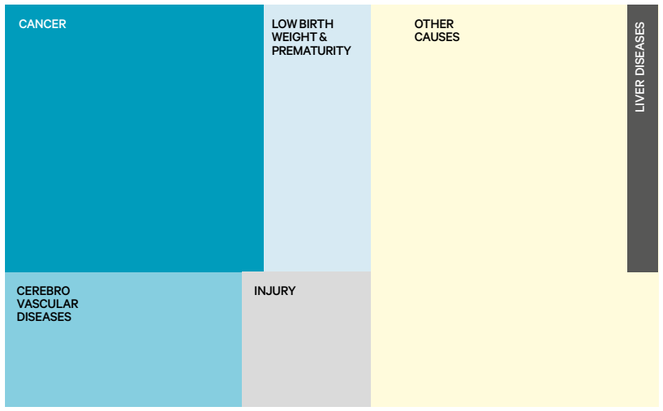
ACP	Advance Care Planning
ADs	Advance Directives
ALCP	Asociación Latinoamericana de Cuidados Paliativos
CPR	Cardiopulmoary Resuscitation-
DNR	Do Not Resuscitate
EML	Essential Medicines List
EMRO	Eastern Mediterranean Region Office
ArcGIS	Geographic Information System software
HIS	Health System Information
IAHPC	International Association for Hospice and Palliative Care
ICS	Institute for Culture and Society (Universidad de Navarra)
LMICs	Low- and Middle-Income Countries
MoH	Ministry of Health
NGOs	Nongovernmental Associations
NCDs	Non-Communicable Diseases
NLM	National Library of Medicine
OPD	Outpatient Department
PHC	Primary health care
PC	Palliative care
PPC	Paediatric palliative care
SAR	Special Administrative Region
S-DDD	Defined daily doses for statistical purposes per million inhabitants per day
SDGs	Sustainable Development Goals
SHS	Serious Health-related Suffering
UHC	Universal health coverage
UN	United Nations
WHO	World Health Organisation
WHPCA	Worldwide Hospice Palliative Care Alliance

Palliative Care in the Eastern Mediterranean Countries 2025: At a Glance

Around 1.56 million people faced SHS in the Eastern Mediterranean Region

CONDITION	SHS IN THOUSANDS
Cancer	334,695
Cerebrovascular diseases	232,983
Low Birth weight & prematurity	178,644
Injury	147,860
Liver disease	103,646
Other causes	565,174
Total	**1,563,002**

[1] Source: The Lancet Commission on Global Access to Palliative Care and Pain Relief. Serious health-related suffering database, 2015.



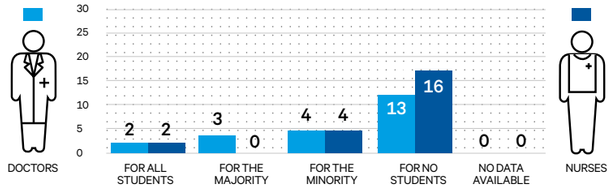
Education and Training

7/22

countries officially recognize PC as a medical specialty or subspecialty through national regulatory authorities.

DIPLOMAS
3/22 have other kinds of diplomas with official recognition (i.e., certification of the professional category or job position).

PALLIATIVE CARE EDUCATION FOR FUTURE DOCTORS AND NURSES: THE NUMBER OF COUNTRIES TEACHING MANDATORY PC



Research

6/22

countries host national palliative care conferences at least every three years Lebanon, Jordan, Saudi Arabia, UAE, Kuwait and Morocco.

6/22

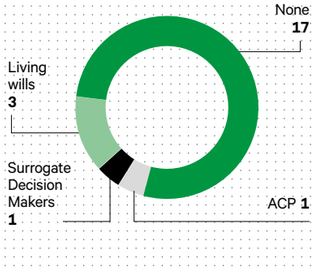
countries report a more sustained level of **peer-reviewed articles** on palliative care research: Lebanon, Egypt, Jordan, Iran, Kuwait, Saudi Arabia.

Empowerment people and communities

13/22

have a strong national and sub-national presence of PC advocacy and promoting **patient rights.**

NATIONAL POLICY OR GUIDELINE ON ADVANCE CARE PLANNING (ACP) OR ADVANCE DIRECTIVES



Health Policies

NATIONAL PALLIATIVE CARE PLAN, PROGRAMME, POLICY, OR STRATEGY

LEVEL	CONTENT	COUNTRIES
4	Actualized, evaluated or audited in last 5 years	1
3	Actualized but not evaluated or audited in last 5 years	6
2	Developed over 5 years ago	4
1	Not known or does not exist	11

Specialized services

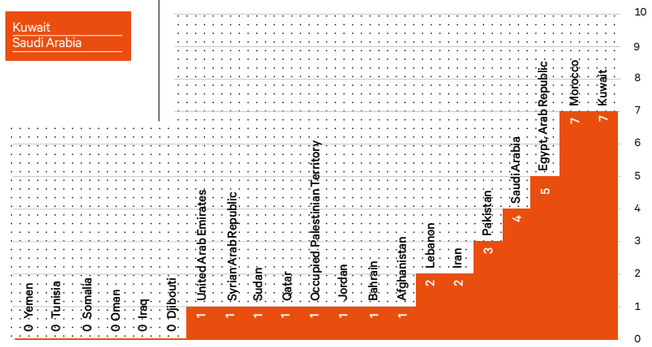
PROVISION OF PALLIATIVE CARE

LEVEL 1 NO OR MINIMAL	LEVEL 2 EXIST BUT ONLY IN SOME GEOGRAPHIC AREAS	LEVEL 3 EXISTS IN MANY PARTS OF THE COUNTRY	LEVEL 4 SISTEMATICALLY PROVIDED
Afghanistan	Bahrain	Jordan	Kuwait
Iran	Djibouti	Qatar	Saudi Arabia
Iraq	Egypt	United Arab Emirates	
Pakistan	Lebanon		
Syrian Arab Republic	Morocco		
Sudan	Occupied Palestinian Territory		
Tunisia	Oman		
Yemen	Somalia		

258

specialized PC services.

SPECIALIZED PEDIATRIC PALLIATIVE CARE SERVICES
38 pediatric services present in 22 countries



Use of Medicines

7/22

Urban Availability of Essential medicines at **primary care centres**

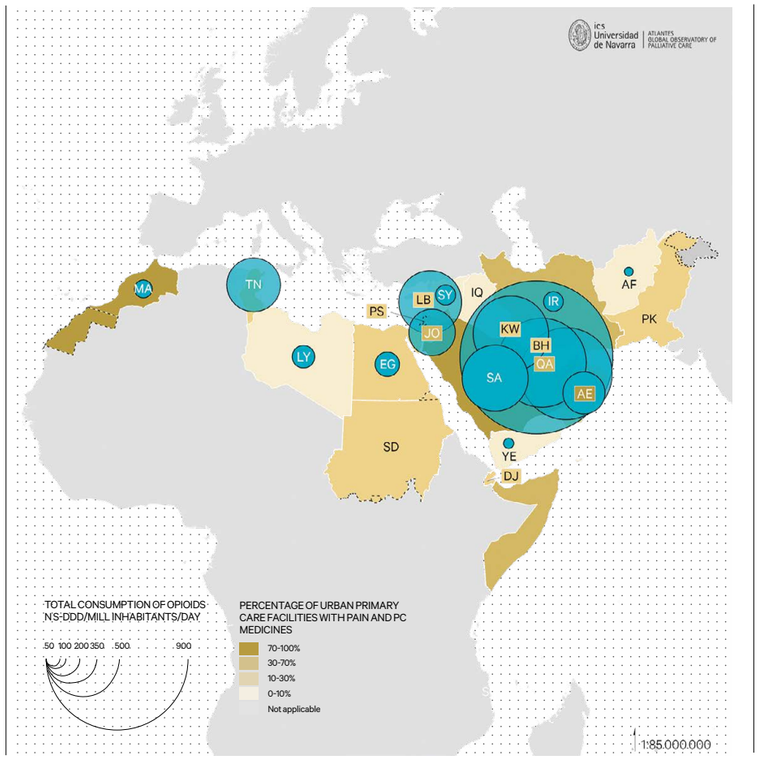
3/22

Urban Availability of Immediate-**Release Oral Morphine**

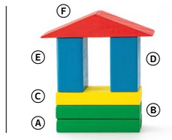
In the Eastern Mediterranean Region, access to essential medicines and oral morphine is higher in urban centers, while rural areas often report little or no availability.

USE OF OPIOIDS

Global
238 S-DDD



GLOBAL FRAMEWORK FOR THE DEVELOPMENT OF PALLIATIVE CARE IN COUNTRIES AND AREAS (WHO, 2021)



Ⓐ EMPOWERMENT OF PEOPLE AND COMMUNITIES
Ⓑ POLICIES
Ⓒ RESEARCH
Ⓓ USE OF ESSENTIAL MEDICINES
Ⓔ EDUCATION AND TRAINING
Ⓕ PROVISION OF PC

LEVEL OF DEVELOPMENT

1 EMERGING
2 PROGRESSING
3 ESTABLISHED
4 ADVANCED

Thematic maps

EM Map 1: Empower people and communities

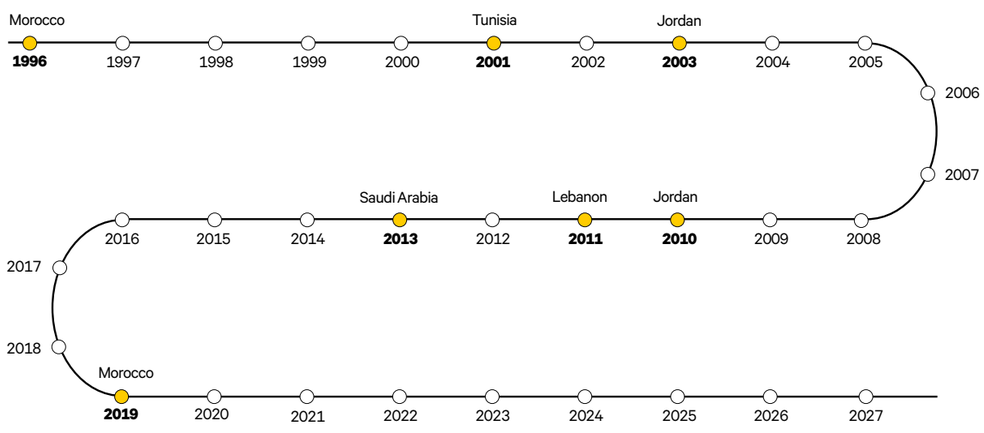
The empowerment of people and communities relates to the capacity of a country to empower individuals, families, and communities as partners in the development of health and social services, as well as in their involvement in shared decision-making about their own health. This includes the availability of advocacy resources to support the participation of patients and caregivers in the development of palliative programs.

GROUPS DEDICATED TO PROMOTING THE RIGHTS OF PATIENTS IN NEED OF PC, THEIR CAREGIVERS, AND DISEASE SURVIVORS

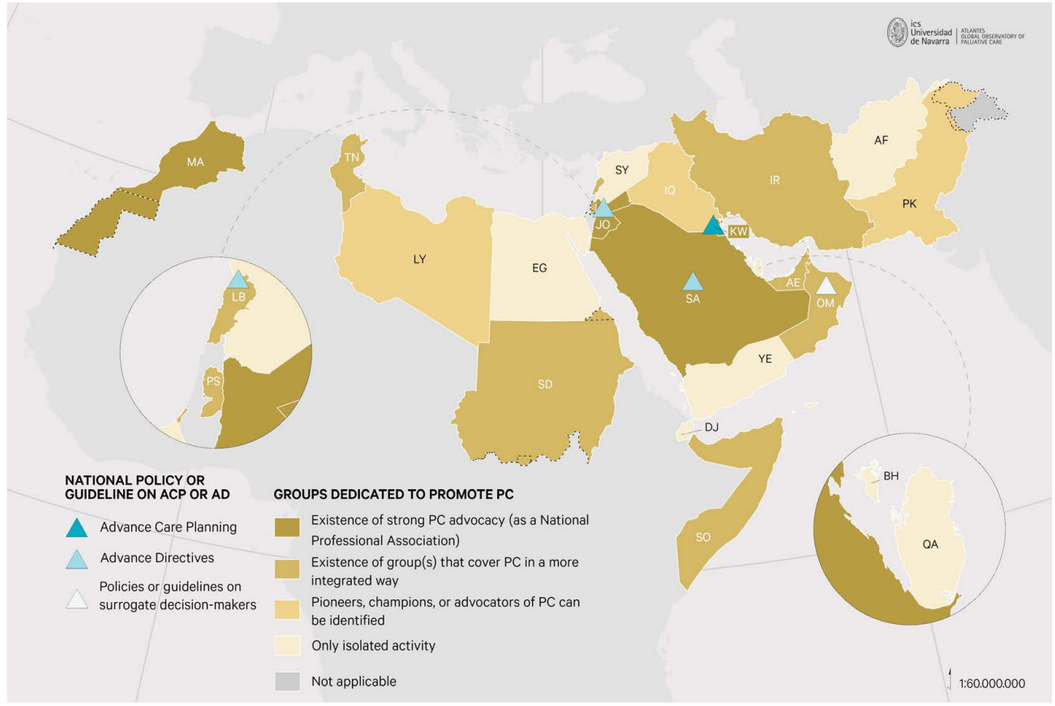
Across the Eastern Mediterranean Region, advocacy efforts remain limited and uneven. National PC associations have been established in Jordan (2003, 2010), Lebanon (2011), Morocco (1996, 2019), Saudi Arabia (2013), and Tunisia (2001), representing the earliest structured initiatives in the region, although their activity and continuity vary.

Additional initiatives are reported through NGOs and disease-focused organizations, such as cancer societies and pain medicine groups in Afghanistan, Egypt, and Bahrain, with PPC advocacy emerging in Lebanon, Egypt, and Morocco. In many other countries, activity is restricted to isolated or hospital-based initiatives (e.g. Djibouti, Somalia, Yemen, Iraq, Bahrain), reflecting the variability of civil society engagement across the region.

Time line of National Assocations' creation



EM Map 1: Empower people and communities



Map 1. Empowerment of people and communities.

NATIONAL POLICY OR GUIDELINE ON ADVANCE DIRECTIVES OR ADVANCE CARE PLANNING (ACP)

The recognition of individuals, families, and communities as partners in the development of health services may be reflected in national policies that promote their involvement in shared decision-making about their health. This shared decision-making can take shape through mechanisms such as ACP, living wills, or the designation of surrogate decision-makers.

ACP is defined as the process of planning someone's future health care, what someone would or would not like to receive if becoming seriously ill or injured and is unable to communicate their preferences or make decisions, and giving the opportunity to think, discuss, and record preferences for the type of care and the outcomes someone would consider acceptable. Ideally, ACP will result in preferences being documented in a plan known as an advance care directive and the appointment of a substitute decision-maker to help ensure their choices are respected. Living Wills (or Advance Directives) are legal documents that specify the type of medical care that an individual wishes to receive or decline in the event they are unable to communicate their wishes. And finally, surrogate decision-makers' policies, also known as a health care proxy or as agents, are individuals designated as advocates for incompetent patients. If a patient is unable to make decisions for themselves about personal care, some agents must make decisions for them.

In the Eastern Mediterranean Region, most countries remain at the lowest level of development, with no national policies or guidelines regulating ACP. Isolated discussions have been reported in countries such as Lebanon, Jordan, and Saudi Arabia, but these are generally limited to ethical frameworks or institutional protocols rather than binding regulations. In Egypt, Bahrain, and Morocco, decisions at the end of life are usually left to families, in the absence of structured procedures. Kuwait is an exception, with more explicit references to ACP in national regulations, although implementation remains limited. Only a small number of countries are developing preliminary references within broader health or cancer strategies, but comprehensive ACP frameworks with legal recognition remain absent across the region. ●

Map 2: Health policy related to PC

The political commitment and leadership expressed in governance and policy frameworks (strategies, standards, and guidelines) is essential to PC development. It includes the development of a legal framework and regulations that guarantee the rights of patients, access to PC services and essential medicines, and the financing and inclusion of PC in the National Health Service and benefits package. It also includes health system design and health care organization, in addition to stewardship and multi-stakeholder action.

NATIONAL PALLIATIVE CARE POLICIES OR STRATEGIES

In the Eastern Mediterranean Region, the development of national PC policies and strategies shows considerable variation. A group of countries, including Jordan, Kuwait, Morocco, Saudi Arabia, Iran, the UAE, and Sudan, have strategies updated within the last five years. Among them, Jordan and Kuwait stand out for having well-defined coordinating entities with clear functions, staff, and budget. In contrast, in Iran, Lebanon, Morocco, and Saudi Arabia, coordinating structures exist but are incomplete, often lacking technical sections, staff, or dedicated funding.

Other countries, such as Egypt, Lebanon, Tunisia, and the Occupied Palestinian Territory, developed national PC strategies or included PC within broader health plans more than five years ago. However, these frameworks have not been consistently updated or audited. In places like the Occupied Palestinian Territory, Oman, and the UAE, PC responsibilities are defined only at the political level, without a functioning coordinating entity.

The majority of countries in the region, including Afghanistan, Bahrain, Djibouti, Iraq, Pakistan, Qatar, Somalia, the Syrian Arab Republic, and Yemen, still lack a standalone PC plan or dedicated authority within the MoH. In these settings, responsibilities for PC governance remain undefined, and there are no concrete functions, budgets, or staff allocated. Overall, while some progress is observed in a limited number of countries—particularly in parts of the Arabian Peninsula and in Jordan—most of the region remains at an early stage of policy development, with frameworks that are fragmented or yet to be consolidated.

Key notes on some countries

Only a few countries in the region (Jordan, Kuwait, Morocco, Saudi Arabia, Iran, the UAE, and Sudan) have updated national PC strategies, while the majority still lack a formal policy framework. Even where plans exist, coordinating entities are often incomplete or limited, resulting in uneven levels of policy development across the region.

INCLUSION OF PALLIATIVE CARE IN THE LIST OF PRIORITY SERVICES FOR UNIVERSAL HEALTH COVERAGE IN THE NATIONAL HEALTH SYSTEM

The explicit inclusion of palliative care in the package of priority services for UHC remains very limited across the Eastern Mediterranean Region. Only a few countries, such as Jordan, Kuwait, Morocco, Saudi Arabia, Iran, the UAE, and Sudan, report references to PC in national health strategies or regulations, though often within broader frameworks (e.g. cancer or non-communicable disease plans). In most cases, inclusion is not part of the General Health Law, and implementation depends on ministerial decrees, institutional protocols, or pilot initiatives.

A smaller group of countries, including Egypt, Lebanon, Tunisia, and the Occupied Palestinian Territory, have referenced PC in plans developed more than five years ago, without recent updates or formal monitoring mechanisms. For the majority of countries in the region, such as Afghanistan, Bahrain, Djibouti, Iraq, Oman, Pakistan, Qatar, Somalia, the Syrian Arab Republic, and Yemen, no official recognition of PC as a priority service for UHC has been documented, and responsibilities at the primary care level remain undefined.

Overall, while some progress has been made in selected high- and middle-income countries of the region—particularly in the Arabian Peninsula and in Jordan—the inclusion of PC in national health packages remains at an early stage.

NATIONAL AUTHORITY FOR PALLIATIVE CARE WITHIN THE GOVERNMENT OR THE MINISTRY OF HEALTH

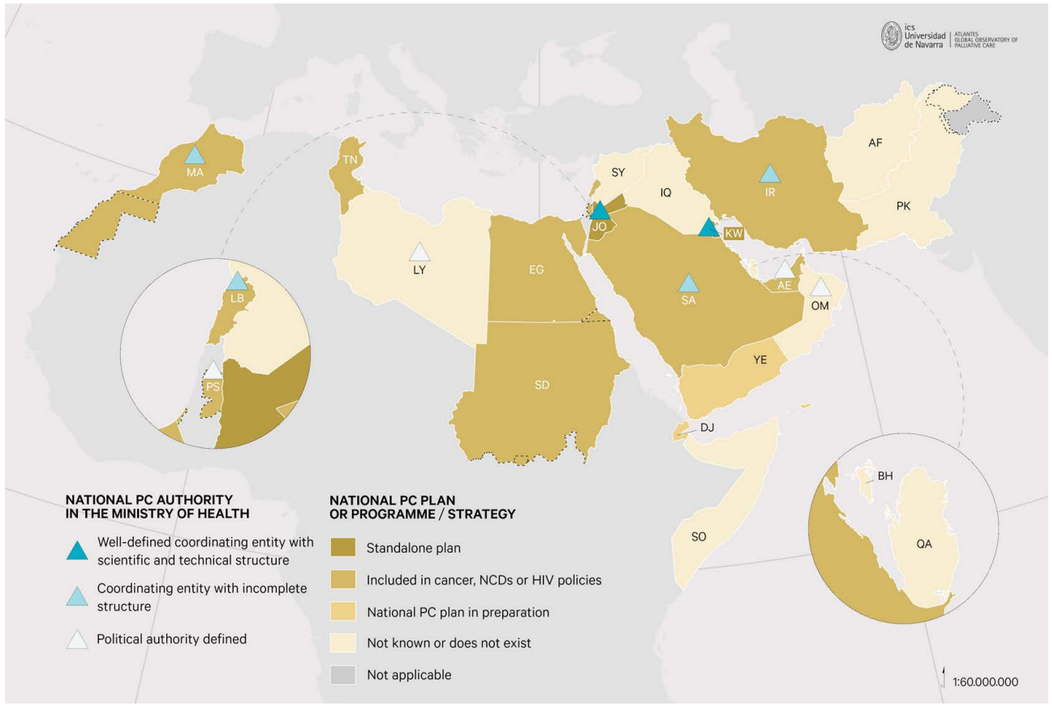
Across the Eastern Mediterranean Region, only a few countries report a coordinating entity for PC that is well-defined and structured with scientific and technical capacity. This is the case for Jordan and Kuwait, where national PC authorities have concrete functions, staff, and budget, allowing for stronger implementation and monitoring.

Several countries report the existence of a coordinating entity, but with an incomplete structure, often lacking technical sections, dedicated staff, or budgetary support. This applies to Iran, Lebanon, Morocco, and Saudi Arabia, where authorities exist formally but remain limited in their operational capacity.

In a smaller group of countries, such as the UAE, Oman, and the Occupied Palestinian Territory, PC is recognized at the political level, but without a functioning coordinating entity to carry out technical or operational tasks.

The majority of countries in the region, however, including Afghanistan, Bahrain, Djibouti, Iraq, Pakistan, Qatar, Somalia, Syrian Arab Republic, Tunisia, and Yemen, report no defined national authority for PC within the MoH, with responsibilities left undefined and without resources allocated.

Map 2: Health policy related to PC



Map 2. Health Policy related to Palliative Care

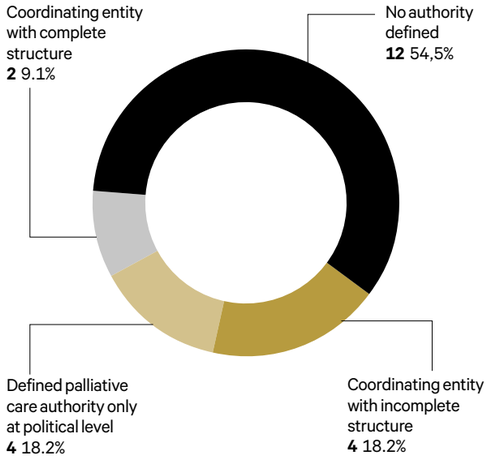


Figure 7. Responsible authority for PC within the Ministries of Health.

Key notes on some countries

JORDAN

The coordinating entity for PC is well established within the MoH, with technical and scientific sections, staff, and budget, serving as a model for institutional commitment in the region.

KUWAIT

A national PC authority has been created with clear functions and resources, actively supporting the implementation of the national PC plan.

Map 3: Research

Research aims at improving the level of scientific evidence to guide the care of people and decisions about the organization of health services. Two indicators measure the extent to which countries are progressing concerning PC research: (a) the existence of national congresses or scientific meetings specifically related to PC, and (b) PC research production estimated through peer-reviewed articles.

EXISTENCE OF CONGRESSES OR SCIENTIFIC MEETINGS AT THE NATIONAL LEVEL SPECIFICALLY RELATED TO PALLIATIVE CARE

In the Eastern Mediterranean Region, only a small number of countries report regular national congresses or scientific meetings specifically dedicated to PC. These include Lebanon, Jordan, Saudi Arabia, UAE, Kuwait and Morocco, where events are organized periodically by professional associations, universities, or specialized centers, often in collaboration with regional or international partners. A few other countries, such as Iran, Egypt and Qatar, hold PC tracks within broader medical or oncology congresses.

In contrast, the majority of countries in the region report either sporadic scientific meetings (Level 2) or none at all (Level 1), limiting opportunities for sustained professional exchange and research dissemination. In several settings, continuing medical education activities substitute for national congresses, but they lack the scope of structured national or regional conferences.

PALLIATIVE CARE RESEARCH ON THE COUNTRY ESTIMATED BY PEER-REVIEWED ARTICLES

The perception of PC research production across the Eastern Mediterranean Region is generally low. Most countries report either very low or low levels of scientific output, often limited to isolated academic initiatives, single-institution studies, or case reports with limited visibility in peer-reviewed journals. A small group of countries, notably Egypt, Jordan, Iran, Kuwait, and Saudi Arabia, has a more sustained presence in regional and international publications, frequently linked to academic centers or collaborations with international institutions. Lebanon stands out as the only country reporting a very high level of production. Nevertheless, no country in the region reaches the level of extensive or consolidated research production observed in some European or North American contexts. The scarcity of dedicated funding, limited research infrastructure, and the absence of postgraduate training programs in PC remain major barriers. Despite these challenges, the increasing organization of congresses and emerging collaborations signal a growing awareness of the importance of research as a foundation for PC development in the region. ●

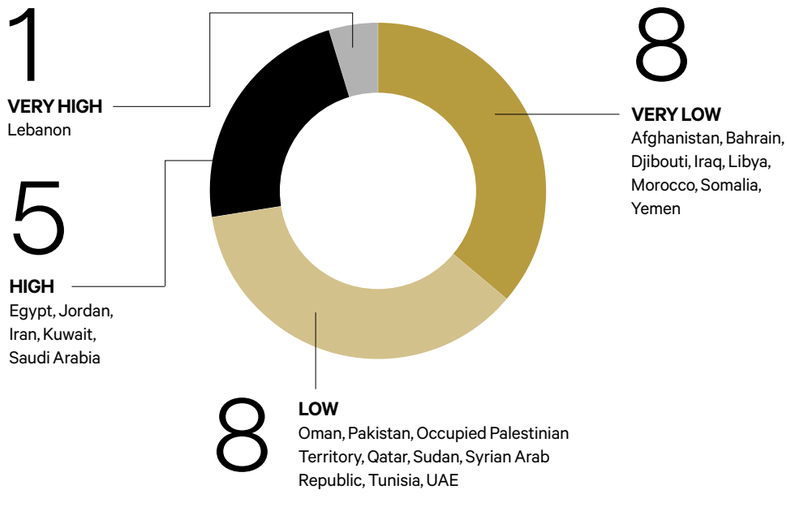
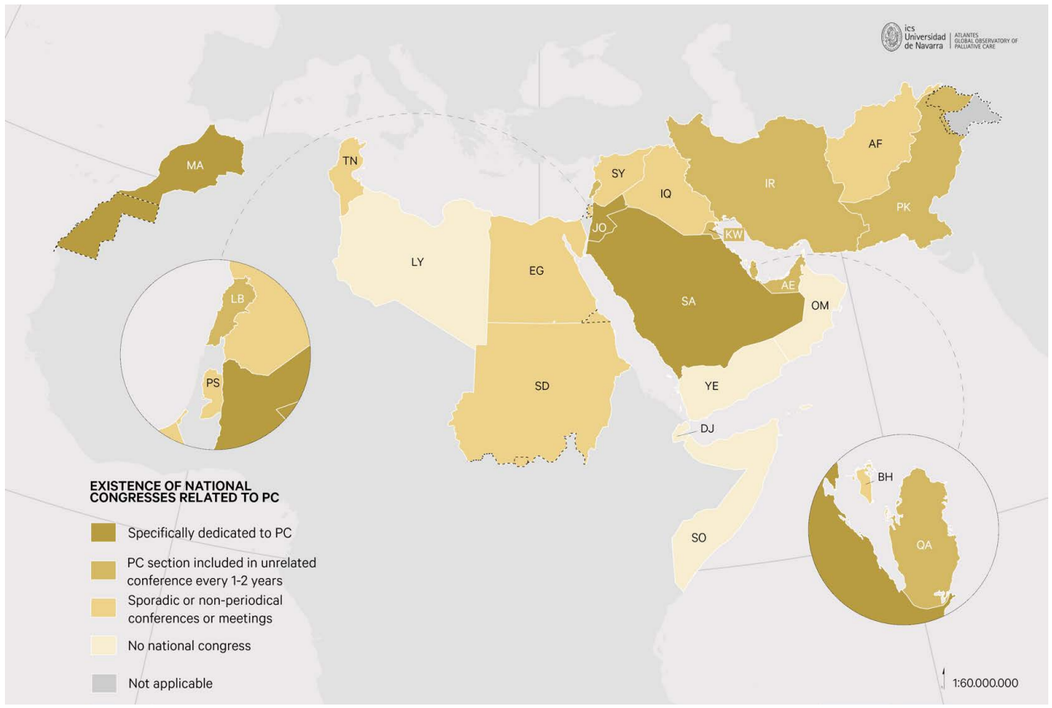


Figure 8. Perception of the production of PC-related peer-reviewed articles .

Map 3: Research



Map 3. Research

EM Map 4: Essential Medicines

This chapter focuses on the availability and access to essential medicines for PC across all levels of the health system, with special emphasis on the use of opioids for the management of pain and other symptom supported by respective risk management strategies. This list of essential medicines includes non-opioids and non-steroidal anti-inflammatory medicines; opioids analgesics; and medicines for other common symptoms in palliative care (see the box).

This list of essential medicines as defined in the WHO

Acetylsalicylic acid	Docusate sodium
Ibuprofen	Fluoxetine
Paracetamol: acetaminophen	Haloperidol
Codeine	Hyoscine butylbromide
Fentanyl	Hyoscine hydrobromide
Morphine. Therapeutic alternatives: hydromorphone, oxycodone	Lactulose
	Loperamide
	Metoclopramide
Methadone	Midazolam
Amitriptyline	Ondansetron. Therapeutic alternatives: dolasetron, granisetron, palonosetron, tropisetron.
Cyclizine	
Dexamethasone	
Diazepam	

To measure availability and accessibility, the following measures have been explored: a) Reported annual opioid consumption – excluding methadone – in S-DDD per million inhabitants/day, b) Availability of essential medicines for pain and PC in the country at the primary level, c) General availability of immediate-release oral morphine (liquid or tablet) at the primary level, and d) availability of different opioids and in different formulations at the primary level.

REPORTED ANNUAL OPIOID CONSUMPTION —EXCLUDING METHADONE—IN S-DDD PER MILLION INHABITANTS/DAY

According to the INCB, the average consumption of strong opioids (excluding methadone) between 2020–2022, measured in defined daily doses per million inhabitants per day (S-DDD), remains very low in the Eastern Mediterranean Region, with wide disparities between countries. Reported opioid consumption ranges from 0 S-DDD in Iraq and Pakistan, 1 S-DDD in Afghanistan, and 12 S-DDD in Yemen, to 904 S-DDD in Bahrain and 521 S-DDD in the UAE. Intermediate values are documented in countries such as Qatar, Kuwait, Saudi Arabia, Lebanon, Jordan, Tunisia, and Oman. In contrast, Egypt, Iran, Morocco, the Syrian Arab Republic, Libya, and Sudan remain far below internationally recognized adequacy thresholds. While the regional average appears elevated due to a few countries with higher consumption, this masks profound inequities in access to pain relief and palliative care, with most countries remaining well below levels considered adequate for basic medical needs.

Average consumption of opioids in DDD (S-DDD) for statistical purposes 2020-2022

Country	S-DDD
Iraq	0
Pakistan	0
Afghanistan	1
Yemen	12
Morocco	58
Iran	70
Syrian Arab Republic	73
Libya	87
Egypt, Arab Republic	100
Oman	211
Jordan	238
Tunisia	283
Lebanon	340
Saudi Arabia	360
Kuwait	418
Qatar	504
UAE	521
Bahrain	904

Djibouti, Occupied Palestinian Territory, Somalia and Sudan: not available.

Key notes. Opioid Consumption in the Eastern Mediterranean Region

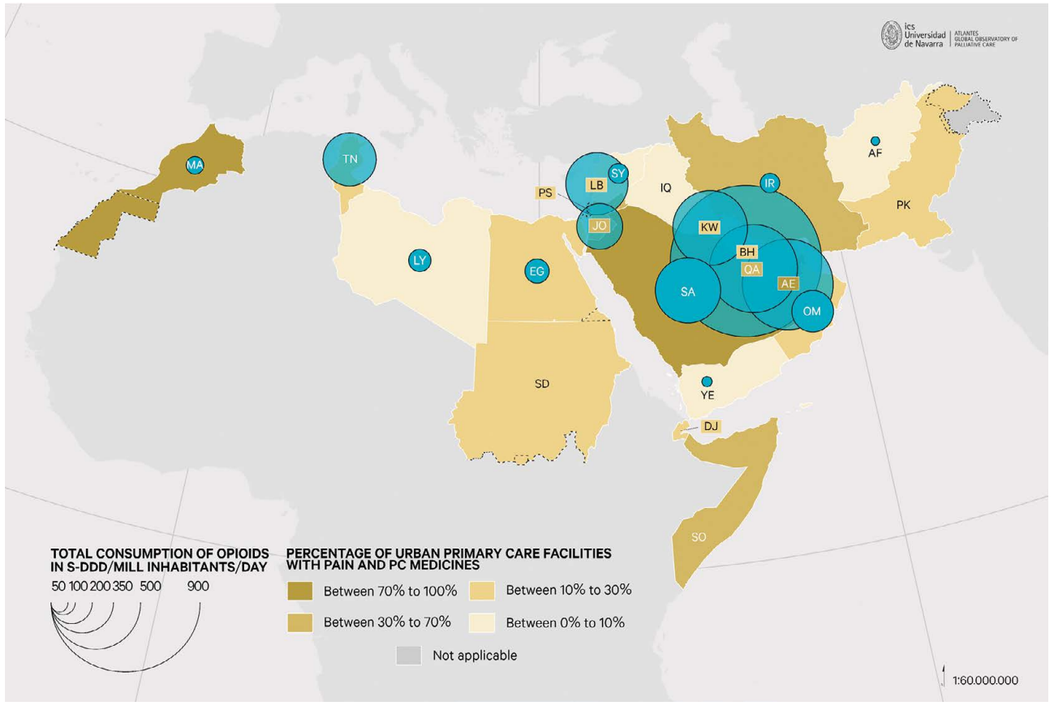
1. **Extreme disparities in access:** Opioid consumption varies more than 900-fold across the region, from 0 S-DDD in Iraq and Pakistan to nearly 1,000 S-DDD in Bahrain, highlighting profound inequities in access to essential pain relief and PC.

2. **Low consumption in most countries:** More than half of the countries report consumption levels below 250 S-DDD, often reflecting restrictive regulations, insufficient prescribers, and limited distribution in public health systems.

3. **Higher consumption concentrated in Gulf States:** The highest consumption rates are concentrated in high-income countries of the Arabian Peninsula, particularly Bahrain, Qatar, Kuwait, Saudi Arabia, and UAE, which account for a disproportionate share of regional access.

4. **Systemic barriers remain:** In many middle- and low-income countries, opioid availability is inconsistent at the primary care level. Immediate-release oral morphine and injectable formulations are often unavailable or irregularly supplied, limiting effective pain management and PC delivery.

EM Map 4: Essential Medicines



Map 4. Essential medicines.

AVAILABILITY OF ESSENTIAL MEDICINES FOR PAIN AND PALLIATIVE CARE IN THE COUNTRY AT THE PRIMARY LEVEL

In the Eastern Mediterranean Region, only a minority of countries report consistent availability of essential PC medicines at the primary health care level. These include Morocco, Saudi Arabia, and the UAE, where oral and injectable morphine and other key medicines are more regularly available. However, in most countries, availability is limited to secondary or tertiary facilities, with primary care centers reporting only partial or sporadic access. This situation is particularly noted in Egypt, Lebanon, and Pakistan, where immediate-release oral morphine and other formulations are inconsistently supplied. In several countries, including Afghanistan, Bahrain, Iraq, Libya, the Syrian Arab Republic, and Yemen, primary health centers report no or minimal availability of PC medicines, reflecting a critical gap in access at the community level.

Rural and remote populations face even greater challenges: while some urban centers maintain limited stocks through hospitals or specialized cancer centers, rural areas often lack services entirely, with access hindered by distance, weak infrastructure, and irregular distribution systems. This urban–rural divide is reported in Egypt, Pakistan, and Sudan, where coverage is concentrated in capitals and major cities.

Regulatory frameworks and procurement systems also shape access. In Saudi Arabia, Qatar, and the UAE, essential medicines are included in national formularies, yet availability at the primary level depends on ministerial protocols and centralized hospital pharmacies. In contrast, in countries such as Lebanon, Sudan, and Libya, supply chain fragility, recurrent stock-outs, and limited prescriber authorization constrain access despite formal inclusion in essential medicines lists.

Access for pediatric patients and home-based care remains particularly limited, with few formulations adapted for children and little provision of opioids beyond hospital settings. Even in countries with higher opioid consumption, such as Iran or Jordan, community-level access is restricted and often contingent on specialist referral.

EM Map 4: Essential Medicines

%	Nº	Countries
Poor 0-10%	6	Afghanistan, Bahrain, Iraq, Libya, Syrian Arab Republic, Yemen
Fair 10-30%	9	Djibouti, Egypt, Kuwait, Lebanon, Occupied Palestinian Territory, Oman, Pakistan, Sudan, Tunisia
Good 30-70%	4	Iran, Jordan, Qatar, Somalia
Very good 70-100%	3	Morocco, Saudi Arabia, UAE

Figure 9. Percentage of primary health centers where EM are available.

Essential medicines at the primary level in the Eastern Mediterranean Region

- **Urban–rural divide:** Availability is concentrated in major urban centers, while rural and remote areas often report minimal or no access.
- **Formal inclusion but limited implementation:** Many countries list opioids in national formularies, but real-world availability at the primary care level is weak.
- **Systemic barriers:** Regulatory restrictions, supply chain fragility, and insufficient provider authorization remain major obstacles.
- **Special populations underserved:** Pediatric formulations and home-based access are rare, further limiting effective symptom control.

GENERAL AVAILABILITY OF IMMEDIATE-RELEASE ORAL MORPHINE (LIQUID OR TABLET) AT THE PRIMARY LEVEL

Across the Eastern Mediterranean Region, access to immediate-release oral morphine at the primary health care level is extremely limited and uneven. According to available data, 18 countries fall into the "poor" category, where availability is almost non-existent. Only one country reports "fair" access, while three countries achieve a "good" level of availability. No country in the region reaches the "very good" threshold, reflecting a critical gap in community-level provision.

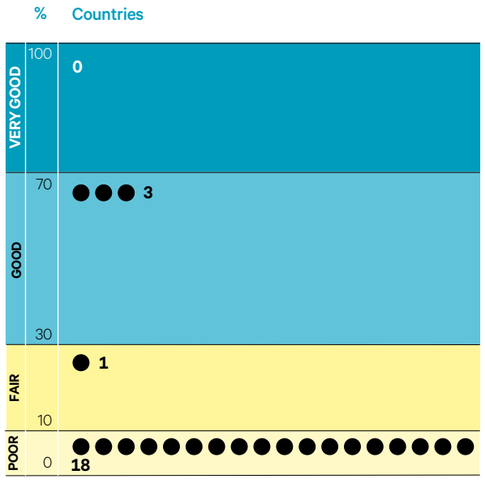


Figure 10. General availability of immediate-release oral morphine (liquid or tablet) at the primary level

In high-income countries of the Arabian Peninsula, including Kuwait, Qatar, and Saudi Arabia, oral morphine is available but largely centralized in hospitals and oncology centers, with limited penetration into primary care. Jordan also reports broader distribution through national cancer and PC programs, though availability remains inconsistent in rural areas.

By contrast, countries such as Egypt and Morocco list morphine in their national formularies, yet distribution is confined to tertiary hospitals in major cities, and stockouts are frequent. In Lebanon, Tunisia and UAE, access is somewhat better than in the lowest-performing countries, but remains dependent on specialist prescribers or hospital pharmacies rather than integration into primary care facilities.

The most fragile states—including Afghanistan, Iraq, Libya, Occupied Palestinian Territory Somalia, the Syrian Arab Republic, Sudan, and Yemen—report almost no availability of oral morphine at the primary care level, with access restricted to isolated tertiary hospitals, if at all. Ongoing conflict, weak infrastructure, and disrupted supply chains exacerbate these disparities.

Overall, a consistent pattern emerges across the region: while some countries include morphine in their essential medicines lists, this does not translate into reliable, equitable access in practice. Regulatory restrictions, fragile procurement systems, limited training of prescribers, and urban–rural inequities remain major barriers to community-level availability of immediate-release oral morphine. ●

EM Map 5. Palliative Care Education

This chapter presents the availability of undergraduate education resources integrated into medical curricula. Across the Eastern Mediterranean Region, undergraduate education in PC remains limited and uneven.

Only a minority of medical schools include mandatory PC content. Full integration is reported in Morocco, with higher proportions in Lebanon, Jordan, and the Occupied Palestinian Territory. In contrast, most countries either report minimal inclusion—such as Egypt, Pakistan, and Saudi Arabia—or none at all, as in Afghanistan, Iraq, Libya, Somalia, Syria, and Yemen.

In the Arabian Peninsula, universities in Jordan, Saudi Arabia, and the UAE integrate PC into medical curricula, usually embedded within oncology or internal medicine rotations, though coverage is not yet universal. In Qatar and Kuwait, education is offered mainly through electives or optional rotations, often in collaboration with specialized facilities such as children's hospices.

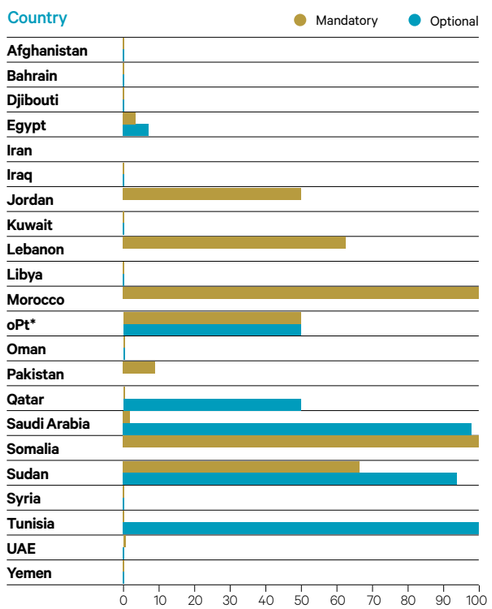
In the Levant and North Africa, progress has been noted in Lebanon, Egypt, Tunisia, and Morocco. Lebanon reports standardized inclusion across most medical schools, while Morocco introduced compulsory modules in medical education following curriculum reforms in 2015, though nursing education still lacks dedicated content. In Egypt, only a handful of schools offer structured training, mostly as electives, and Tunisia provides optional certificates rather than core modules.

In fragile health systems, including Afghanistan, Somalia, Yemen, Iraq, Libya, and Syria, structured undergraduate education in PC is absent. While some institutions (e.g., in Gaza or Sudan) have piloted modules, electives, or postgraduate diplomas, these remain isolated initiatives and do not constitute systematic undergraduate training.

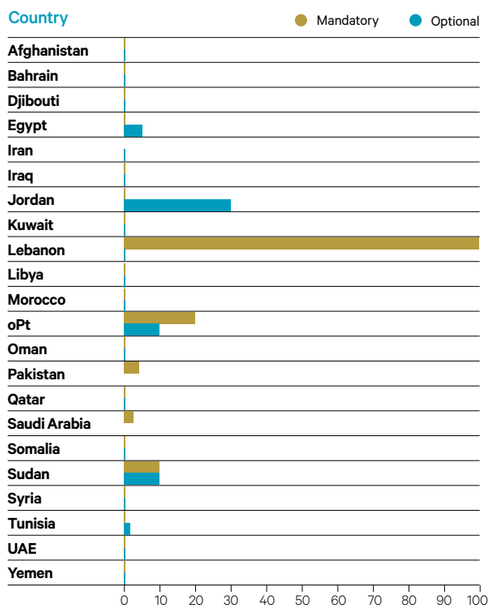
PC TEACHING IN NURSING SCHOOLS

Training opportunities for nurses in PC across the Eastern Mediterranean Region remain very limited. Structured integration is reported mainly in Lebanon, where PC is included in undergraduate nursing curricula, while other countries such as Jordan, Sudan, and the Occupied Palestinian Territory have introduced partial or optional components. In most others—including Afghanistan, Iraq, Libya, Somalia, Syria, Yemen, and Djibouti—nursing graduates complete their education without any formal exposure to PC. Optional or elective content is reported in a few countries, including Saudi Arabia and Tunisia, but overall nursing education in PC is still fragmented and at an early stage of development in the region.

Palliative Care Teaching in Medical Schools

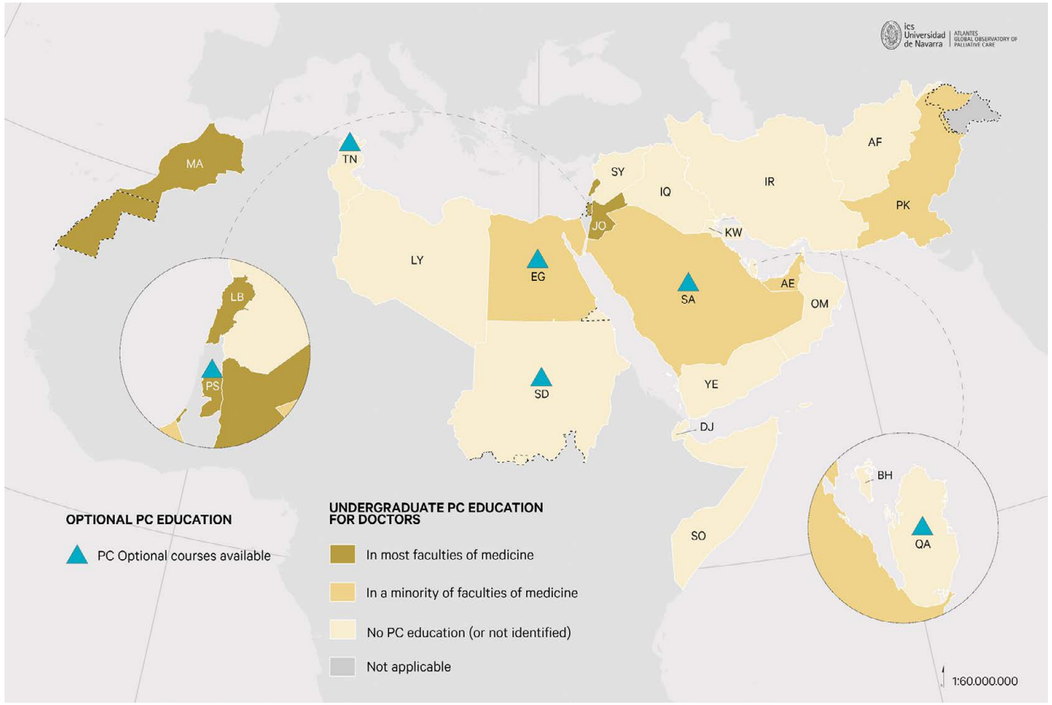


Palliative Care Teaching in Nursing Schools

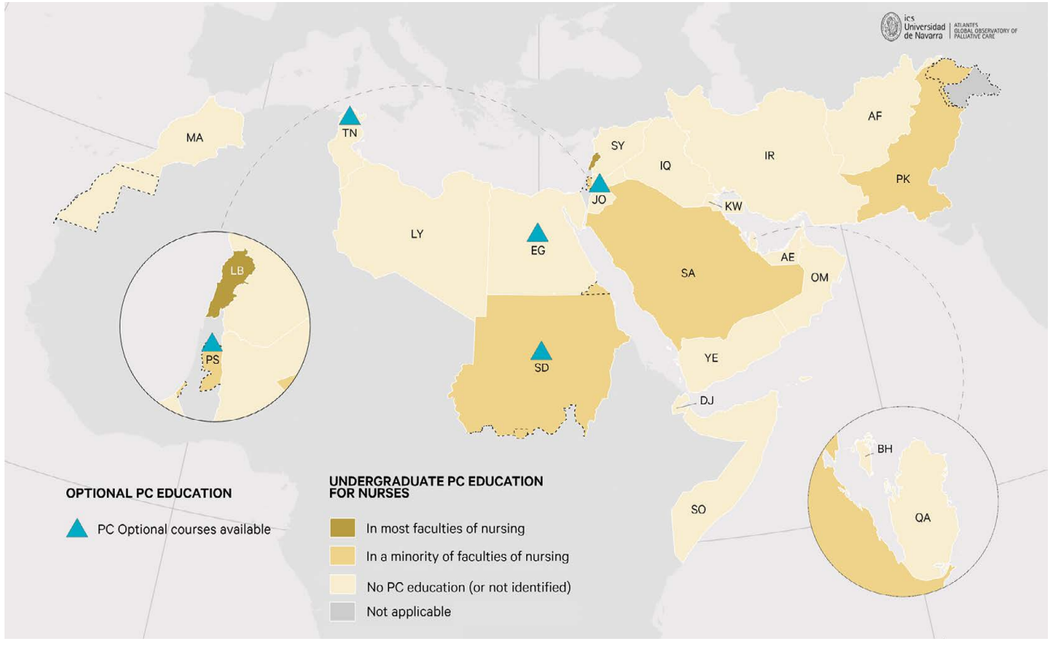


* Occupied Palestinian Territory.

EM Map 5. Palliative Care Education

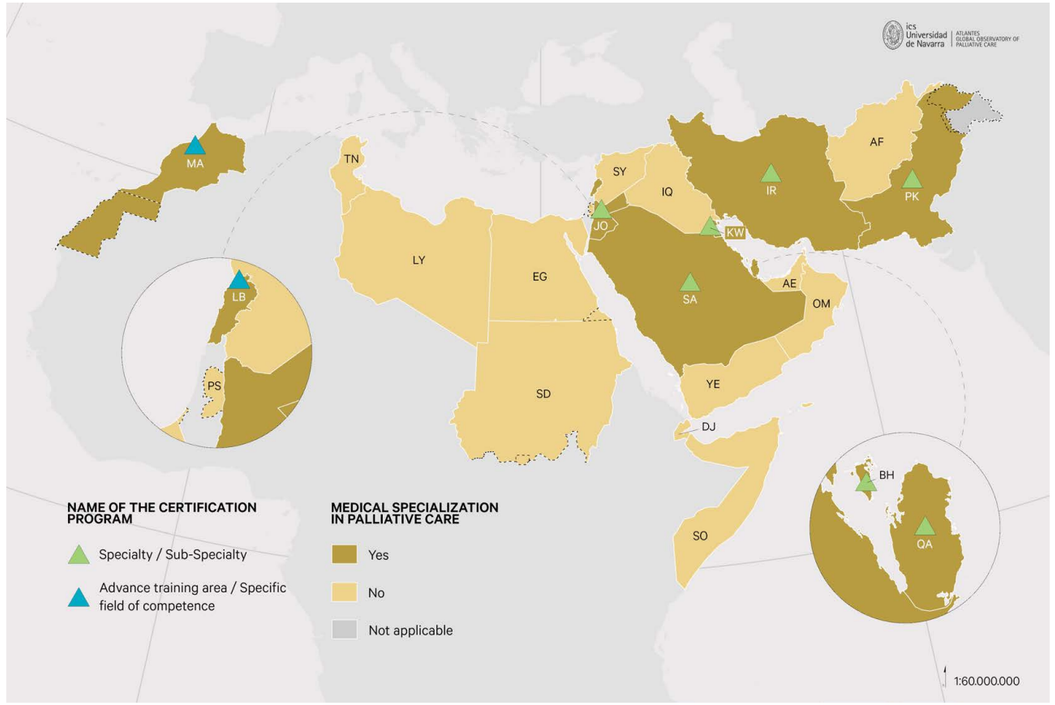


Map 5.1. Palliative Care Education (Doctors).



Map 5.2. Palliative Care Education (Nurses).

EM Map 5. Palliative Care Education



Map 5.3. Palliative Care Education (Specialization).

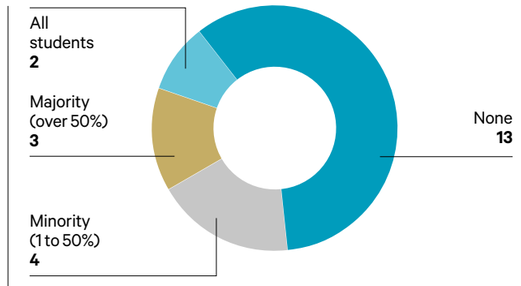


Figure 11. Proportion of future physicians across the Eastern Mediterranean Region receiving mandatory palliative care.

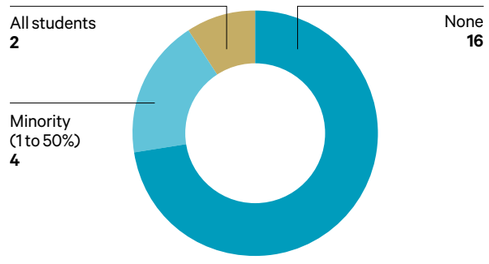


Figure 12. Proportion of future nurses across the Eastern Mediterranean Region receiving mandatory PC teaching.

Map 5. Palliative Care Education

SPECIALIZATION IN PALLIATIVE MEDICINE FOR PHYSICIANS

Palliative medicine is recognized as a specialty or subspecialty (or equivalent designation) by competent national authorities in Bahrain, Iran, Jordan, Kuwait, Pakistan, Qatar, and Saudi Arabia. Several of these countries, such as Jordan, Saudi Arabia, and Pakistan, have accredited fellowship programs, while others, like Kuwait and Qatar, rely partly on international training complemented by local recognition processes.

In a few additional countries, including Sudan, Lebanon and Tunisia, postgraduate diplomas or complementary certificates in PC exist and are officially recognized, even though they do not constitute a formal specialty.

Other countries, such as Iran, Morocco, the UAE, Occupied Palestinian Territory, and Egypt, report postgraduate programs, advanced courses, or university-based master's degrees in PC, but these lack formal recognition at the national level.

In the majority of countries, however, palliative medicine has no official recognition within the professional framework, and structured postgraduate pathways remain absent. ●

Specialization in palliative medicine for physicians

Country	Description
Jordan	Palliative medicine is officially recognized as a subspecialty by the MoH. Structured fellowship and postgraduate training programs are offered at the King Hussein Cancer Center.
Saudi Arabia	Recognized as a subspecialty under the Saudi Commission for Health Specialties, with accredited fellowship programs in PC since 2013, following the CanMEDS framework.
Kuwait	Palliative medicine is officially recognized as a subspecialty by the MoH. Physicians may complete accredited fellowships abroad, which are recognized upon return, and a small but growing cadre of specialists is now active.
Pakistan	Palliative medicine is recognized as a subspecialty by the College of Physicians & Surgeons Pakistan. Accredited two-year clinical fellowships are available at Aga Khan University (Karachi) and Shaukat Khanum Cancer Hospital (Lahore).
Qatar	Officially recognized as a subspecialty by the Ministry of Public Health since 2021. Postgraduate fellowship programs in adult palliative medicine provide structured training for physicians.
Bahrain	The National Health Regulatory Authority recognizes "Hospice and Palliative Medicine" as a medical specialty for physician licensing. Recognition is documented in licensing standards, enabling physicians to practice with a defined scope in PC.

Map 6. Integrated Health Services

This chapter refers to the capacity of the national health and social system to meet the needs of adults and children with SHS. This includes services integrated into primary care as well as specialized platforms such as hospices, home care programs, hospital-based teams, and outpatient clinics, and also considers their interaction with other areas of the health system, accessibility, and engagement of private sector providers.

For this study, we explored whether there exists, in Eastern Mediterranean countries, a system of specialized PC services or teams with geographic reach and delivered through different platforms. Four levels of provision were defined: 1) no or minimal provision of PC specialized services or teams, 2) isolated provision (only in some geographic areas), 3) generalized provision (available in many parts of the country but with some gaps), and 4) integrated provision (specialized PC services or teams systematically provided).

According to these definitions, no Eastern Mediterranean country has yet reached integrated provision of PC. Most countries are at the progressing level, with services available in some geographic areas but not yet nationwide, while only a few have established a more generalized level of provision.

Overall level of Palliative Care provision

Level 1. Emerging

1. Afghanistan
2. Bahrain
3. Libya
4. Morocco
5. Somalia
6. Syrian Arab Republic
7. Yemen

Level 2. Progressing

1. Djibouti
2. Egypt
3. Iran
4. Iraq
5. Jordan
6. Lebanon
7. Occupied Palestinian Territory
8. Oman
9. Pakistan
10. Qatar
11. Sudan
12. Tunisia
13. UAE

Level 3. Established

1. Kuwait
2. Saudi Arabia

Level 4. Integrated

—

PALLIATIVE CARE SPECIALIZED SERVICES

Specialized PC services or teams refer to health care services whose main activity is the provision of PC. These services/teams often provide care for patients with complex needs or severe suffering and, therefore, require staff with specialized training. For this study, within a service, if there are teams identified with distinct functions (such as home-based and hospital-based care), these teams are counted as separate services. If a service's staff performs different roles, like attending both home and hospital care, it is regarded as a single service.

The Atlas identifies a heterogeneous situation across the Eastern Mediterranean Region. Countries at the emerging level (Afghanistan, Bahrain, Libya, Morocco, Somalia, Syrian Arab Republic, Yemen) report either no specialized PC services or very limited provision, often restricted to single oncology wards or small pilot initiatives.

At the progressing level, 13 countries (Djibouti, Egypt, Iran, Iraq, Jordan, Lebanon, Occupied Palestinian Territory, Oman, Pakistan, Qatar, Sudan, Tunisia, UAE) have developed a growing but still fragmented network of services. Egypt reports 26 specialized services, Jordan over 32, Lebanon 14, Morocco 11 units and 26 mobile teams, and the UAE 16 programs across public and private hospitals. These remain concentrated in large cities and tertiary centers, with rural and peripheral regions reporting weak coverage.

Only two countries, Kuwait and Saudi Arabia, are classified as established, with broader national networks. Kuwait has 22 specialized services integrated within the national cancer system, including hospital-based, outpatient, home, and pediatric programs. Saudi Arabia has developed widespread PC availability through major hospitals, home-based programs, and consultation teams.

No Eastern Mediterranean country has yet reached integrated provision with full national coverage.

Map 6. Integrated Health Services

PALLIATIVE CARE SPECIALIZED SERVICES RANKED IN QUARTILES ACCORDING TO POPULATION RATIO

The figure presents the distribution of specialized PC services per 100,000 inhabitants across countries in the Eastern Mediterranean Region, grouped by quartiles. Countries are distributed as follows:

- **Q1 (Lowest): ≤ 0.02** – Afghanistan, Egypt, Iran, Iraq, Sudan, Syrian Arab Republic, Tunisia.
- **Q2: > 0.02 and ≤ 0.12** – Bahrain, Djibouti, Morocco, Occupied Palestinian Territory, Pakistan, Somalia, Yemen.
- **Q3: > 0.12 and ≤ 0.28** – Jordan, Lebanon, Oman, Qatar, UAE.
- **Q4 (Highest): > 0.28** – Kuwait, Saudi Arabia.

The regional median is 0.05 and the average is 0.16 specialized PC services per 100,000 inhabitants. The variation is substantial, ranging from countries with virtually no provision of services, such as Iraq, Pakistan, Somalia, and Yemen, to countries like Saudi Arabia and Kuwait, which report relatively higher ratios of specialized PC services per population.

Palliative Care Specialized Services

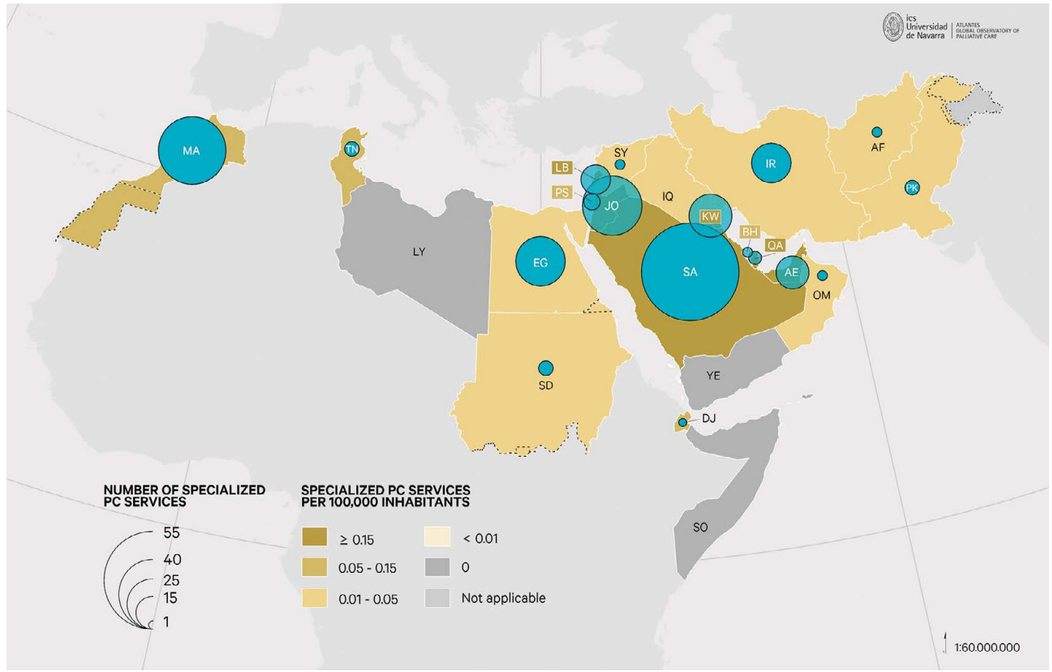
Quartile	Country	N services	Services per 100,000 inhab.
Q4	Kuwait	22	0.45
Q4	Saudi Arabia	55	1.60
Q3	Qatar	4	0.15
Q3	UAE	16	0.15
Q3	Jordan	32	0.28
Q2	Egypt	26	0.03
Q2	Lebanon	14	0.24
Q2	Morocco	37	0.12
Q2	Djibouti	1	0.09
Q2	oPt*	6	0.12
Q2	Bahrain	2	0.13
Q2	Oman	2	0.09
Q2	Somalia	0	0.00
Q1	Iraq	2	0.00
Q1	Pakistan	5	0.00
Q1	Yemen	0	0.00
Q1	Sudan	5	0.02
Q1	Iran	20	0.02
Q1	Syrian Arab Republic	2	0.01
Q1	Afghanistan	2	0.01
Q1	Tunisia	5	0.05

* Occupied Palestinian Territory.

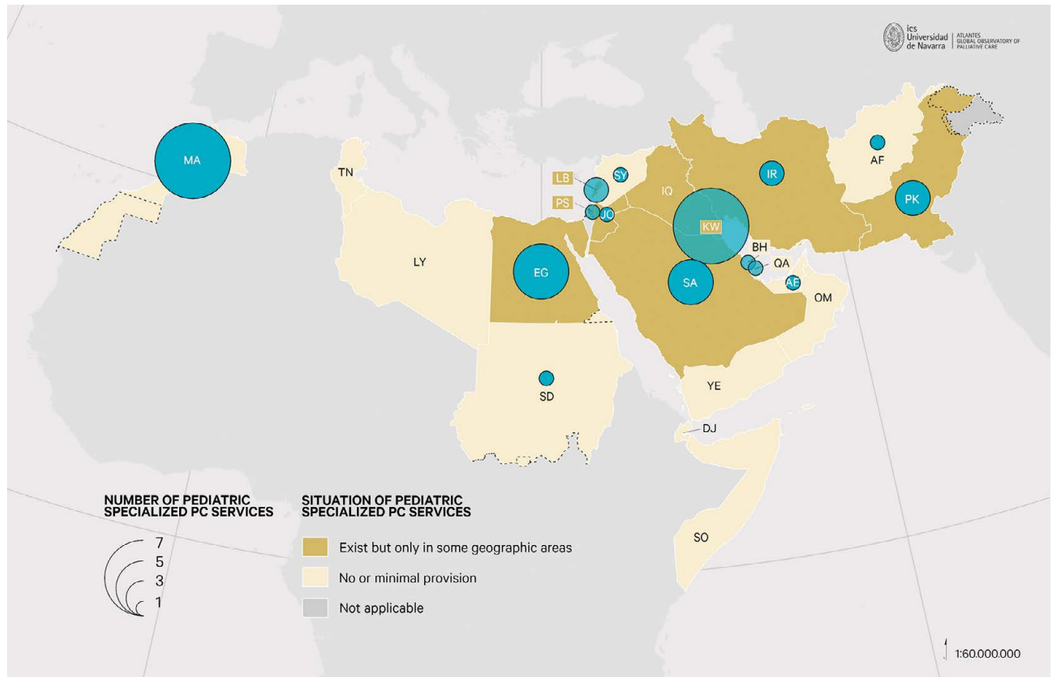
Median: **0.05**
Average: **0.16**

White Paper on standards and norms for hospice and palliative care . European Journal Of Palliative Care, 2009; 16(6) EAPC update

Map 6. Integrated Health Services



Map 6.1. Specialized palliative care services .



Map 6. 2. Specialized PC services for children .

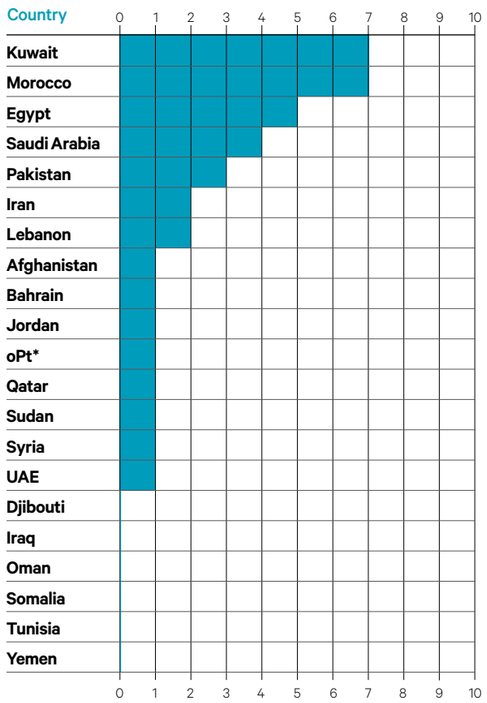
Map 6. Integrated Health Services

PEDIATRIC SPECIALIZED PALLIATIVE CARE SERVICES

No country in the Eastern Mediterranean Region reported an advanced level of integration of PPC, meaning that specialized services or teams for children are not systematically available nationwide. Only Kuwait reported generalized provision, where multiple PPC services exist across several regions, though with gaps in coverage.

In total, the region hosts 38 PPC services across 13 countries. Most of these are isolated services, concentrated in urban centers and linked to cancer hospitals or tertiary facilities, as seen in Egypt, Iran, Lebanon, Pakistan AND Saudi Arabia. In several other countries, such as Afghanistan, Bahrain, Jordan, Occupied Palestinian Territory, Qatar, Sudan, the Syrian Arab Republic and UAE, PPC services are minimal and limited to one or two teams. In the remaining countries—including Djibouti, Iraq, Libya, Oman, Somalia, Tunisia, and Yemen—there is no evidence of specialized PPC services.

Number of Specialized Pediatric PC Services



* Occupied Palestinian Territory.
Libya: N/A

Map 6. Integrated Health Services

Some key notes of specialized pediatric palliative care services

AFGHANISTAN
The Irene Salimi Children Hospital in Kabul operates the country's only pediatric PC unit, admitting up to 1,000 children annually.

EGYPT
The Children's Cancer Hospital Egypt (Cairo) and a few NGO/university hospitals provide PPC, covering around 50 children monthly.

IRAN
Two pediatric PC centers exist, including a developed unit at Mofid Pediatric Hospital in Tehran.

JORDAN
KHCC hosts the only dedicated PPC team, offering inpatient, outpatient, home care, and training; other hospitals provide supportive but not specialized PPC.

KUWAIT
Seven PPC services exist, including BACCH, the first pediatric hospice in the region, and pediatric units in public hospitals.

LEBANON
PPC is provided through two dedicated services: AUBMC, offering inpatient care, and Balsam, delivering home-based PC.

OCCUPIED PALESTINIAN TERRITORY
Rantisi Pediatric Hospital in Gaza provides PPC through a small dedicated team.

PAKISTAN
PPC is available at Aga Khan University Hospital, Indus Health Network (Karachi), and the Children's Cancer Hospital (Lahore).

QATAR
A small inpatient PPC service exists, led by a physician and nurse, with limited scope and resources.

SAUDI ARABIA
Dedicated PPC teams operate in tertiary hospitals (KFSH-RC, National Guard, KFMC), complemented by Alyamamh pediatric hospice (2019).

SUDAN
PPC is largely adult-focused; a nurse trained abroad provides limited pediatric care at Khartoum Oncology Hospital.

SYRIAN ARAB REPUBLIC
PPC is provided only at Jabel al Zawiyah Children's Hospital in Idlib, supported by NGOs.

UAE
PPC is available at the American Hospital Dubai and Al Qassimi Hospital in Sharjah, while other centers also provide care for children within their broader palliative programs.

Country reports

COUNTRY REPORTS

EM

Afghanistan

General data

POPULATION, 2024
42,647,492

PHYSICIANS/1000 INH, 2020-2022
0.21

Socioeconomic data

COUNTRY INCOME LEVEL, 2022
Low

HUMAN DEVELOPMENT INDEX RANKING, 2023
181

GDP PER CAPITA (US$), 2023
415.71

HEALTH EXPENDITURE, 2021
81.32

UNIVERSAL HEALTH COVERAGE, 2021
41

WHO FRAMEWORK FOR PALLIATIVE CARE DEVELOPMENT

Ⓐ EMPOWERMENT OF PEOPLE AND COMMUNITIES
Ⓑ POLICIES
Ⓒ RESEARCH
Ⓓ USE OF ESSENTIAL MEDICINES
Ⓔ EDUCATION AND TRAINING
Ⓕ PROVISION OF PC

LEVEL OF DEVELOPMENT

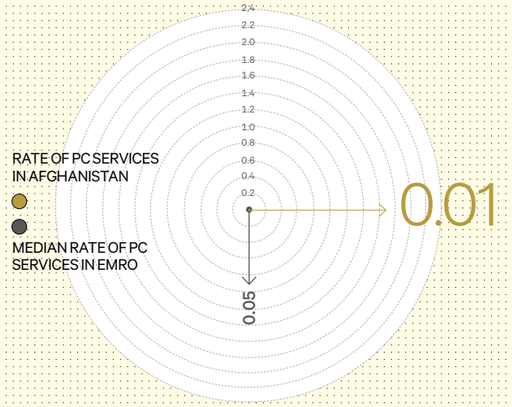
1	2	3	4
EMERGING	PROGRESSING	ESTABLISHED	ADVANCED

Ⓕ Provision of PC (Specialized Services)

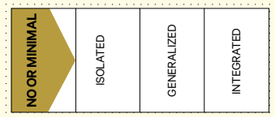
Total number of Specialized PC services: **2**

Rate of PC services per 100,000 inhabitants: **0.01**

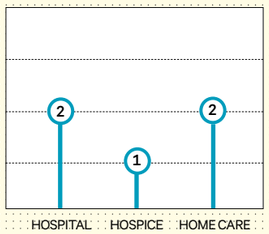
Afghanistan in the context of EMRO



Geographic distribution and integration of PC services



Level of development of different types of PC services



Pediatric PC Services

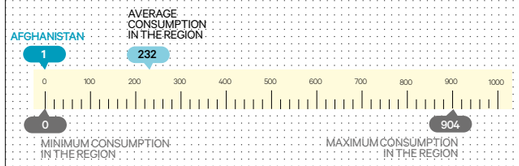
GEOGRAPHIC DISTRIBUTION AND INTEGRATION	TOTAL NUMBER
1 ○ ○ ○	1

Afghanistan

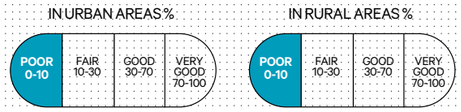
Ⓓ Use of essential medicines

Opiods consumption (excluding methadone): **1** S-DDD/MILL INHABITANTS/DAY

Afghanistan in the context of EMRO



Overall availability of essential medicines for pain and PC at the primary level



General availability of immediate-release oral morphine at the primary level

Ⓒ Research

PC-related research articles	Existence of PC congresses or scientific meetings
1 ○ ○ ○	1 1 ○ ○

National Association: No.

Consultants: Mohammed Qais Niazai.

Information was synthesized from scientific and gray literature, assisted by AI tools, and subsequently reviewed and validated by local palliative care experts.

Data collected: January-June 2025.

Report validated by consultants: Yes

Endorsed by National PC Association: N/A

Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching: **0/22**

Nursing schools with mandatory PC teaching: **0/21**

Recognition of PC specialty: 1 ○ ○ ○

Ⓑ Policies

National PC plan or strategy: 1 ○ ○ ○

Responsible authority for PC in the Ministry of Health: 1 ○ ○ ○

Inclusion of PC in the basic health package at the primary care level: 1 ○ ○ ○

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients	Advanced care planning-related policies
1 ○ ○ ○	1 ○ ○ ○

EM Afghanistan

People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their caregivers, and disease survivors.

1

Only isolated activity can be detected.

The Afghan Society Against Cancer actively promotes palliative care awareness by organizing conferences and partnering with international organizations. Additionally, the International Assistance Mission (IAM) implements a Community-Based Palliative Care (CBPC) Project that focuses on enhancing local capacity and increasing awareness of palliative care needs, despite the lack of formal national palliative care services. No other specific groups dedicated to advocating for the rights of patients requiring palliative care, their caregivers, or disease survivors are documented.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

1

There is no national policy or guideline on advance care planning.

Afghanistan lacks a national policy or guideline addressing advance care planning for life-sustaining treatment or end-of-life care. There is no documented evidence of such frameworks.

Policies

Ind 3

3.1. There is a current national PC plan, program, policy, or strategy.

1

Do not know or does not exist.

Afghanistan does not have a current national palliative care plan, program, policy, or strategy. Existing efforts to develop palliative care services are ongoing but are limited in scope and lack coordination. The National Health Strategy 2016–2020 and the National Health Policy 2015–2020 do not explicitly address palliative care, concentrating instead on broader health system strengthening.

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

1

Not known or does not exist neither standalone nor is included in another national plan.

EM Afghanistan

Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

1

Not known or does not exist.

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

1

Not at all.

Palliative care is not included in Afghanistan's Basic Package of Health Services (BPHS) or Essential Package of Hospital Services (EPHS), which constitute the core of the national Universal Health Coverage (UHC) framework. It is absent from the package of priority health services, and the health system has not integrated palliative care into mainstream services.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

1

There is no coordinating entity.

There is no dedicated department, unit, or authority within Afghanistan's Ministry of Public Health (MoPH) responsible for palliative care. Governance structures prioritize general health services, and there is no indication of specific functions, allocated budget, or designated staff for palliative care within the Ministry.

5.2. The national authority has concrete functions, budget and staff.

1

Does not have concrete functions or resources (budget, staff, etc.).

EM Afghanistan

Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC .

2

Only sporadic or non-periodical conferences or meetings related to palliative care take place.

The first national palliative care conference in Afghanistan was held in 2013 by the Afghan Society Against Cancer., where 56 Afghani and international delegates attended the conference. There is no available data on subsequent conferences.

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

1

Minimal or nonexistent number of articles published on the subject in that country.

Local peer-reviewed research on palliative care is limited, with most data originating from international studies referencing Afghanistan. National research agendas have not documented the inclusion of palliative care topics.

Medicines

Ind 8

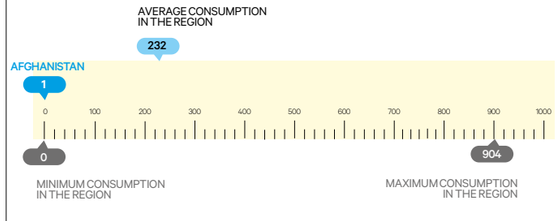
Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

Average consumption of opioids, in defined daily doses (S-DDD) for statistical purposes per million inhabitants per day, 2022.

1

S-DDD PER MILLION INHAB /DAY

COUNTRY VS REGION



EM Afghanistan

Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

1

Poor: Between 0% to 10%.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

1

Poor: Between 0% to 10%.

In Afghanistan, access to essential medicines for pain and palliative care at the primary level is severely limited. Despite being a major opium-producing country, regulatory restrictions and clinician hesitancy significantly hinder the availability and use of medical opioids such as morphine. Although morphine injection is accessible in some hospitals, it is infrequently used for cancer pain management. Oral morphine and other opioid formulations, including oxycodone, codeine, and hydromorphone, are not listed on the Essential Medicines List and are not available in public health facilities. As a result, only 0.2% of individuals requiring palliative care have access to it, indicating extremely poor opioid availability and utilization.

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

Immediate-release oral morphine, in either liquid or tablet form, is not explicitly mentioned in available data, and systemic shortages of essential medicines are widespread in Afghanistan. Access to pain and palliative care medications is severely restricted.

EM Afghanistan

Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)

0/22

11.2. The proportion of medical schools with OPTIONAL teaching in PC.

0/22

11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).

0/21

11.4. The proportion of nursing schools with OPTIONAL teaching in PC.

0/21

Palliative care is not included as a mandatory or elective subject in the undergraduate curricula of medical or nursing schools in Afghanistan. Medical education is provided by over 40 public and private institutions, including major faculties at Kabul University of Medical Sciences, Nangarhar University, and Herat University, among others. Private universities such as Kateb and Ghalib also operate medical faculties. Despite this, no accredited medical school is known to include palliative care in its curriculum. Similarly, Afghanistan's nursing education system, comprising nine public Institutes of Health Sciences and numerous private institutions, lacks structured palliative care education. Kabul Medical University offers the only Bachelor of Science in Nursing program, but it also does not include palliative care.

Ind 12

Existence of an official specialization process in palliative medicine for physicians, recognized by the competent authority in the country.

1 ○ ○ ○

There is no process on specialization for palliative care physicians.

There is no formal specialization or accredited postgraduate training program in palliative medicine for physicians in Afghanistan. Neither the MoPH nor the Ministry of Higher Education recognizes palliative medicine as a medical specialty or offers residency or fellowship programs in this field. Existing training opportunities are limited to short-term workshops, continuing education, or awareness events, without structured curricular inclusion. Initiatives such as the International Assistance Mission's Community-Based Palliative Care Project have provided basic training at the community level, but these do not constitute formal specialization. Afghan physicians interested in palliative care typically rely on self-directed learning or international training programs.

EM Afghanistan

Provision of PC / Specialized Services

Ind 13

13.1. There is a system of specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.

13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.

13.3. Free-standing HOSPICES (including hospices with inpatient beds).

13.4. HOME CARE teams (specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.

13.5. Total number of specialized PC services or teams in the country.

1 ○ ○ ○

No or minimal provision of palliative care specialized services or teams exist in the country.

2 ○ ○ ○

Ad hoc/ in some parts of the country.

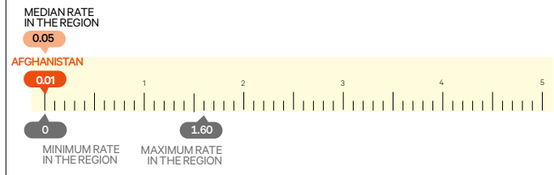
1 ○ ○ ○

Not at all.

2 ○ ○ ○

Ad hoc/ in some parts of the country.

RATE OF SPECIALIZED PC SERVICES/100,000 INH



2 ← SPECIALIZED PALLIATIVE CARE SERVICES

Afghanistan has an extremely limited number of specialized palliative care services or teams. The only documented services are at the cancer ward of Jamhuriat Hospital in Kabul, which offers palliative care within its oncology units, though with severely constrained capacity—30 beds each for medical oncology, surgical oncology, and day care. Additionally, the Irene Salimi Children Hospital in Kabul operates a pediatric palliative care unit with a target of admitting 1,000 patients annually. No other specialized palliative care facilities or multidisciplinary teams are reported nationwide. Regional hospitals in Mazar-e Sharif and Herat lack palliative care services. The International Assistance Mission (IAM) runs a Community-Based Palliative Care Project focused on capacity-building rather than service provision.

Ind 14

14.1. There is a system of specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.

14.2. Number of pediatric specialized PC services or teams in the country.

1 ○ ○ ○

No or minimal provision of palliative care specialized services or teams for children exists in country.

1 PPC TEAMS

The Irene Salimi Children Hospital in Kabul operates Afghanistan's first pediatric palliative care unit, aiming to admit 1,000 children annually. The hospital provides care for children and their families facing life-limiting conditions, accompanying them through end-of-life care according to international standards. The facility is part of a broader mission to improve pediatric health services in Afghanistan, also offering pediatric surgery and orthopedics. The hospital has a capacity of 50 beds and serves as a specialized training institute for child health professionals. Its palliative care unit is a unique service in Afghanistan, addressing a critical gap in pediatric palliative care access for the country's large child population.

EM

Bahrain

General data

POPULATION, 2024
1,588,670

PHYSICIANS/1000 INH, 2020-2022
N/A

Socioeconomic data

COUNTRY INCOME LEVEL, 2022
High

HUMAN DEVELOPMENT INDEX RANKING, 2023
38

GDP PER CAPITA (US$), 2023
29,218.86

HEALTH EXPENDITURE, 2021
1,146.47

UNIVERSAL HEALTH COVERAGE, 2021
76

WHO FRAMEWORK FOR PALLIATIVE CARE DEVELOPMENT

Ⓐ EMPOWERMENT OF PEOPLE AND COMMUNITIES
Ⓑ POLICIES
Ⓒ RESEARCH
Ⓓ USE OF ESSENTIAL MEDICINES
Ⓔ EDUCATION AND TRAINING
Ⓕ PROVISION OF PC

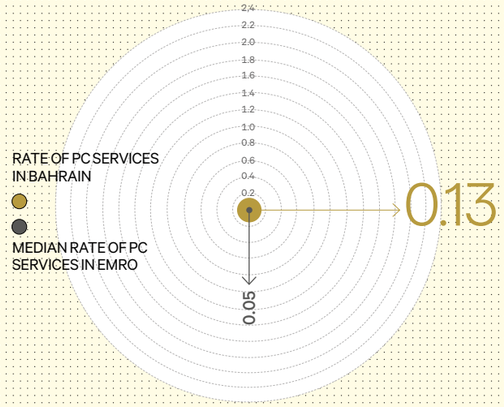
LEVEL OF DEVELOPMENT: 1 EMERGING · 2 PROGRESSING · 3 ESTABLISHED · 4 ADVANCED

Ⓕ Provision of PC (Specialized Services)

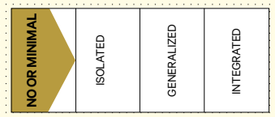
Total number of Specialized PC services: **2**

Rate of PC services per 100,000 inhabitants: **0.13**

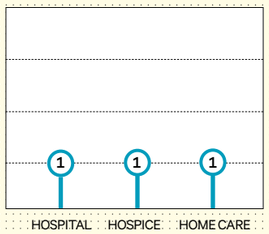
Bahrain in the context of EMRO



Geographic distribution and integration of PC services



Level of development of different types of PC services



Pediatric PC Services

GEOGRAPHIC DISTRIBUTION AND INTEGRATION: 1

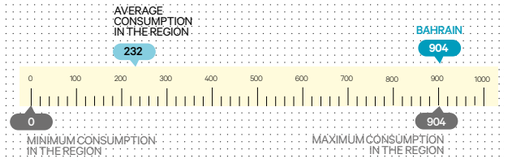
TOTAL NUMBER: 1

EM Bahrain

Ⓓ Use of essential medicines

Opioids consumption (excluding methadone): **904** S-DDD/MILL INHABITANTS/DAY

Bahrain in the context of EMRO



Overall availability of essential medicines for pain and PC at the primary level

General availability of immediate-release oral morphine at the primary level

Ⓒ Research

PC-related research articles: 1

Existence of PC congresses or scientific meetings: 2

National Association: No.
Consultants: Husain Ismaeel; Waleed Hamouda.

Data collected: January-June 2025.
Report validated by consultants: Yes
Endorsed by National PC Association: N/A
Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching: 0/2

Nursing schools with mandatory PC teaching: 0/3

Recognition of PC specialty: 4

Ⓑ Policies

National PC plan or strategy: 1

Responsible authority for PC in the Ministry of Health: 1

Inclusion of PC in the basic health package at the primary care level: 1

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients: 1

Advanced care planning-related policies: 1

EM Bahrain

People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their caregivers, and disease survivors.

1

Only isolated activity can be detected.

There is no documented evidence of a dedicated national patient advocacy group for palliative care in Bahrain. While palliative care services are in their early stages, formal groups specifically promoting the rights of patients requiring palliative care, their caregivers, or disease survivors have not been identified in the available literature. Professional organizations and oncology nursing staff at major hospitals, such as Salmaniya Medical Complex, provide some support to patients and families. Additionally, there are regional collaborations through conferences and hospital-based initiatives. However, overall advocacy efforts remain limited.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

1

There is no national policy or guideline on advance care planning.

Bahrain does not have a published, comprehensive national policy or guideline specifically addressing advance care planning for life-sustaining treatment or end-of-life care. Although the National Health Regulatory Authority outlines general healthcare policies, these do not include provisions for palliative care-specific advance care planning. Do-not-resuscitate orders and code status discussions are not practiced, and decisions related to palliative care are generally made by patients' families rather than through structured, formalized procedures. Efforts to develop such policies have recently begun.

Policies

Ind 3

3.1. There is a current national PC plan, program, policy, or strategy.

1

Do not know or does not exist.

Bahrain does not have a current national palliative care plan, program, policy, or strategy with a defined implementation framework. The country is in the early stages of developing palliative care services, and integration into the mainstream health system remains limited.

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

1

Not known or does not exist neither standalone nor is included in another national plan.

EM Bahrain

Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

1

Not known or does not exist.

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

1

Not at all.

Palliative care is not explicitly included in Bahrain's national Universal Health Coverage (UHC) benefit package or defined as part of the priority health services. Currently, palliative care services are primarily offered to cancer patients who have exhausted curative treatment options, with a limited scope and integration within the broader health system.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

1

There is no coordinating entity.

Bahrain does not have a designated national authority, department, or unit within the Ministry of Health solely responsible for palliative care. There is no available published information indicating the existence of a dedicated structure, staff, specific functions, organizational responsibilities, or budget allocated to palliative care at the national level.

5.2. The national authority has concrete functions, budget and staff.

1

Does not have concrete functions or resources (budget, staff, etc.).

EM Bahrain

Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC.

2

Only sporadic or non-periodical conferences or meetings related to palliative care take place.

Bahrain hosts scientific meetings that include palliative care topics, such as the Bahrain Conference on Oncology and Palliative Care, which is co-organized by government hospitals and partner institutions. However, there is no further evidence of national congresses or scientific meetings dedicated exclusively to palliative care.

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

1

Indicates a minimal or nonexistent number of articles published on the subject in that country.

Few palliative care-related articles from Bahrain are indexed in international academic databases; specific figures for 2020–2025 are not available. Although recent qualitative studies have explored oncology nurses' experiences with terminally ill patients, palliative care is not a prominent focus within national research agendas. Between 1991 and 2020, only two articles with Bahrain-affiliated authors were published in palliative care journals, accounting for 0.5% of total publications from the Eastern Mediterranean Region.

Medicines

Ind 8

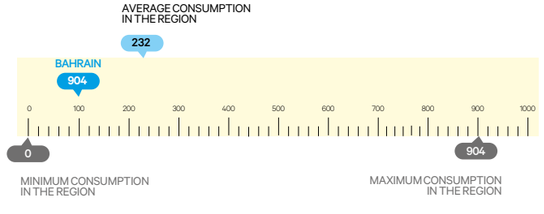
Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

Average consumption of opioids, in defined daily doses (S-DDD) for statistical purposes per million inhabitants per day, 2022.

904

S-DDD PER MILLION INHAB /DAY

COUNTRY VS REGION



EM Bahrain

Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

1

Poor: Between 0% to 10%.

Access to essential pain and palliative care medications at the primary level in Bahrain is limited. The country faces barriers to opioid access, including policy restrictions and insufficient professional expertise.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

1

Poor: Between 0% to 10%.

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

The general availability of immediate-release oral morphine (liquid or tablet) at the primary level in Bahrain is limited. There is no documented evidence of the consistent availability of immediate-release oral morphine or other opioid formulations in either public or private healthcare sectors.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

EM Bahrain

Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)

0/2

11.2. The proportion of medical schools with OPTIONAL teaching in PC.

0/2

11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).

0/3

11.4. The proportion of nursing schools with OPTIONAL teaching in PC.

0/3

Bahrain has two accredited medical schools—Arabian Gulf University (AGU) and the Royal College of Surgeons in Ireland – Medical University of Bahrain (RCSI Bahrain)—and three accredited nursing schools, including RCSI Bahrain, King Hamad University Hospital Healthcare Academy, and AGU. There is no direct evidence indicating that palliative care is formally integrated as a mandatory or optional component in the undergraduate curricula of either medical or nursing programs.

Ind 12

Existence of an official specialization process in palliative medicine for physicians, recognized by the competent authority in the country.

4

Palliative medicine is a specialty or subspeciality (another denomination equivalent) recognized by competent national authorities.

Bahrain's National Health Regulatory Authority (NHRA) officially recognizes "Hospice and Palliative Medicine" as a medical specialty for physician licensing. This recognition is documented in the NHRA's Physicians Qualifications Requirements and licensing standards. A 2022 comparative analysis of palliative care in the Eastern Mediterranean Region identifies Bahrain, alongside countries such as Saudi Arabia, Qatar, Iran, and Jordan, as recognizing palliative care as a medical subspecialty. This regulatory acknowledgment enables physicians in Bahrain to obtain licensure specifically in the field of palliative medicine.

EM Bahrain

Provision of PC / Specialized Services

Ind 13

13.1. There is a system of specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.

1

No or minimal provision of palliative care specialized services or teams exist in the country.

13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.

1

Not at all.

13.3. Free-standing HOSPICES (including hospices with inpatient beds).

1

No or minimal provision of PC specialized services or teams exist.

13.4. HOME CARE teams (specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.

1

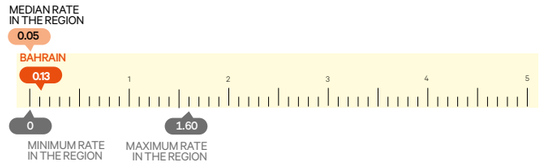
No or minimal provision of palliative care specialized services or teams exist in the country.

13.5. Total number of specialized PC services or teams in the country.

2

Bahrain does not have a national network of specialized palliative care services. Existing services are limited and primarily delivered within oncology departments of major hospitals, such as the Salmaniya Medical Complex. These services focus mainly on adult cancer patients, and there are no reports of dedicated pediatric palliative care services in national literature or international surveys. The scope and availability of specialized palliative care teams remain minimal across the country.

RATE OF SPECIALIZED PC SERVICES/100,000 INH



← SPECIALIZED PALLIATIVE CARE SERVICES

Ind 14

14.1. There is a system of specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.

1

No or minimal provision of palliative care specialized services or teams for children exists in country.

14.2. Number of pediatric specialized PC services or teams in the country.

1

PPC TEAMS

Bahrain does not have specialized palliative care services or teams dedicated to children. Palliative care is primarily offered within oncology departments of major hospitals, such as Salmaniya Medical Complex, and focuses mainly on adult patients. There are no dedicated pediatric palliative care services documented in national literature or international surveys.

EM

Djibouti

General data

POPULATION, 2024
1,168,722

PHYSICIANS/1000 INH, 2020-2022
N/A

Socioeconomic data

COUNTRY INCOME LEVEL, 2022
Lower middle

HUMAN DEVELOPMENT INDEX RANKING, 2023
175

GDP PER CAPITA (US$), 2023
3,554.84

HEALTH EXPENDITURE, 2021
87.75

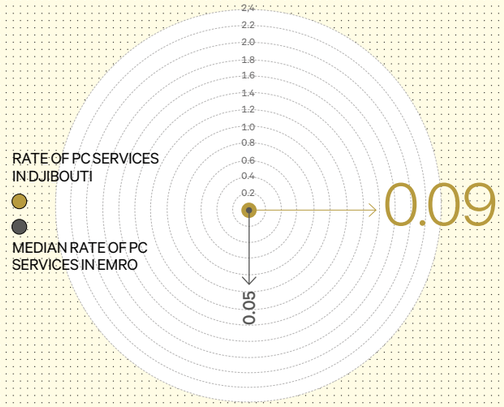
UNIVERSAL HEALTH COVERAGE, 2021
44

Ⓕ Provision of PC (Specialized Services)

Total number of Specialized PC services: **1**

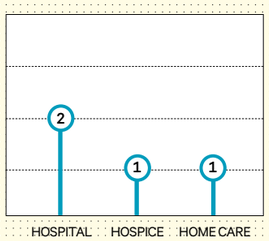
Rate of PC services per 100,000 inhabitants: **0.09**

Djibouti in the context of EMRO



Geographic distribution and integration of PC services

Level of development of different types of PC services



Pediatric PC Services

GEOGRAPHIC DISTRIBUTION AND INTEGRATION: 1

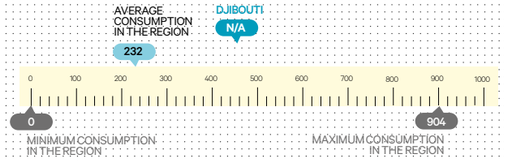
TOTAL NUMBER: 0

EM Djibouti

Ⓓ Use of essential medicines

Opioids consumption (excluding methadone): **N/A** S-DDD/MILL INHABITANTS/DAY

Djibouti in the context of EMRO



Overall availability of essential medicines for pain and PC at the primary level

General availability of immediate-release oral morphine at the primary level

Ⓒ Research

PC-related research articles: 1

Existence of PC congresses or scientific meetings: 1

National Association: No.
Consultants: Awaleh Ahmed.

Data collected: December 2023 - March 2024.
Report validated by consultants: Yes
Endorsed by National PC Association: N/A
Report reviewed by the Ministry of Health
Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching: **0/1**

Nursing schools with mandatory PC teaching: **0/2**

Recognition of PC specialty: 1

Ⓑ Policies

National PC plan or strategy: 1

Responsible authority for PC in the Ministry of Health: 1

Inclusion of PC in the basic health package at the primary care level: 2

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients: 1

Advanced care planning-related policies: 1

EM Djibouti

People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their care-givers, and disease survivors.

1 ○ ○ ○

Only isolated activity can be detected.

No evidence found.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

1 ○ ○ ○

There is no national policy or guideline on advance care planning.

Djibouti has yet to establish a national policy on advance planning for end-of-life medical decisions. Currently, palliative care options are not systematically communicated to patients with terminal illnesses, and in the absence of formal guidelines, families often take the lead in decision-making.

Policies

Ind 3

3.1. There is a current national PC plan, program, policy, or strategy.

1 ○ ○ ○

Do not know or does not exist.

In Djibouti, the first national cancer control plan, which includes a palliative care component, is currently being adopted and is expected to be finalized by the end of 2024. A specific national palliative care plan is also being developed, but has not yet been validated.

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

2 ○ ○ ○

A national palliative care plan is in preparation.

EM Djibouti

Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

1 ○ ○ ○

Not known or does not exist.

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

2 ○ ○ ○

Decree or law to include palliative care in the list of health services provided at the primary care level in preparation.

In Djibouti, palliative care is mentioned in Decree No. 2024-219/PR/MS, which regulates private sector healthcare facilities. Article 1 explicitly includes palliative care among the services provided by multidisciplinary clinics, polyclinics, and hospitals. These facilities must offer preventive, curative, palliative, diagnostic, hospitalization, and functional rehabilitation care. However, these services remain focused on individual services, excluding a collective prevention approach, which is the sole responsibility of state public services. This mention of palliative care, while present, remains limited in terms of implementation within the framework of primary care and universal health coverage.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

1 ○ ○ ○

There is no coordinating entity.

No evidence found.

5.2. The national authority has concrete functions, budget and staff.

1 ○ ○ ○

Does not have concrete functions or resources (budget, staff, etc.).

EM Djibouti

Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC.

1

There are no national congresses or scientific meetings related to palliative care.

To date, there are no palliative care specialists or dedicated activities, coordinated or not, in this area in Djibouti.

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

1

Indicates a minimal or nonexistent number of articles published on the subject in that country.

A comprehensive scoping review conducted in March 2023, covering publications from 2017 onward, did not identify any peer-reviewed articles on palliative care in Benin that met all the inclusion criteria for this indicator.

Medicines

Ind 8

Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

N/A

EM Djibouti

Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

2

Fair: Between 10% to 30%.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

2

Fair: Between 10% to 30%.

In Djibouti, pain management medications classified as tier 1 and 2 are widely accessible across all health facilities and can be obtained over the counter in private pharmacies. However, access to tier 3 medications—specifically strong opioids—is restricted to level 3 hospitals and the national cancer center. This limited distribution confines the availability of essential analgesics for severe pain to a few specialized healthcare institutions.

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

Immediate-release oral morphine is not available in Djibouti. Accessible strong opioids are only available in level 3 hospitals and the cancer center, and are not offered at the primary care level.

EM Djibouti

Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)	0/1	The creation of the Faculty of Medicine in 2007 marked a turning point in addressing the shortage of physicians following independence. Before this initiative, medical training abroad—particularly in France, Africa, and Cuba—had mixed outcomes, as some students did not return or faced challenges reintegrating due to diverse educational backgrounds. With support from WHO and Tunisia, a harmonized medical curriculum was established, including seven years of study at the University of Djibouti and internships in Tunisia. Despite this progress, palliative care remains absent from the curricula of both medical and paramedical schools in the country. Neither the Faculty of Medicine nor the paramedical training institute offers dedicated instruction in this field, aside from a few limited modules related to cancer. Paramedical education includes nursing, midwifery, and other non-physician health professions.
11.2. The proportion of medical schools with OPTIONAL teaching in PC.	0/1	
11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).	0/2	
11.4. The proportion of nursing schools with OPTIONAL teaching in PC.	0/2	

Ind 12

Existence of an official specialization process in palliative medicine for physicians, recognized by the competent authority in the country.	1 ○ ○ ○ There is no process on specialization for palliative care physicians.	No evidence found.

EM Djibouti

Provision of PC / Specialized Services

Ind 13

13.1. There is a system of specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.	2 ○ ○ Isolated provision: Exists but only in some geographic areas.	Djibouti has a single clinical service dedicated to palliative care, located in an urban area, offering limited primary care services and inpatient beds. Furthermore, no specialized mobile team is available to provide care to patients at home or in the community, which significantly limits access to palliative care for patients living far from existing facilities.
13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.	2 ○ ○ Progressing. Ad hoc/ in some parts of the country.	
13.3. Free-standing HOSPICES (including hospices with inpatient beds).	1 ○ ○ ○ Not at all.	
13.4. HOME CARE teams (specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.	1 ○ ○ ○ Not at all.	
13.5. Total number of specialized PC services or teams in the country.		RATE OF SPECIALIZED PC SERVICES/100,000 INH MEDIAN RATE IN THE REGION 0.05 DJIBOUTI 0.09 0 MINIMUM RATE IN THE REGION 1.60 MAXIMUM RATE IN THE REGION 1 ← SPECIALIZED PALLIATIVE CARE SERVICES

Ind 14

14.1. There is a system of specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.	1 ○ ○ ○ No or minimal provision of palliative care specialized services or teams for children exists in country.	No evidence found.
14.2. Number of pediatric specialized PC services or teams in the country.	0 PPC TEAMS	

EM

Egypt

General data

POPULATION, 2024
116,538,258

PHYSICIANS/1000 INH, 2020-2022
0.71

Socioeconomic data

COUNTRY INCOME LEVEL, 2022
Lower middle

HUMAN DEVELOPMENT INDEX RANKING, 2023
100

GDP PER CAPITA (US$), 2023
3,457.46

HEALTH EXPENDITURE, 2021
179.68

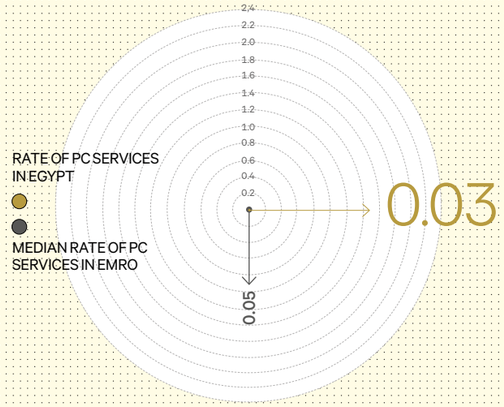
UNIVERSAL HEALTH COVERAGE, 2021
70

Ⓕ Provision of PC (Specialized Services)

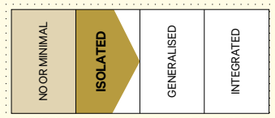
Total number of Specialized PC services **26**

Rate of PC services per 100,000 inhabitants **0.03**

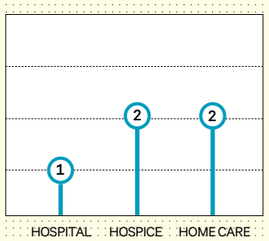
Egypt in the context of EMRO



Geographic distribution and integration of PC services



Level of development of different types of PC services



Pediatric PC Services

GEOGRAPHIC DISTRIBUTION AND INTEGRATION: 2

TOTAL NUMBER: 5

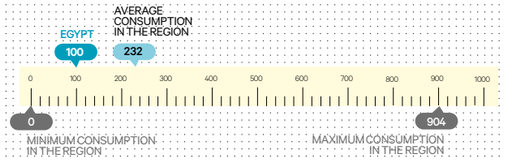
EM

Egypt

Ⓓ Use of essential medicines

Opioids consumption (excluding methadone) **100** S-DDD/MILL INHABITANTS/DAY

Egypt in the context of EMRO



Overall availability of essential medicines for pain and PC at the primary level

General availability of immediate-release oral morphine at the primary level

Ⓒ Research

PC-related research articles: 3

Existence of PC congresses or scientific meetings: 2

National Association: No.
Consultants: Maged El Ansary; Tandiar Samir Mosaad Ghattas.

Data collected: December 2023-March 2024.
Report validated by consultants: Yes
Endorsed by National PC Association: N/A
Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching **1/29**

Nursing schools with mandatory PC teaching **0/42**

Recognition of PC specialty: 2

Ⓑ Policies

National PC plan or strategy: 2

Responsible authority for PC in the Ministry of Health: 1

Inclusion of PC in the basic health package at the primary care level: 1

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients: 1

Advanced care planning-related policies: 1

EM Egypt

People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their caregivers, and disease survivors.

1

Only isolated activity can be detected.

In Egypt, there are currently no organizations exclusively dedicated to advocating for the rights of palliative care patients, their caregivers, or providing legal support in this area. The Egyptian Society for Regional Anaesthesia and Pain Medicine (ESRAPM) promotes expertise in pain management and regional anaesthesia, indirectly contributing to palliative care. A specialized group focused on supporting palliative care patients and caregivers is under development to address this critical gap. Additionally, two NGO-run hospitals have recognized the need for pediatric palliative care and are working to improve services for underserved populations. The JOSAAB Foundation's Hospice Egypt project, primarily targeting adults, advocates for end-of-life care and highlights the broader need for comprehensive palliative services in the country. In May 2025, the Shamsia Research center coordinated the launch of the first draft mapping of palliative care facilities in Egypt, with the participation of nine key partners from the NGO, academic, and legal sectors.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

1

There is no national policy or guideline on advance care planning.

No evidence found.

Policies

Ind 3

3.1. There is a current national PC plan, program, policy, or strategy.

2

Developed over 5 years ago.

Although palliative care is referenced in National Cancer Strategies, it is not covered by the National Health Insurance. Furthermore, there are no government policies recognizing it as an essential service or a national plan for its development.

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

3

There is a dedicated section on palliative care contained within another national plan such as for cancer, NC diseases or HIV.

EM Egypt

Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

1

Not known or does not exist.

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

1

Not at all.

No evidence found.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

1

There is no coordinating entity.

No evidence found.

5.2. The national authority has concrete functions, budget and staff.

1

Does not have concrete functions or resources (budget, staff, etc.).

EM Egypt

Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC.

2

Only sporadic or non-periodical conferences or meetings related to palliative care take place.

There are only sporadic or non-periodical conferences or meetings related to palliative care.

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

3

Represents a considerable amount or articles published.

A systematic review conducted in March 2023 identified 70 peer-reviewed articles from Egypt focusing on palliative care.

Medicines

Ind 8

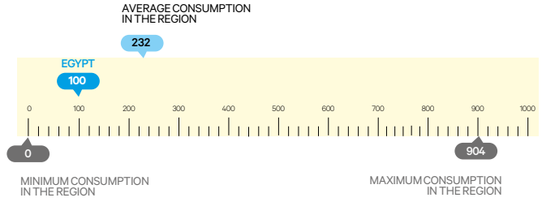
Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

Average consumption of opioids, in defined daily doses (S-DDD) for statistical purposes per million inhabitants per day, 2022.

100

S-DDD PER MILLION INHAB /DAY

COUNTRY VS REGION



EM Egypt

Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

2

Fair: Between 10% to 30%.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

1

Poor: Between 0% to 10%.

Egypt's Essential Medicines List (2018–2019) includes a wide range of palliative care medicines, classified under "Medicines for Pain and Palliative Care". These include paracetamol (oral, injectable, drops), ibuprofen, acetylsalicylic acid, morphine (injection and 30 mg tablet), codeine, fentanyl (injection and transdermal patch), tramadol, methadone, diazepam, dexamethasone, and ondansetron. Although these medicines are listed nationally, their consistent availability in primary care settings varies. Urban centers such as Cairo and Alexandria have stronger health infrastructure and supply systems, supporting more regular access. In contrast, rural and remote areas face stockouts, transport delays, and limited pharmacy coverage. These factors, along with fewer trained health professionals and partial integration of palliative care into rural services, affect the availability of medicine outside major cities.

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

Immediate-release oral morphine, in either liquid or tablet form, is not available at the primary care level in Egypt, in both urban and rural areas. Legal restrictions prohibit its possession in primary health care units. For over two decades, the only registered oral morphine formulation has been the 30 mg slow-release tablet, typically accessible only in tertiary hospitals located in major cities. Since late 2014, this formulation has faced critical shortages, leading to its near-total unavailability. Primary health centres and outpatient pharmacies do not stock oral morphine. Currently, tramadol, a weaker opioid, is the only immediate-release oral opioid that is registered and widely accessible across health care settings.

EM Egypt

Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)	1/29	In Egypt, palliative care education is limited within undergraduate medical and nursing curricula. Among the 29 medical schools nationwide, only one includes compulsory palliative care teaching, while two offer it as an optional subject. Available literature indicates that nursing schools do not include palliative care as a mandatory subject. Nonetheless, two institutions reportedly offer it as an optional component.
11.2. The proportion of medical schools with OPTIONAL teaching in PC.	2/29	
11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).	0/42	
11.4. The proportion of nursing schools with OPTIONAL teaching in PC.	2/42	

Ind 12

Existence of an official specialization process in palliative medicine for physicians, recognized by the competent authority in the country.	2 — There is no process for specialization for palliative care physicians but exists other types of professional training diplomas without official and national recognition (i.e., advanced training courses or masters in some universities or institutions.	In Egypt, there is no official or nationally recognized specialization process in palliative medicine for physicians. However, alternative informal training options exist.

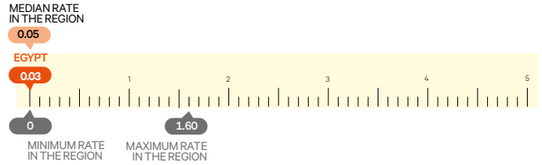
EM Egypt

Provision of PC / Specialized Services

Ind 13

13.1. There is a system of specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.	2 — Isolated provision: Exists but only in some geographic areas.	Egypt has a total of 26 specialized palliative care services, reflecting a service ratio of approximately 0.03 per 100,000 inhabitants (based on 2023 population estimates). Although comprehensive national data remain limited, emerging evidence suggests a gradual increase in service availability across the country. Among these, Hospice Egypt stands out by providing free-of-charge hospice care at patients' homes, as well as offering accommodation for terminally ill individuals who lack caregivers.
13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.	1 — Not at all.	
13.3. Free-standing HOSPICES (including hospices with inpatient beds).	2 — Ad hoc/ in some parts of the country.	
13.4. HOME CARE teams (specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.	2 — Ad hoc/ in some parts of the country.	
13.5. Total number of specialized PC services or teams in the country.	26 ← SPECIALIZED PALLIATIVE CARE SERVICES	

RATE OF SPECIALIZED PC SERVICES/100,000 INH



Ind 14

14.1. There is a system of specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.	2 — Isolated provision: palliative care specialized services or teams for children exist but only in some geographic areas.	In Egypt, specialized pediatric palliative care services are available but limited. The Children's Cancer Hospital Egypt (CCHE) in Cairo provides comprehensive PPC, serving approximately 50 children monthly, which constitutes 20% of the hospital's pediatric patients. Additionally, two NGO-affiliated hospitals and three university hospitals in Cairo offer PPC services.
14.2. Number of pediatric specialized PC services or teams in the country.	5 PPC TEAMS	

EM

Iran

General data

POPULATION, 2024
90,608,707

PHYSICIANS/1000 INH, 2020-2022
N/A

Socioeconomic data

COUNTRY INCOME LEVEL, 2022
Upper middle

HUMAN DEVELOPMENT INDEX RANKING, 2023
75

GDP PER CAPITA (US$), 2023
4,465.64

HEALTH EXPENDITURE, 2021
392.54

UNIVERSAL HEALTH COVERAGE, 2021
74

WHO FRAMEWORK FOR PALLIATIVE CARE DEVELOPMENT

Ⓐ EMPOWERMENT OF PEOPLE AND COMMUNITIES
Ⓑ POLICIES
Ⓒ RESEARCH
Ⓓ USE OF ESSENTIAL MEDICINES
Ⓔ EDUCATION AND TRAINING
Ⓕ PROVISION OF PC

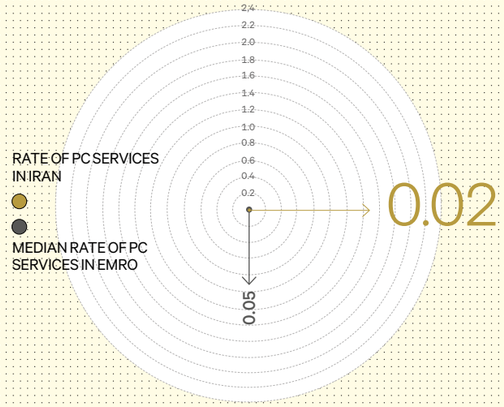
LEVEL OF DEVELOPMENT: 1 EMERGING · 2 PROGRESSING · 3 ESTABLISHED · 4 ADVANCED

Ⓕ Provision of PC (Specialized Services)

Total number of Specialized PC services: **20**

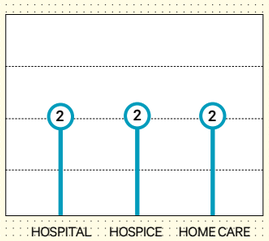
Rate of PC services per 100,000 inhabitants: **0.02**

Iran in the context of EMRO



Geographic distribution and integration of PC services

Level of development of different types of PC services



Pediatric PC Services

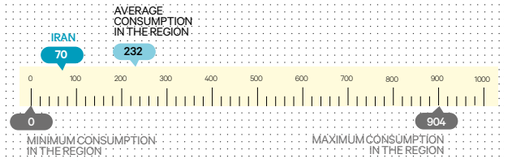
GEOGRAPHIC DISTRIBUTION AND INTEGRATION: 2

TOTAL NUMBER: **2**

Ⓓ Use of essential medicines

Opiods consumption (excluding methadone): **70** S-DDD/MILL INHABITANTS/DAY

Iran in the context of EMRO



Overall availability of essential medicines for pain and PC at the primary level

General availability of immediate-release oral morphine at the primary level

Ⓒ Research

PC-related research articles: 3

Existence of PC congresses or scientific meetings: 3

National Association: No.

Consultants: Mamak Tahmasebi; Maryam Rassouli.

Data collected: January-June 2025.

Report validated by consultants: Yes

Endorsed by National PC Association: N/A

Report reviewed by the Ministry of Health

Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching: **0/65**

Nursing schools with mandatory PC teaching: **0/192**

Recognition of PC specialty: 4

Ⓑ Policies

National PC plan or strategy: 3

Responsible authority for PC in the Ministry of Health: 3

Inclusion of PC in the basic health package at the primary care level: 2

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients: 3

Advanced care planning-related policies: 1

EM Iran

People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their caregivers, and disease survivors.

3

Existence of group(s) that cover palliative care in a more integrated way or over a wider range of disease/ program areas.

In Iran, several charities and NGOs promote the rights of patients in need of palliative care, together with their caregivers and survivors. MAHAK provides comprehensive support for children with cancer, though there is no public information on a dedicated PC ward or specialists. MACSA delivers cancer support and palliative services at the outpatient, inpatient, and home levels through an interdisciplinary team, offering care from diagnosis to end-of-life and extending support into bereavement. These organizations are occasionally involved in MoH meetings, reflecting their advocacy role, but their reach remains limited nationally. The main academic hub for palliative care is at the Cancer Institute, the country's largest referral center, which runs a clinic, consult services, a dedicated ward, and tele-palliative care, currently led by two palliative medicine specialists and a fellow resident.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

1

There is no national policy or guideline on advance care planning.

In Iran, there are currently no national policies or guidelines that specifically address advance care planning (ACP) for medical decisions regarding life-sustaining treatment or end-of-life care. The legislative framework is shaped by Islamic regulations, which necessitate consultation with religious experts in most decision-making processes. Notably, the concept of a 'last will' exists, although it does not fully correspond to the formal definitions of ACP. Nevertheless, progress is being made, as several subcommittees are actively engaged in developing national guidelines in this area.

Policies

Ind 3

3.1. There is a current national PC plan, program, policy, or strategy.

3

Actualized in last 5 years, but not actively evaluated or audited.

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

3

There is a dedicated section on palliative care contained within another national plan such as for cancer, NC diseases or HIV.

More than a decade ago, a national palliative care programme was developed within the Ministry of Health and Medical Education (MoHME), though it has not yet been fully implemented. Nevertheless, significant regulatory progress has been made, particularly regarding the establishment of outpatient palliative care centres for cancer patients. The Iran National Cancer Control Plan explicitly incorporates supportive and palliative care and includes a set of performance indicators. These cover the number of cancer centres offering outpatient supportive and palliative care, the existence of regulations to establish such centres, the availability of training courses for nurses and physicians, the number of courses delivered, the involvement of non-governmental, private, and charitable providers, the presence of clinical guidelines and protocols for home-based, end-of-life, and outpatient care, and the number of cancer centres delivering these services.

EM Iran

Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

2

The indicators to monitor and evaluate progress with clear targets exist but have not been yet implemented.

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

2

Decree or law to include palliative care in the list of health services provided at the primary care level in preparation.

Efforts to integrate palliative care into primary health care (PHC) in Iran have included research aimed at developing appropriate service packages and models of care. This integration remains in its early stages, but ongoing dialogue between the Deputy of Nursing and the Deputy of Public Health at the MoHME reflects a growing institutional commitment to advancing this process.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

3

There is a coordinating entity but has an incomplete structure (lack of scientific or technical section).

5.2. The national authority has concrete functions, budget and staff.

2

There are concrete functions but do not have a budget or staff.

Palliative care is recognized as a priority within Iran's MoH. The Support and Palliative Care Working Group of the Department of Health acts as the coordinating body and is a fully scientific entity. Its mandate extends beyond nursing, encompassing system development and planning for an interdisciplinary team that includes medicine, nursing, psychology, social work, and other disciplines. Key achievements include the formulation of policies, implementation of short-term training programs in pediatric palliative care, and the establishment of palliative care units for both adults and children.

EM Iran

Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC.

3

At least one non-palliative care congress or conference (cancer, HIV, chronic diseases, etc.) that regularly has a track or section on palliative care, each 1-2 years (and no national conference specifically dedicated to PC).

Although dedicated national palliative care congresses have not been consistently held, palliative care topics have been addressed at occasional meetings and within larger national congresses on cancer and pain management. For example, lectures and dedicated panels on palliative care were featured at events such as the International Congress of Anaesthesiology and the International Congress of Interventional Pain Management, held at the end of 2024.

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

3

Represents a considerable amount or articles published.

A search of PubMed Central for peer-reviewed articles on palliative care in Iran reveals a significant body of research. A search using the terms 'palliative care' and 'Iran' yielded 317 results in English, published between 2019 and 2024.

Medicines

Ind 8

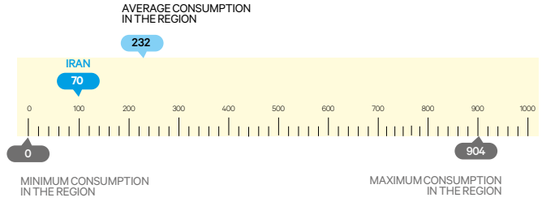
Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

Average consumption of opioids, in defined daily doses (S-DDD) for statistical purposes per million inhabitants per day, 2022.

70

S-DDD PER MILLION INHAB /DAY

COUNTRY VS REGION



EM Iran

Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

3

Good: Between 30% to 70%.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

3

Good: Between 30% to 70%.

The 2024 study by Ghanbari et al. offers only partial insight into the availability of essential pain and palliative care medicines in Iran. Among the WHO Model List of Essential Medicines, the study provides data on acetaminophen, ibuprofen, diazepam, and amitriptyline. In the public sector, acetaminophen showed the highest availability, with 63.6% of the most-sold generic formulations accessible. However, the study does not distinguish between urban and rural settings, limiting the assessment of geographic disparities. Furthermore, it omits key medications such as morphine and fentanyl, preventing a comprehensive evaluation of access to essential palliative care medicines. Given that the data were collected in 2021, they may not accurately reflect the current situation, particularly in light of ongoing medication shortages reported across the country.

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

In Iran, immediate-release oral morphine (in liquid or tablet form) is generally not available at the primary care level. While injectable morphine is accessible for acute and urgent pain management, most opioid analgesics are classified as controlled substances and are primarily distributed through hospitals and specific outpatient facilities under the strict supervision of the Iran Food and Drug Organization (FDO). Community pharmacies typically do not dispense these medications, except for oral tramadol and certain codeine-containing combinations. Since 2016, oral oxycodone tablets have been authorised for limited distribution through select community pharmacies. Notably, immediate-release oral oxycodone is available at the primary care level, unlike morphine, highlighting a significant disparity in accessibility between these two opioids. This selective availability underscores ongoing regulatory and distribution challenges in ensuring equitable access to essential pain medications within Iran's healthcare system.

EM Iran

Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)

0/65

11.2. The proportion of medical schools with OPTIONAL teaching in PC.

0/65

11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).

0/192

11.4. The proportion of nursing schools with OPTIONAL teaching in PC.

0/192

In Iran, medical sciences education is centrally regulated, with a standardized curriculum applied across all universities and nursing schools. Palliative care is not formally recognized as a distinct or required subject at the undergraduate level in either medicine or nursing. Instead, only limited elements are integrated into other courses, while some institutions offer optional modules or brief exposure to related topics. Overall, undergraduate training in palliative care remains fragmented and voluntary, with no mandatory inclusion in the national curricula for medical or nursing education.

Ind 12

Existence of an official specialization process in palliative medicine for physicians, recognized by the competent authority in the country.

4

Palliative medicine is a specialityor subspeciality (another denomination equivalent) recognized by competent national authorities.

Palliative medicine was established as a recognized subspecialty 13 years ago. Physicians from various specialties—including radio-oncology, anaesthesia, and internal medicine—undertake a 12-month training program in palliative medicine. In addition, continuous medical education has been expanded to include approved and implemented training courses for physicians and nurses, as well as certified courses for social workers in the field of supportive and palliative care.

EM Iran

Provision of PC / Specialized Services

Ind 13

13.1. There is a system of specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.

2

Isolated provision: Exists but only in some geographic areas.

13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.

2

Ad hoc/ in some parts of the country.

13.3. Free-standing HOSPICES (including hospices with inpatient beds).

2

Ad hoc/ in some parts of the country.

13.4. HOME CARE teams (specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.

2

Ad hoc/ in some parts of the country.

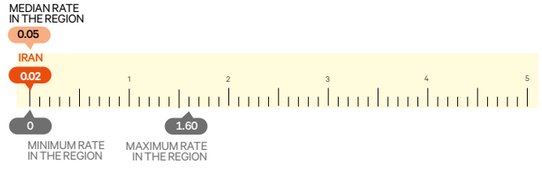
13.5. Total number of specialized PC services or teams in the country.

20

← SPECIALIZED PALLIATIVE CARE SERVICES

Palliative care services in Iran remain in their early stages and are available only at a limited number of centers in major cities. While most patients and their families prefer to receive healthcare at home, near the end of life they tend to receive these services in hospitals. The expansion of palliative care in Iran is constrained by several challenges, including gaps in governance, limited infrastructure, low public awareness, and restricted availability of opioid medications. Despite these obstacles, several charities and NGOs are dedicated to providing palliative care services to patients and their families.

RATE OF SPECIALIZED PC SERVICES/100,000 INH



Ind 14

14.1. There is a system of specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.

2

Isolated provision: palliative care specialized services or teams for children exist but only in some geographic areas.

14.2. Number of pediatric specialized PC services or teams in the country.

2

PPC TEAMS

There are two pediatric palliative care centers in the country. One of these, a well-developed facility, is situated at Mofid Pediatric Hospital.

EM

Iraq

General data

POPULATION, 2024
46,042,015

PHYSICIANS/1000 INH, 2020-2022
0.87

Socioeconomic data

COUNTRY INCOME LEVEL, 2022
Upper middle

HUMAN DEVELOPMENT INDEX RANKING, 2023
126

GDP PER CAPITA (US$), 2023
5,565.13

HEALTH EXPENDITURE, 2021
248.92

UNIVERSAL HEALTH COVERAGE, 2021
59

WHO FRAMEWORK FOR PALLIATIVE CARE DEVELOPMENT

Ⓐ EMPOWERMENT OF PEOPLE AND COMMUNITIES
Ⓑ POLICIES
Ⓒ RESEARCH
Ⓓ USE OF ESSENTIAL MEDICINES
Ⓔ EDUCATION AND TRAINING
Ⓕ PROVISION OF PC

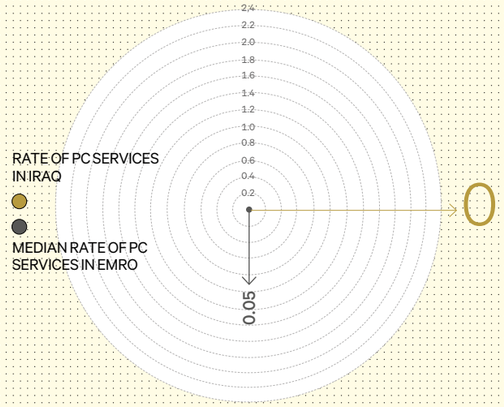
LEVEL OF DEVELOPMENT: 1 EMERGING · 2 PROGRESSING · 3 ESTABLISHED · 4 ADVANCED

Ⓕ Provision of PC (Specialized Services)

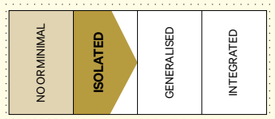
Total number of Specialized PC services: **2**

Rate of PC services per 100,000 inhabitants: **0**

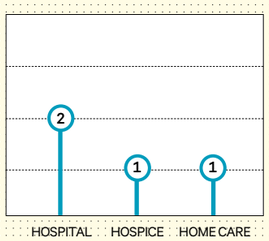
Iraq in the context of EMRO



Geographic distribution and integration of PC services



Level of development of different types of PC services



Pediatric PC Services

GEOGRAPHIC DISTRIBUTION AND INTEGRATION: 2

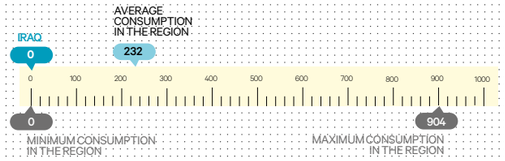
TOTAL NUMBER: 0

EM Iraq

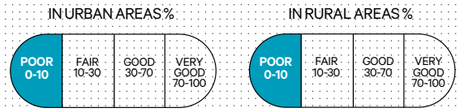
Ⓓ Use of essential medicines

Opiods consumption (excluding methadone): **0** S-DDD/MILL INHABITANTS/DAY

Iraq in the context of EMRO



Overall availability of essential medicines for pain and PC at the primary level



General availability of immediate-release oral morphine at the primary level

Ⓒ Research

PC-related research articles: 1

Existence of PC congresses or scientific meetings: 2

National Association: No.

Consultants: Mazin Faisal Farhan Al-Jadiry.

Information was synthesized from scientific and gray literature, assisted by AI tools, and subsequently reviewed and validated by local palliative care experts.

Data collected: January-June 2025.

Report validated by consultants: Yes

Endorsed by National PC Association: N/A

Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching: **0/22**

Nursing schools with mandatory PC teaching: **0/30**

Recognition of PC specialty: 2

Ⓑ Policies

National PC plan or strategy: 1

Responsible authority for PC in the Ministry of Health: 1

Inclusion of PC in the basic health package at the primary care level: 1

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients: 2

Advanced care planning-related policies: 1

EM Iraq

People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their caregivers, and disease survivors.

2

Pioneers, champions, or advocators of palliative care can be identified, but without a formal organization constituted.

In Iraq, palliative care advocacy has predominantly depended on individual professionals rather than established institutions. Notably, the philosophy of palliative care was introduced into paediatric oncology at Baghdad's Children Welfare Teaching Hospital in 2011. These initiatives, however, lacked structured institutional backing. Iraq has no national palliative care association, advocacy group, clinical guidelines, or regular conferences, and public awareness remains extremely limited. Nevertheless, over the past three years, ongoing training efforts —both online and in-person— have been conducted in paediatric oncology through international collaborations, aiming to build capacity and expand knowledge. While these developments indicate progress, civil society engagement in advocating for palliative care rights remains in an early and fragile phase.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

1

There is no national policy or guideline on advance care planning.

Iraq does not currently have a national policy or guideline addressing advance care planning or medical decisions related to end-of-life care. Formal frameworks to regulate surrogate decision-making or the use of advance directives have not yet been established. The concept of palliative care is still not widely integrated into clinical understanding, and conversations about death remain culturally sensitive and are often avoided. This presents challenges for incorporating advance care planning into routine clinical practice. Additionally, there is no official guidance in place regarding living wills or the legal status of healthcare proxies, highlighting the need for a structured approach to end-of-life decision-making.

Policies

Ind 3

3.1. There is a current national PC plan, program, policy, or strategy.

1

Not known or does not exist.

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

1

Not known or does not exist neither standalone nor is included in another national plan.

Iraq currently does not have a national palliative care plan, programme, or policy. There is no standalone strategy, and palliative care has not yet been integrated into broader national health frameworks, including those focused on cancer, non-communicable diseases, or HIV. At present, services are primarily limited to isolated institutional initiatives, without formal coordination or policy direction from national authorities. Consequently, there are no established indicators or measurable targets in place to monitor progress. The absence of a structured implementation framework reflects the early stage of palliative care integration within the national health system, highlighting a key area for future development.

EM Iraq

Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

1

Not known or does not exist.

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

1

Not at all.

Palliative care services are not currently included in Iraq's package of priority health services at the primary care level. Palliative care is not part of the national essential health package and has yet to be integrated into the delivery of primary healthcare. At present, no decree or legal provision is in place or under development to support the inclusion of these services, and palliative care is not mentioned in the General Health Law. This reflects an early stage in the integration of palliative care within the broader health system, with no identified recent initiatives to incorporate it into essential health service packages or establish a formal legal framework for its provision.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

1

There is no authority defined.

5.2. The national authority has concrete functions, budget and staff.

1

Does not have concrete functions or resources (budget, staff, etc.).

Palliative care services are not yet included in Iraq's package of priority health services at the primary care level. At present, palliative care is not part of the basic health services covered under Universal Health Coverage (UHC), nor is it integrated into the structure of primary healthcare delivery. No decree or legal framework has been identified to support its inclusion, and the General Health Law does not currently reference palliative care. This reflects the early phase of integration into national health planning. While recent reports do not indicate progress in this area, they also highlight a clear opportunity to initiate structured efforts toward incorporating palliative care into essential health packages and establishing a formal legal foundation for its development.

EM Iraq

Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC.

2

Only sporadic or non-periodical conferences or meetings related to palliative care take place.

There are currently no recurring national congresses or scientific meetings specifically dedicated to palliative care in Iraq, and the country does not yet have a national palliative care association to support ongoing scientific exchange. Nonetheless, important capacity-building efforts in paediatric palliative care have taken place between 2022 and 2024 through collaboration with WHO/EMRO and the ICPCN. These included a virtual policy meeting in October 2022 and an onsite workshop in April 2024 focused on opioid access and regulation, with the participation of Ministry of Health officials and key stakeholders. While these activities reflect growing engagement at the policy level, the establishment of a sustained scientific platform remains an area with potential for further development. Individual professionals have contributed significantly through participation in international events, laying the groundwork for future national initiatives.

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

1

Minimal or nonexistent number of articles published on the subject in that country.

Palliative care research in Iraq remains at a nascent stage. Over the past five years, there has been a notable absence of peer-reviewed publications from national institutions specifically focused on this field. No dedicated research groups, formal forums, or regular scientific conferences have been established to promote scholarly activity in palliative care. Despite the lack of structured funding and institutional support, some initial contributions --such as a situational report published in 2017 by a leading clinician --have laid the groundwork for future academic engagement and the development of national research capacity.

Medicines

Ind 8

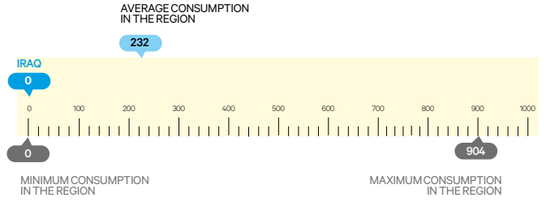
Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

Average consumption of opioids, in defined daily doses (S-DDD) for statistical purposes per million inhabitants per day, 2022.

0

S-DDD PER MILLION INHAB /DAY

COUNTRY VS REGION



EM Iraq

Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

1

Poor: Between 0% to 10%.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

1

Poor: Between 0% to 10%.

The availability of essential medicines for pain and palliative care at the primary care level in Iraq remains limited in both urban and rural areas. Oral morphine is available only intermittently, while injectable morphine is primarily restricted to hospital settings and is not accessible through primary care services. Other essential palliative care medicines from the WHO Model List —such as amitriptyline, haloperidol, and antiemetics— are not consistently available at the first level of care. Pain management remains largely centralised within oncology units, and no established system is in place to ensure the distribution of palliative care medicines in community or rural settings. Overall, medicine availability at the primary care level is currently low, underscoring a key area for improvement in service accessibility.

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

The availability of immediate-release oral morphine (liquid or tablet) at the primary care level in Iraq remains very limited in both urban and rural settings. Access is mostly confined to hospital use, with no structured distribution system in place at the community level. Opioid prescriptions are subject to strict regulations, typically restricted to inpatient settings and requiring authorisation by two physicians. Legal and cultural factors, along with limited training among healthcare providers and gaps in regulatory mechanisms, further restrict the use of morphine in outpatient and primary care contexts. As a result, immediate-release oral morphine is rarely accessible at the first level of care across the country.

EM Iraq

Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)

0/22

11.2. The proportion of medical schools with OPTIONAL teaching in PC.

0/22

11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).

0/30

11.4. The proportion of nursing schools with OPTIONAL teaching in PC.

0/30

In Iraq, palliative care has not yet been incorporated as a compulsory subject in undergraduate medical or nursing education. Currently, no medical or nursing schools are known to offer mandatory training in this area, and there is no formal structure for undergraduate or postgraduate instruction in palliative care. Most healthcare professionals gain knowledge through personal experience rather than systematic education. While some elective modules, pilot programmes, and online training opportunities are available --mainly targeting physicians --these remain limited in scope and are not consistently integrated into academic curricula. The need to formally include palliative care in health education is increasingly recognised, presenting a valuable opportunity for future curriculum development.

Ind 12

Existence of an official specialization process in palliative medicine for physicians, recognized by the competent authority in the country.

2

There is no process on specialization for palliative care physicians but exists other type of professional training diplomas without official and national recognition (i.e., advanced training courses or masters in some universities of institutions).

Iraq does not currently have a nationally recognised specialisation process in palliative medicine. While diplomas obtained abroad are acknowledged, there is no formal national system in place for certification or accreditation in this field. At present, academic structures and local training programmes in palliative medicine are not established, and most specialised knowledge is acquired through international training opportunities. Iraqi physicians interested in the field often pursue education and clinical experience in palliative care through centres abroad.

EM Iraq

Provision of PC / Specialized Services

Ind 13

13.1. There is a system of specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.

2

Ad hoc/ in some parts of the country.

13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.

2

Ad hoc/ in some parts of the country.

13.3. Free-standing HOSPICES (including hospices with inpatient beds).

1

Not at all.

13.4. HOME CARE teams (specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.

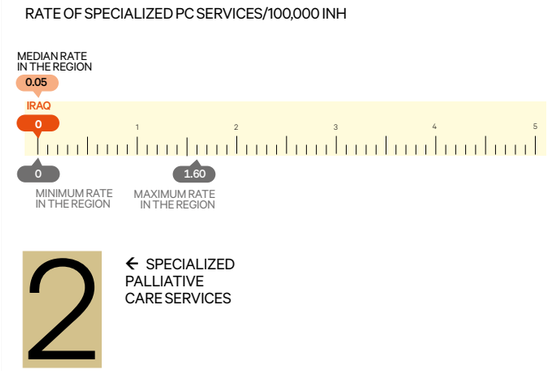
1

Not at all.

13.5. Total number of specialized PC services or teams in the country.

2

The provision of specialized palliative care services in Iraq remains limited and unevenly distributed. Currently, only two adult palliative care services have been identified nationwide, corresponding to approximately 0.01 services per 100,000 population. These are concentrated in Baghdad and in one location in the north, without a broader national network. Within the public sector, some hospitals, such as the Children Welfare Teaching Hospital, provide palliative care on an ad hoc basis; however, such services are not routinely available across public or private facilities. Iraq does not yet have free-standing hospices, and there are no established home-based or community-linked palliative care teams. As a result, care is primarily delivered in hospital settings, with limited outreach to homes or primary care centres.



Ind 14

14.1. There is a system of specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.

2

Isolated provision: palliative care specialized services or teams for children exist but only in some geographic areas.

14.2. Number of pediatric specialized PC services or teams in the country.

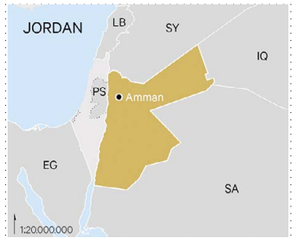
0

PPC TEAMS

Specialized pediatric palliative care services in Iraq are currently limited to a single initiative based at the Children Welfare Teaching Hospital (CWTH) in Baghdad. Since 2011, palliative care practices have been gradually incorporated within the hospital's pediatric oncology unit, including core elements such as pain management and aspects of psychosocial support for children with advanced cancer. While this represents an important step forward, CWTH does not operate as a stand-alone pediatric palliative care service, and there is no formal multidisciplinary team in place. According to recent reports, no home-based services, regional outreach teams, or community-based programs have yet been established, and pediatric palliative care is not currently available in other cities or within the private sector.

EM

Jordan



General data

POPULATION, 2024
11,552,876

PHYSICIANS/1000 INH, 2020-2022
2.51

Socioeconomic data

COUNTRY INCOME LEVEL, 2022
Lower middle

HUMAN DEVELOPMENT INDEX RANKING, 2023
100

GDP PER CAPITA (US$), 2023
4,455.51

HEALTH EXPENDITURE, 2021
299.07

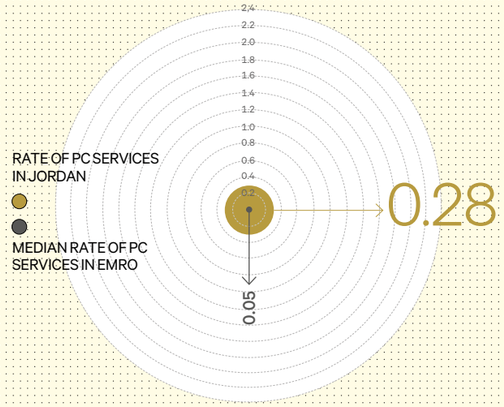
UNIVERSAL HEALTH COVERAGE, 2021
65

Ⓕ Provision of PC (Specialized Services)

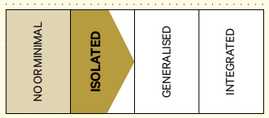
Total number of Specialized PC services: **32**

Rate of PC services per 100,000 inhabitants: **0.28**

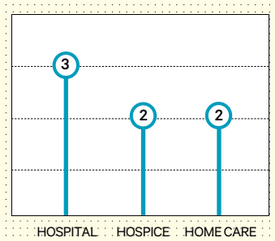
Jordan in the context of EMRO



Geographic distribution and integration of PC services



Level of development of different types of PC services



Pediatric PC Services

GEOGRAPHIC DISTRIBUTION AND INTEGRATION: 2

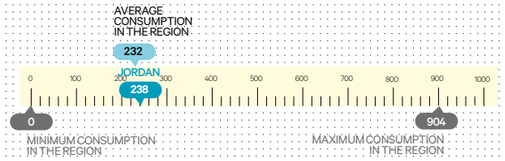
TOTAL NUMBER: 1

EM Jordan

Ⓓ Use of essential medicines

Opioids consumption (excluding methadone): **238** S-DDD/MILL INHABITANTS/DAY

Jordan in the context of EMRO



Overall availability of essential medicines for pain and PC at the primary level

General availability of immediate-release oral morphine at the primary level

Ⓒ Research

PC-related research articles: 3

Existence of PC congresses or scientific meetings: 4

National Association: Jordan Palliative Care Society; National Palliative Care Committee.

Consultants: Anwar Al-Nassan; Omar Shamieh.

Data collected: January-June 2025.

Report validated by consultants: Yes

Endorsed by National PC Association: Yes (by the National Palliative Care Committee)

Report reviewed by the Ministry of Health

Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching: **3/6**

Nursing schools with mandatory PC teaching: **0/17**

Recognition of PC specialty: 4

Ⓑ Policies

National PC plan or strategy: 4

Responsible authority for PC in the Ministry of Health: 4

Inclusion of PC in the basic health package at the primary care level: 4

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients: 4

Advanced care planning-related policies: 3

EM Jordan

People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their caregivers, and disease survivors.

4

Strong national and sub-national presence of palliative care advocacy and promoting patient rights (as a professional association of Palliative Care, i.e.).

In Jordan, several organizations actively support palliative care patients, caregivers, and survivors. The Jordan National Palliative Care Committee, established in 2003 under the MoPH with WHO support, leads national palliative care development. The King Hussein Cancer Center (KHCC) provides extensive palliative care services, including the country's only pediatric palliative care program. The Jordan Palliative Care Society, founded in 2010, collaborates with health authorities to improve service delivery and specialist training. Established in 1993, the Al-Malath Foundation was the Middle East's first hospice provider, offering free medical, psychological, and bereavement support. The Al Oun for Alzheimer's Patient Care Association, founded in 2020 and affiliated with Alzheimer's Disease International since 2022, provides caregiver education, support groups, and a helpline. These initiatives align with the MoH's 2023–2025 strategy, which prioritizes equitable access to palliative care services across Jordan.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

3

There is/are national policies or guidelines on living wills and/or on advanced directives.

In Jordan, DNR orders are formally recognized and implemented in many hospitals, grounded in medical ethics and Islamic principles. A DNR decision requires consensus from three licensed physicians and consent from the patient and their family, especially when CPR is considered non-beneficial for terminally ill patients. Islamic jurisprudence allows withdrawal of futile treatments, but life support can only be withdrawn in cases of brain death, with family approval. Although DNR policies exist in several hospitals, staff experience in applying them varies. End-of-life care discussions remain culturally and religiously sensitive, underscoring the need for public education and culturally appropriate communication.

Policies

Ind 3

3.1. There is a current national PC plan, program, policy, or strategy.

4

Actualized in last 5 years, and actively evaluated or audited.

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

4

Yes, there is a standalone national palliative care plan and/or there is national palliative care law/legislation/ government decrees on PC.

Palliative care in Jordan is integrated into the National Cancer Control Plan (NCCP) and the national non-communicable diseases program. Launched in 2003 as a WHO demonstration project, the initiative prioritized training, education, and opioid policy reform. Significant developments include the creation of the Jordan Palliative Care Society and improved access to opioids, despite ongoing challenges such as coordination issues, limited funding, and workforce shortages. The 2016–2018 national strategy and the 2023 NCCP update have enhanced palliative care education, service delivery, and funding structures. Progress is monitored through measurable indicators set by the National Palliative Care Committee and the MoH's Cancer Control program. Collaborations with universities have enabled the certification of palliative care nurses. Legislative reforms have expanded access to narcotics. Palliative care services are provided by the King Hussein Cancer Center, Royal Medical Services, universi-

EM Jordan

Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

4

The Indicators to monitor and evaluate progress are currently implemented.

ty and private hospitals, nonprofit home care agencies, and the main public oncology hospital.

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

4

Palliative care is included in the list of health services provided at the primary care level in the General Health Law.

In Jordan, palliative care is formally included in the national health strategy. The MoH's 2023–2025 plan prioritises integrating palliative care into the essential health services package, aiming for equitable access nationwide. Specialist institutions like the King Hussein Cancer Center (KHCC) provide comprehensive palliative care, including the largest home care program, operating five days a week within a 100-mile radius of Amman. Additionally, efforts are ongoing to incorporate palliative care into primary care through team-based models, such as the Family Health Teams (FHTs), supporting national goals to achieve Universal Health Coverage (UHC). Although these initiatives mark important progress, continued efforts are necessary to fully integrate palliative care across all healthcare levels and ensure consistent access to services for all patients throughout Jordan.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

4

The coordinating entity for palliative care is a well-defined and has a good structure (scientific & technical).

5.2. The national authority has concrete functions, budget and staff.

4

There are concrete functions, staff and budget.

In Jordan, the MoH established the National Palliative and Home Care Committee, which plays a central role in developing and overseeing palliative care services nationally. The Committee is tasked with implementing the National Palliative and Home Care Strategic Framework, endorsed by the government in April 2018. This framework covers six key domains: policy, finance, service delivery, opioid access, capacity building, and information, research, monitoring, and evaluation. Government endorsement has enabled broad national engagement in policy-making, service provision, workforce development, education, training, and research related to palliative care. The Committee's leadership has been essential in advancing the integration and expansion of services, supporting the goal of improving access to comprehensive and equitable palliative care throughout Jordan.

EM Jordan

Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC.

4

At least one national conference specifically dedicated to palliative care every 3 years.

Jordan actively hosts several significant national events focused on palliative care. The King Hussein Cancer Research Conference, organized annually by KHCC, most recently took place on 15–16 November 2024 under the patronage of HRH Princess Ghida Talal. The annual conference of the Jordan Oncology Society includes a dedicated section on palliative care, providing a platform to discuss developments in the field. Additionally, the Jordan Palliative Care Society plays a key role in educating patients, families, and healthcare professionals, raising awareness and offering specialized training. KHCC also holds an annual palliative care symposium to mark International Hospice Day, attracting attendees nationwide.

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

3

Represents a considerable amount of articles published.

A PubMed search revealed numerous articles from the past five years by Jordanian researchers focusing on palliative care. Topics covered include the integration of palliative care into the healthcare system, training and education for healthcare professionals, and patient-centerd care at the end of life. Research also addresses cultural challenges, public awareness, and the effectiveness of home-based palliative care services in Jordan. Some studies examine the use of technology and data management to improve palliative care delivery. Others explore the specific needs of patients with chronic diseases and cancer. The increasing number of publications reflects growing research efforts to enhance palliative care within Jordan's healthcare system and its social context.

Medicines

Ind 8

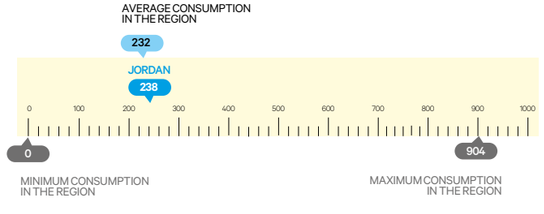
Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

Average consumption of opioids, in defined daily doses (S-DDD) for statistical purposes per million inhabitants per day, 2022.

238

S-DDD PER MILLION INHAB /DAY

COUNTRY VS REGION



EM Jordan

Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

3

Good: Between 30% to 70%.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

3

Good: Between 30% to 70%.

In Jordan, opioids for pain and palliative care are mainly available at tertiary healthcare facilities, including the KHCC, Royal Medical Services, and MoH referral hospitals. At the primary healthcare level, opioids are generally unavailable, restricting pain management options. Oral morphine, in both liquid and tablet forms, is accessible at tertiary centers, though shortages of other opioids such as oxycodone and hydromorphone persist. pediatric opioid formulations tend to be stocked only at tertiary care centers. While other essential medicines for palliative care are more widely available, access to opioids, especially morphine, remains limited in rural areas. This uneven distribution highlights challenges in ensuring equitable availability of pain relief medications across Jordan's healthcare system.

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

2

Fair: Between 10% to 30%.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

2

Fair: Between 10% to 30%.

In Jordan, immediate-release oral morphine, both liquid and tablet forms, along with tramadol and fentanyl patches, are primarily available at tertiary healthcare facilities such as the KHCC, Royal Medical Services, and MoH referral hospitals. These opioids are largely inaccessible at the primary healthcare level, particularly in rural areas. Liquid and immediate-release morphine may also be obtained through KHCC, Royal Medical Services referral hospitals, King Abdullah University Hospitals, and via prescriptions from private pain and palliative care providers. This uneven distribution highlights a significant disparity in opioid availability between urban and rural areas. As a result, patients in rural settings requiring immediate-release morphine for pain management must be referred to higher-level public or private hospitals, creating barriers to timely and equitable care.

EM Jordan

Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)	3/6
11.2. The proportion of medical schools with OPTIONAL teaching in PC.	0/6
11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).	0/17
11.4. The proportion of nursing schools with OPTIONAL teaching in PC.	5/17

Jordan has six accredited medical schools, three of which—The University of Jordan, Jordan University of Science and Technology, and Hashemite University—offer compulsory palliative care training. This is integrated into hematology and oncology clinical rounds, with mandatory sessions for fourth- and sixth-year students. The curriculum covers hospice and palliative care principles, end-of-life care, symptom management (pain, dyspnoea, nausea, delirium), ethical decision-making, and communication skills in clinical settings. In nursing education, palliative care training is more limited. Of the 17 nursing schools in Jordan, only five—Applied Science Private University, Philadelphia University, Jordan University of Science and Technology, Zarqa University, and Jerash University—offer palliative care education, solely as an optional subject within their nursing programs.

Ind 12

Existence of an official specialization process in palliative medicine for physicians, recognized by the competent authority in the country.

4

Palliative medicine is a specialty or subspeciality (another denomination equivalent) recognized by competent national authorities.

In Jordan, palliative medicine was officially recognized as a subspecialty in 2017. The KHCC offers a two-year fellowship in palliative medicine, accredited by the Jordanian Medical Council, providing training across various clinical settings, including inpatient hospice, outpatient clinics, and home healthcare. The University of Jordan offers a Master of Science in Clinical Nursing specialization in palliative care. Additionally, it provides a course titled "Introduction to Palliative and End of Life Care" as part of continuous education. Despite these educational advances, there remains a significant shortage of palliative care specialists. Estimates suggest that between 185 and 235 full-time equivalent physicians are needed to meet the country's demand for specialist palliative care services.

EM Jordan

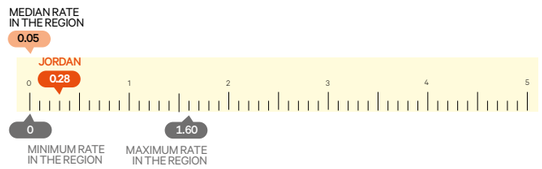
Provision of PC / Specialized Services

Ind 13

13.1. There is a system of specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.	2 — Isolated provision: Exists but only in some geographic areas.
13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.	3 — Are part of most/all hospitals in some form.
13.3. Free-standing HOSPICES (including hospices with inpatient beds).	2 — Ad hoc/ in some parts of the country.
13.4. HOME CARE teams (specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.	2 — Ad hoc/ in some parts of the country.
13.5. Total number of specialized PC services or teams in the country.	32 ← SPECIALIZED PALLIATIVE CARE SERVICES

As of 2023, Jordan has over 32 specialized palliative care services across various regions, including hospital consultation teams, inpatient hospice units with dedicated beds, and home-based care. The KHCC operates 10 adult teams—five home care, two outpatient, two inpatient consultation, and one inpatient hospice—and one pediatric team. The Royal Medical Services provide 12 adult teams in multiple hospitals. Additional teams exist at King Abdullah University Hospital (KAUH) in Irbid, Al Basheer Hospital, Darwazeh Hospital, and the Al-Malath Foundation, which offers hospice and home care. The private sector contributes around five outpatient and inpatient consultation services. KHCC's home care program covers all governorates except the far south.

RATE OF SPECIALIZED PC SERVICES/100,000 INH



Ind 14

14.1. There is a system of specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.	2 — Isolated provision: palliative care specialized services or teams for children exist but only in some geographic areas.
14.2. Number of pediatric specialized PC services or teams in the country.	1 PPC TEAMS

In Jordan, specialized pediatric palliative care (PPC) services are mainly centred at KHCC, which hosts the country's only dedicated PPC team. KHCC offers a comprehensive range of services including medical consultations, inpatient and outpatient care, home healthcare, and a medical device lending programme. It also runs a fellowship training programme in PPC. Originally focused on children with cancer, KHCC's services now cover various life-threatening conditions. While children with cancer receive treatment in pediatric oncology wards at KHCC and Royal Medical Services (RMS) hospitals such as Queen Rania Paediatric Hospital, only KHCC provides specialised PPC programmes. RMS and MoH hospitals offer supportive and pain management services but lack dedicated PPC units with interdisciplinary teams.

EM

Kuwait

General data

POPULATION, 2024
4,973,861

PHYSICIANS/1000 INH, 2020-2022
N/A

Socioeconomic data

COUNTRY INCOME LEVEL, 2022
High

HUMAN DEVELOPMENT INDEX RANKING, 2023
52

GDP PER CAPITA (US$), 2023
33,729.8

HEALTH EXPENDITURE, 2021
1,860.78

UNIVERSAL HEALTH COVERAGE, 2021
78

WHO FRAMEWORK FOR PALLIATIVE CARE DEVELOPMENT

Ⓐ EMPOWERMENT OF PEOPLE AND COMMUNITIES
Ⓑ POLICIES
Ⓒ RESEARCH
Ⓓ USE OF ESSENTIAL MEDICINES
Ⓔ EDUCATION AND TRAINING
Ⓕ PROVISION OF PC

LEVEL OF DEVELOPMENT

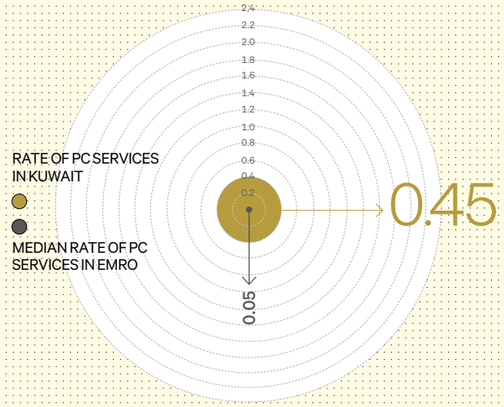
1 EMERGING · 2 PROGRESSING · 3 ESTABLISHED · 4 ADVANCED

Ⓕ Provision of PC (Specialized Services)

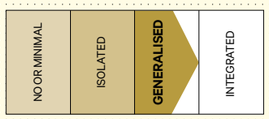
Total number of Specialized PC services **22**

Rate of PC services per 100,000 inhabitants **0.45**

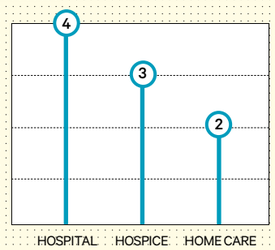
Kuwait in the context of EMRO



Geographic distribution and integration of PC services



Level of development of different types of PC services



Pediatric PC Services

GEOGRAPHIC DISTRIBUTION AND INTEGRATION: 3

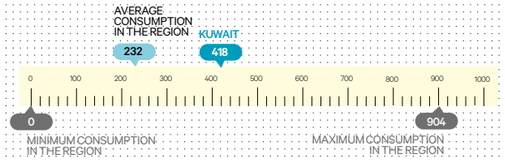
TOTAL NUMBER: **7**

EM Kuwait

Ⓓ Use of essential medicines

Opiods consumption (excluding methadone) **418** S-DDD/MILL INHABITANTS/DAY

Kuwait in the context of EMRO



Overall availability of essential medicines for pain and PC at the primary level

General availability of immediate-release oral morphine at the primary level

Ⓒ Research

PC-related research articles: 3

Existence of PC congresses or scientific meetings: 3

National Association: Palliative Medicine Association in Kuwait.
Consultants: Abdel R. Arkandi; Qutaibah Alotaibi.

Data collected: January-June 2025.
Report validated by consultants: Yes
Endorsed by National PC Association: Yes
Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching **0/1**

Nursing schools with mandatory PC teaching **0/2**

Recognition of PC specialty: 4

Ⓑ Policies

National PC plan or strategy: 3

Responsible authority for PC in the Ministry of Health: 4

Inclusion of PC in the basic health package at the primary care level: 3

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients: 4

Advanced care planning-related policies: 4

EM Kuwait

People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their caregivers, and disease survivors.

4

Strong national and sub-national presence of palliative care advocacy and promoting patient rights (as a professional association of Palliative Care, i.e.).

In Kuwait, various organisations support the rights of patients needing palliative care, their caregivers, and disease survivors. The Kuwait Cancer Control Center (KCCC) offers integrated oncology and palliative care addressing medical, psychosocial, spiritual, and nutritional needs. The Bayt Abdullah Children's Hospice (BACCH), under the Kuwait Association for the Care of Children in Hospital (KACCH), advocates for children with life-limiting conditions and their families, while KACCH also promotes the psychosocial rights of hospitalised children. The Palliative Medicine Association focuses on adult care and professional education, and the Al-Sidra Association provides psychological and home hospice support for cancer patients. Patients' end-of-life rights are outlined in Kuwait's Code of Ethics for Medical and Allied Healthcare Professionals.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

4

There is a national policy on advance care planning.

In Kuwait, the legal and policy framework includes provisions related to advance care planning (ACP) and end-of-life patient rights. Medical Practice Law No. 70 (2020) permits patients to appoint a surrogate and express healthcare preferences. ACP is also referenced in MoH Decree No. 57 (2022) and Ministry of Justice regulations. The Operational and Management Policy and Guide for Adults with Terminal Illness, last updated in July 2024, supports patient autonomy and informed consent. While patients may refuse life-sustaining treatment, its withdrawal remains prohibited. However, a unified national policy for ACP, living wills, or advance directives has yet to be established.

Policies

Ind 3

3.1. There is a current national PC plan, program, policy, or strategy.

3

Actualized in last 5 years, but not actively evaluated or audited.

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

4

Yes, there is a standalone national palliative care plan and/or there is national palliative care law/legislation/ government decrees on PC.

Kuwait's MoH has published standalone palliative care policies for both cancer and non-cancer conditions, updated biennially. In 2021, a specific policy focused on palliative care for adults with terminal illnesses, especially non-cancer cases, was released. Since 2016, palliative care has been integrated into the national cancer program, contributing to the accreditation of the KCCC by the European Society for Medical Oncology (ESMO). In 2022, a home healthcare program for bedridden terminal patients was introduced, managed by the Palliative Care Center (PCC) in collaboration with the Primary Healthcare Directorate. Palliative care is also included in legal and ethical frameworks such as patient rights laws and the Code of Ethics. While the PCC monitors and evaluates progress using indicators across multiple service levels, including inpatient care and outpatient services, no indicators are evaluated for non-cancer

EM Kuwait

Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

2

The indicators to monitor and evaluate progress with clear targets exist but have not been yet implemented.

care. Kuwait lacks a cohesive national palliative care framework with measurable targets.

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

3

Included in the essential list of services recognized by a government decree or law but not in the General Health Law.

Since 2017, palliative care has been integrated into primary healthcare services in Kuwait. The Family Medicine Residency program began sending residents to the PCC for training in palliative care, with palliative medicine included in their board exams. In 2022, the MoH launched a home healthcare program for bedridden patients with terminal illnesses, managed by the Primary Healthcare Directorate. This program, developed with the PCC's support, involves training primary healthcare providers and providing home visits. While the service is established within primary healthcare, its capacity currently serves less than 50% of the community. Despite these initiatives, palliative care services are not listed as a priority within Kuwait's UHC package at the primary care level.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

4

The coordinating entity for palliative care is a well-defined and has a good structure (scientific & technical).

5.2. The national authority has concrete functions, budget and staff.

4

There are concrete functions, staff and budget.

In Kuwait, palliative care is overseen by the Director of Technical Affairs within the MoH, under the Assistant Undersecretary for Technical Affairs. The Palliative Medicine Department at the PCC serves as the national authority, responsible for service provision, staffing, and technical leadership. It participates in all relevant national committees and task forces. Palliative care governance is coordinated at secondary and tertiary levels through the Committee on Hospital Clinical Services and Policies, and at the primary care level through the Primary healthcare Directorate. The MoH funds and delivers palliative care services nationwide, including home care.

EM Kuwait

Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC.

3

At least one non-palliative care congress or conference (cancer, HIV, chronic diseases, etc.) that regularly has a track or section on palliative care, each 1-2 years (and no national conference specifically dedicated to PC).

The PCC in Kuwait held its first national conference dedicated to palliative care in 2018. Following the COVID-19 pandemic, the PCC has continued to organize annual two-day workshops focusing on both cancer and non-cancer palliative care. Additionally, the PCC consistently participates in broader national healthcare conferences by leading dedicated PC sessions each year. These initiatives aim to enhance awareness, education, and capacity building in palliative medicine across Kuwait's healthcare system. However, publicly available sources providing detailed documentation on the PCC's annual workshops and conference sessions remain limited. Kuwait is hosted the International Conference on Palliative Care and Ethics, Medicine (ICPCEM) on 11 March 2025, in Kuwait City.

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

3

Represents a considerable amount of articles published.

Over the past five years, there have been significant contributions to palliative care research authored by local stakeholders in Kuwait. These publications highlight important progress in the field, though the overall output remains limited compared to countries with more established palliative care research programs. A search of PubMed identified 14 peer-reviewed articles authored by Kuwaiti researchers or collaborators.

Medicines

Ind 8

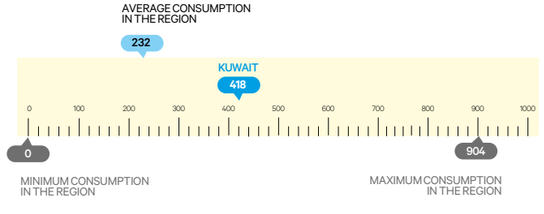
Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

Average consumption of opioids, in defined daily doses (S-DDD) for statistical purposes per million inhabitants per day, 2022.

418

S-DDD PER MILLION INHAB /DAY

COUNTRY VS REGION



EM Kuwait

Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

2

Fair: Between 10% to 30%.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

2

Fair: Between 10% to 30%.

The country has over 100 primary healthcare centers across six regions, providing basic medical services. However, access to specific palliative care medications is limited, as stronger opioids and certain drugs are only available through hospital pharmacies. This centralized distribution system impacts rural areas, where patients may need to travel to urban hospitals to obtain specialized medications. Common drugs like paracetamol and NSAIDs are accessible, but medications listed on the WHO Model List of Essential Medicines for palliative care are rarely available at the primary level. Some studies report that underutilization continues due to prescribing practices and cultural factors.

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

In Kuwait, immediate-release oral morphine, whether in liquid or tablet form, is not typically available at the primary healthcare level, whether in urban or rural areas. Strong opioids, including morphine, are not accessible for palliative pain management at primary care centers. The availability of these medications is centralized, with morphine being prescribed and dispensed only through hospital pharmacies under strict regulations. Primary healthcare physicians, while trained in palliative care and supervising home healthcare services, do not have direct access to strong opioids for managing pain at the primary care level.

EM Kuwait

Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)

0/1

11.2. The proportion of medical schools with OPTIONAL teaching in PC.

0/1

11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).

0/2

11.4. The proportion of nursing schools with OPTIONAL teaching in PC.

0/2

In Kuwait, the Faculty of Medicine at Kuwait University, the primary institution for medical education, does not include palliative care in its undergraduate curriculum, either as a compulsory or optional subject. Despite efforts to advocate for its inclusion, palliative care remains absent from the curriculum. Similarly, the College of Nursing at Kuwait University, the country's main nursing school, does not include palliative care as a compulsory part of its nursing programs but is available on an optional basis through elective clinical rotations. These rotations are supported by palliative care facilities such as Bayt Abdullah Children's Hospice, which provides opportunities for nursing students to gain experience in palliative care practice. However, this training is not formally incorporated into the undergraduate nursing curriculum and is infrequently accessed by students.

Ind 12

Existence of an official specialization process in palliative medicine for physicians, recognized by the competent authority in the country.

4

Palliative medicine is a specialty or subspeciality (another denomination equivalent) recognized by competent national authorities.

In Kuwait, Palliative Medicine is officially recognized as a subspecialty by the MoH, although it remains uncommon. Physicians seeking specialization must complete a postgraduate fellowship in palliative care from accredited institutions—primarily university hospitals in Western countries or recognized programs in Saudi Arabia. These fellowships require an equivalency evaluation before final approval by the MoH. Once recognized, specialists are formally authorized to practice and lead palliative care services across the country. As of 2024, five physicians are specialized in adult palliative care, and four in pediatric palliative care—including one recently appointed at BACCH.

EM Kuwait

Provision of PC / Specialized Services

Ind 13

13.1. There is a system of specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.

3

Generalized provision: Exists in many parts of the country but with some gaps.

13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.

4

Are part of most/all hospitals in some form.

13.3. Free-standing HOSPICES (including hospices with inpatient beds).

3

Found in many parts of the country.

13.4. HOME CARE teams (specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.

2

Ad hoc/ in some parts of the country.

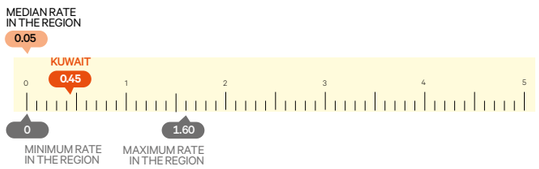
13.5. Total number of specialized PC services or teams in the country.

22

← SPECIALIZED PALLIATIVE CARE SERVICES

As of 2023, Kuwait has a total of 22 specialized palliative care services integrated within the national cancer care system. The KCCC provides comprehensive cancer services, including palliative care. The adult PCC offers both inpatient and outpatient services. Inpatient consultation teams operate in seven general hospitals: Adan, Amiri, Jaber, Jahra, Mubarak, Farwaniyah, and Sabah. Home healthcare services are also available for adult patients. pediatric palliative care is provided through five inpatient services located in major hospitals, one outpatient clinic, and one home care program delivered by BACCH, an independent non-profit organization. In the private sector, three palliative care consultants offer outpatient services, and two provide home-based care.

RATE OF SPECIALIZED PC SERVICES/100,000 INH



Ind 14

14.1. There is a system of specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.

3

Generalized provision: palliative care specialized services or teams for children exist in many parts of the country but with some gaps.

14.2. Number of pediatric specialized PC services or teams in the country.

7

PPC TEAMS

Kuwait has a total of seven specialized pediatric palliative care services. BACCH is the region's first dedicated pediatric hospice, offering inpatient, outpatient, home-based, and hospice care. BACCH provides comprehensive services, including pain and symptom management, end-of-life care, respite, and bereavement support. Additional inpatient pediatric palliative care services are available at Adan, Farwaniyah, Jahra, and NBK Hospitals, the latter specialising in pediatric hematological malignancies. These hospital units integrate complex care and hospice support within pediatric wards. Of the seven services, three are located at BACCH (inpatient, outpatient, and home care), while four correspond to inpatient services in public hospitals. Despite this infrastructure at the secondary and tertiary levels, primary care integration remains limited, and home-based services are not yet widely available across the country.

COUNTRY REPORTS

EM

Lebanon

General data

POPULATION, 2024
5,805,962

PHYSICIANS/1000 INH, 2020-2022
2.62

Socioeconomic data

COUNTRY INCOME LEVEL, 2022
Lower middle

HUMAN DEVELOPMENT INDEX RANKING, 2023
102

GDP PER CAPITA (US$), 2022
N/A

HEALTH EXPENDITURE, 2021
307.13

UNIVERSAL HEALTH COVERAGE, 2021
73

WHO FRAMEWORK FOR PALLIATIVE CARE DEVELOPMENT

Ⓐ EMPOWERMENT OF PEOPLE AND COMMUNITIES
Ⓑ POLICIES
Ⓒ RESEARCH
Ⓓ USE OF ESSENTIAL MEDICINES
Ⓔ EDUCATION AND TRAINING
Ⓕ PROVISION OF PC

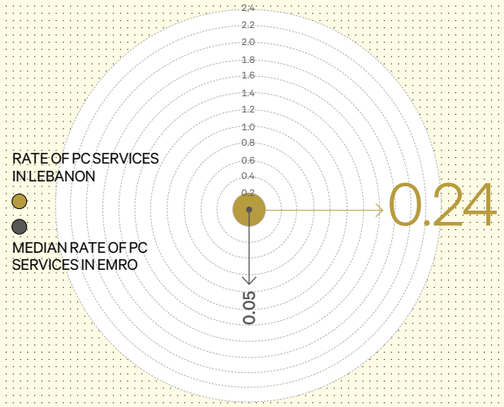
LEVEL OF DEVELOPMENT: 1 EMERGING · 2 PROGRESSING · 3 ESTABLISHED · 4 ADVANCED

Ⓕ Provision of PC (Specialized Services)

Total number of Specialized PC services: **14**

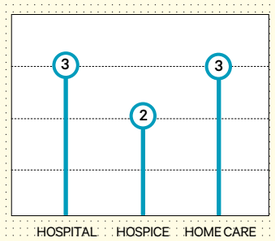
Rate of PC services per 100,000 inhabitants: **0.24**

Lebanon in the context of EMRO



Geographic distribution and integration of PC services

Level of development of different types of PC services



Pediatric PC Services

GEOGRAPHIC DISTRIBUTION AND INTEGRATION: 2

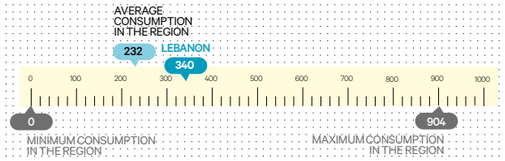
TOTAL NUMBER: **2**

Lebanon

Ⓓ Use of essential medicines

Opioids consumption (excluding methadone): **340** S-DDD/MILL INHABITANTS/DAY

Lebanon in the context of EMRO



Overall availability of essential medicines for pain and PC at the primary level

General availability of immediate-release oral morphine at the primary level

Ⓒ Research

PC-related research articles: 4

Existence of PC congresses or scientific meetings: 3

National Association: Lebanese Palliative Care Society; National Committee for Pain Relief and Palliative Care; The Palliative Care Nursing Association.

Consultants: Farah Demachkieh; Hibah Osman; Michel Daher; Rana Yamout.

Data collected: January-June 2025.

Report validated by consultants: Yes

Endorsed by National PC Association: Yes

Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching: **5/8**

Nursing schools with mandatory PC teaching: **8/8**

Recognition of PC specialty: 3

Ⓑ Policies

National PC plan or strategy: 2

Responsible authority for PC in the Ministry of Health: 3

Inclusion of PC in the basic health package at the primary care level: 2

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients: 3

Advanced care planning-related policies: 3

EM Lebanon

People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their caregivers, and disease survivors.

3

Existence of group(s) that cover palliative care in a more integrated way or over a wider range of disease/program areas.

Organizations and healthcare professionals providing palliative care actively advocate for patients' needs and rights. In 2011, the National Committee for Pain Relief and Palliative Care was created under the auspices of the MoPH to promote education, raise awareness, and improve palliative care services in the country. In 2023, the Lebanese Palliative Care Society was established within the Lebanese Order of Physicians, comprising approximately 30 members. The same year, the Palliative Care Nursing Association was formed under the Order of Nursing in Lebanon, with 50 members. These groups contribute to raising awareness and improving palliative care services in the country.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

3

There is/are national policies or guidelines on living wills and/or on advanced directives.

Lebanon does not have a formal national policy or guideline on advance directives or advance care planning, though some legal provisions exist. Patients can legally appoint a health proxy or surrogate decision-maker, but this practice is rarely implemented or widely known. The Code of Medical Ethics (Article 27, no. 11) prohibits euthanasia and emphasizes preserving patient dignity by limiting excessive treatment with family and physician consent. The Law on Patient Rights and Informed Consent (2004) also allows surrogate decision-making, but it is rarely applied. The National Committee for Palliative Care, in collaboration with the National Ethics and Bioethics Committee and the Lebanese Order of Physicians, has worked on legislation regarding surrogate decision-making and living wills. While recommendations for advance care planning have been included in the National Cancer Plan of Lebanon, implementation is still underway, and no structured policy has been fully enforced.

Policies

Ind 3

3.1. There is a current national PC plan, program, policy, or strategy.

2

Developed over 5 years ago.

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

3

There is a dedicated section on palliative care contained within another national plan such as for cancer, NC diseases or HIV.

While past efforts have been made, including the National palliative care Plan developed over five years ago by the National Committee for palliative care under the MoHP, it has not been implemented. Instead, palliative care is integrated into the National Cancer Control Plan (2023–2028), which includes a supportive care chapter with general recommendations and measurable action points. A one-year evaluation of the cancer plan was conducted, but many palliative care-related targets remain under discussion. Additionally, financial, political, and security crises have hindered regulatory progress. As a result, Lebanon lacks a dedicated national palliative care plan with a fully defined and implemented framework.

EM Lebanon

Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

3

The indicators exist, but have not been updated (implemented out of the determined period).

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

2

Decree or law to include palliative care in the list of health services provided at the primary care level in preparation.

Palliative care is not yet integrated into primary healthcare and is not included in any Universal Health Coverage (UHC) packages within Lebanon's national health system. A 2018 palliative care policy brief recommended integrating palliative care into primary care, but this has not been implemented. The one-year evaluation of the National Health Strategy (2023) outlined Strategic Objective 2.1.2, which aims to develop a unified essential benefits package covering promotive, preventive, primary, hospital, and palliative care for all citizens. However, this package has not yet been established, nor has the health benefits task force responsible for its implementation. A draft law for UHC is currently under discussion in Parliament, but progress remains limited, with work still in the initial stages.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

3

There is a coordinating entity but has an incomplete structure (lack of scientific or technical section).

5.2. The national authority has concrete functions, budget and staff.

3

There are concrete functions and staff, but do not have a budget.

Lebanon does not have a dedicated national authority (unit, branch, or department) within the MoHP responsible for palliative care. In 2011, the National Committee for Pain Relief and Palliative Care was established through Decree No. 1/486, structured into four subcommittees. However, it has been inactive since 2018 and requires revitalization. In 2023, an expert group selected by MoPH developed the National Cancer Plan (2023–2028). An advisory group, including palliative care experts, was formed to oversee implementation. However, efforts rely on volunteer work, and there is no dedicated budget, staff, or structured resources for palliative care within MoPH.

EM Lebanon

Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC.

3

At least one non-palliative care congress or conference (cancer, HIV, chronic diseases, etc.) that regularly has a track or section on palliative care, each 1-2 years (and no national conference specifically dedicated to PC).

Lebanon has hosted national palliative care conferences, with notable events since 2017. These include the 2018 National Conference for Physicians and Nurses at Saint George Hospital-UMC, and the 2019 National Palliative Care Conference organized by the American University of Beirut (AUB). The 2023 conference centerd on the theme of dignity in palliative and end-of-life care. Additional conferences have been held at Hôtel-Dieu de France and Bellevue Hospital in 2025. Palliative care has also been featured in broader cancer care events, such as the 2023 conference at USJ University. A regional palliative care conference took place in 2019, and palliative care topics are regularly integrated into family medicine and oncology meetings. Although there are currently no recurring national congresses solely dedicated to palliative care, the field continues to be represented within larger healthcare forums.

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

4

Denotes an extensive number of articles published on the subject.

With 244 articles found in PubMed meeting inclusion criteria, the publication rate is 4.23 publications per 100,000 inhabitants. While research activity is advancing, funding remains minimal.

Medicines

Ind 8

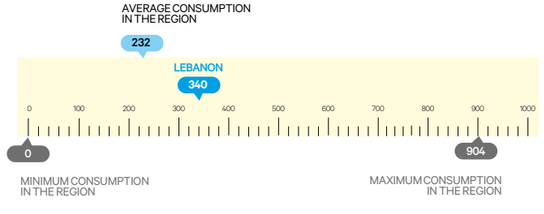
Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

Average consumption of opioids, in defined daily doses (S-DDD) for statistical purposes per million inhabitants per day, 2022.

340

S-DDD PER MILLION INHAB /DAY

COUNTRY VS REGION



EM Lebanon

Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

2

Fair: Between 10% to 30%.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

1

Poor: Between 0% to 10%.

In Lebanon, palliative care is not yet integrated at the primary care level, but some essential medications are available. Approximately 42% of the essential pain and palliative care medications from the WHO Model List are accessible at primary healthcare centers (PHCs), including acetylsalicylic acid, ibuprofen, paracetamol, amitriptyline, dexamethasone, haloperidol, hyoscine butyl bromide, lactulose, and metoclopramide. However, availability is inconsistent due to supply fluctuations and accessibility issues. The same medication lists apply to both urban and rural PHCs, though essential palliative care medicines are more commonly found in urban areas and large hospitals. Pain medications are covered by the MoPH, yet affordability remains a challenge. Additionally, reliable data on opioid distribution is lacking, and even injectable and IR oral morphine is sometimes unavailable in rural areas.

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

In Lebanon, immediate-release (IR) oral morphine (both liquid and tablet forms) is not available at the primary care level, as opioids are not permitted in primary healthcare facilities. Only oncologists, pain specialists (anaesthesiologists), and palliative care physicians are authorized to prescribe opioids. Access to opioids has been a growing challenge due to political instability, economic hardship, and regional conflict, which have also led to a lack of reliable data on annual opioid consumption over the past five years. Lebanon previously had better opioid consumption levels, but recent restrictions have significantly limited access. However, in 2024, local production of IR morphine was initiated, marking a potential improvement in availability and access for patients in need.

EM Lebanon

Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)

5/8

11.2. The proportion of medical schools with OPTIONAL teaching in PC.

0/8

11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).

8/8

11.4. The proportion of nursing schools with OPTIONAL teaching in PC.

0/8

Palliative care is formally integrated into the undergraduate curricula of 62.5% of medical schools (5 out of 8) and 87.5% of nursing schools (6 out of 8). Medical schools incorporating palliative care include Saint George University of Beirut, Lebanese University, the American University of Beirut, Saint Joseph University, and the University of Balamand. Nursing schools with palliative care education include the same institutions, along with Beirut Arab University, Antoine University School of Nursing, and the Lebanese American University. Palliative care is included within mandatory courses, as medical and nursing curricula in Lebanon are standardized and do not allow for elective subjects. However, there is no published information on how extensively it is integrated.

Ind 12

Existence of an official specialization process in palliative medicine for physicians, recognized by the competent authority in the country.

3

There is no process on specialization for palliative care physicians but exists other kind of diplomas with official recognition (i.e., certification of the professional category or of the job position of palliative care physician).

In Lebanon, palliative medicine was officially recognized as a medical specialty by the MoPH in 2013 (the requirement is two years of postgraduate training). However, specialization training or fellowship programs in palliative care have not been available, and most people who are currently licensed have received their palliative care training abroad. The American University of Beirut has developed a one-year postgraduate academic diploma as a specialized training program for multidisciplinary professionals, which was launched in March 2025.

EM Lebanon

Provision of PC / Specialized Services

Ind 13

13.1. There is a system of specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.

2

Isolated provision: Exists but only in some geographic areas.

13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.

3

In a growing number of private hospitals.

13.3. Free-standing HOSPICES (including hospices with inpatient beds).

2

Ad hoc/ in some parts of the country.

13.4. HOME CARE teams (specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.

3

Found in many parts of the country.

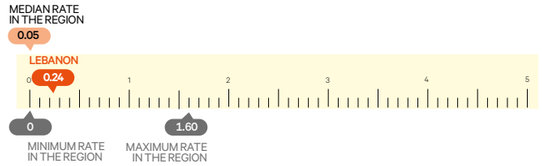
13.5. Total number of specialized PC services or teams in the country.

14

← SPECIALIZED PALLIATIVE CARE SERVICES

Lebanon has a limited system of specialized palliative care services, primarily concentrated in urban areas, especially Beirut. The country lacks a centralized system with updated data on service availability. There are 14 palliative care services in total, including seven hospital-based and seven home-based services. Beirut has the highest concentration, while other regions have minimal coverage. Beqaa, the North, and the South each have one home-based service, and Mount Lebanon and the North each have one hospital-based service. Palliative care is mainly available in large teaching hospitals, including Rafik Hariri University Hospital (public), AUBMC, Clemenceau Medical Center, Saint George Hospital-UMC, Haikal Hospital, and Hôtel-Dieu de France. Home-based services operate independently as donor-funded NGOs, without government or private insurance support, limiting accessibility. These include SANAD (Beirut and Beqaa), Balsam, Sanabel El Nour, SAWA, Imam Sader Foundation, and Palliative Care Passion homecare teams.

RATE OF SPECIALIZED PC SERVICES/100,000 INH



Ind 14

14.1. There is a system of specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.

2

Isolated provision: palliative care specialized services or teams for children exist but only in some geographic areas.

14.2. Number of pediatric specialized PC services or teams in the country.

2

PPC TEAMS

In Lebanon, specialized pediatric palliative care services are extremely limited, with only two providers: the American University of Beirut Medical Center (AUBMC) and Balsam. AUBMC offers inpatient consultation services, while Balsam provides home-based palliative care.

EM

Libya

General data

POPULATION, 2024
7,381,023

PHYSICIANS/1000 INH, 2020-2022
N/A

Socioeconomic data

COUNTRY INCOME LEVEL, 2022
Upper middle

HUMAN DEVELOPMENT INDEX RANKING, 2023
115

GDP PER CAPITA (US$), 2023
6,172.81

HEALTH EXPENDITURE, 2021
-

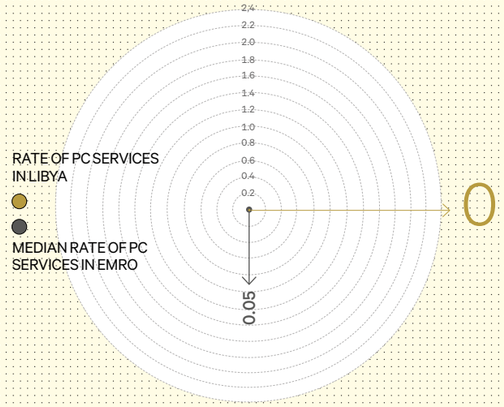
UNIVERSAL HEALTH COVERAGE, 2021
62

Ⓕ Provision of PC (Specialized Services)

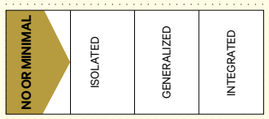
Total number of Specialized PC services: **0**

Rate of PC services per 100,000 inhabitants: **0**

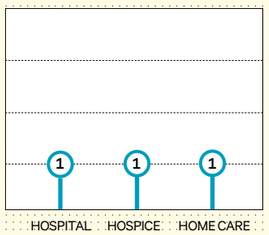
Libya in the context of EMRO



Geographic distribution and integration of PC services



Level of development of different types of PC services



Pediatric PC Services

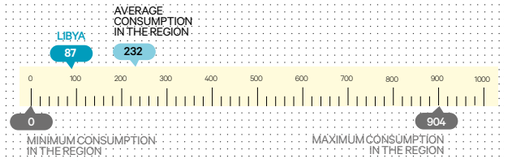
GEOGRAPHIC DISTRIBUTION AND INTEGRATION: 1

TOTAL NUMBER: N/A

Ⓓ Use of essential medicines

Opiods consumption (excluding methadone): **87** S-DDD/MILL INHABITANTS/DAY

Libya in the context of EMRO



Overall availability of essential medicines for pain and PC at the primary level

General availability of immediate-release oral morphine at the primary level

Ⓒ Research

PC-related research articles: 1

Existence of PC congresses or scientific meetings: 1

National Association: No.
Consultants: Masaud Waled.

Data collected: December 2023-March 2024.
Report validated by consultants: Yes
Endorsed by National PC Association: N/A
Report reviewed by the Ministry of Health
Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching: **0/18**

Nursing schools with mandatory PC teaching: **0/9**

Recognition of PC specialty: 1

Ⓑ Policies

National PC plan or strategy: 1

Responsible authority for PC in the Ministry of Health: 2

Inclusion of PC in the basic health package at the primary care level: 1

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients: 2

Advanced care planning-related policies: 1

EM Libya

People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their caregivers, and disease survivors.

2

Pioneers, champions, or advocators of palliative care can be identified, but without a formal organization constituted.

In Libya, there are no formalized associations or civil society groups specifically dedicated to promoting the rights of patients in need of palliative care. However, national health authorities, oncology centers, hospitals, and academic institutions have supported early activities related to palliative care. Initiatives from the Pain Management Association, WHO-supported training, and informal community actions have contributed to awareness raising and capacity building efforts across different settings.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

1

There is no national policy or guideline on advance care planning.

Currently, there is no established national policy or guideline specifically addressing advance directives or advance care planning. The healthcare system is still in the process of development and recovery, and frameworks for palliative care and end-of-life decision-making are relatively underdeveloped. While some hospitals and healthcare providers may incorporate some ACP elements informally, these practices are not standardized or widely implemented across the country. Additionally, cultural and religious values often play a significant role in end-of-life care decisions, which may influence the adoption of formal policies related to advance directives.

Policies

Ind 3

3.1. There is a current national PC plan, program, policy, or strategy.

1

Do not know or does not exist.

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

1

A national palliative care plan is in preparation.

Libya currently does not have a formalized national palliative care plan, program, policy, or strategy. Some efforts to integrate palliative care into the health system exist but remain fragmented and limited in scope. The establishment of the National Cancer Control Authority presents an opportunity to develop a comprehensive national strategy aligned with international standards. The International Palliative Outcome Scale (iPOS) has been translated into the local language, Krio, and is being used by the Connaught Palliative Care Unit, with potential for use in evaluation.

EM Libya

Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

1

Not known or does not exist.

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

1

Not at all.

No evidence found.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

2

The authority for palliative care is defined but only at political level without coordinating entity defined.

There is a dedicated palliative care department for cancer patients within the National Cancer Control Authority. This authority includes an Administration of Diagnosis, Treatment, and Palliative Care specifically for cancer patients. While it has a defined scope, budget, and functions, and focuses exclusively on cancer patients, there is considerable potential to optimize its operations and improve its overall impact.

5.2. The national authority has concrete functions, budget and staff.

2

There are concrete functions but do not have a budget or staff.

EM Libya

Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC.

1

There are no national congresses or scientific meetings related to palliative care.

It remains unclear whether national conferences on chronic diseases or cancer include a specific track or section dedicated to palliative care.

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

1

Minimal or nonexistent number of articles published on the subject in that country.

A comprehensive scoping review conducted in March 2023, covering publications from 2017 onward, did not identify any peer-reviewed articles on palliative care in Libya that all met the inclusion criteria for this indicator.

Medicines

Ind 8

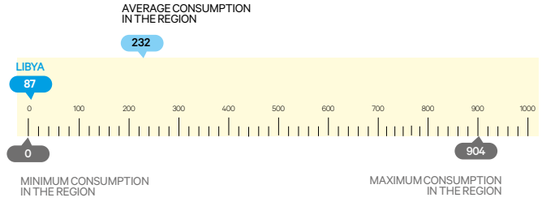
Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

Average consumption of opioids, in defined daily doses (S-DDD) for statistical purposes per million inhabitants per day, 2022.

87

S-DDD PER MILLION INHAB /DAY

COUNTRY VS REGION



EM Libya

Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

1

Poor: Between 0% to 10%.

Based on the 2017 Service Availability and Readiness Assessment report, there is limited availability of essential medicines for pain management and palliative care at the primary care level across the country. Challenges such as logistical constraints, ongoing conflicts, and supply chain issues have significantly impacted the healthcare system, hindering the consistent provision of basic palliative care medicines in primary healthcare facilities.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

1

Poor: Between 0% to 10%.

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

No evidence found.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

EM Libya

Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)	0/18	Palliative care is not formally integrated into the medical or allied health education curricula in Libya. However, some universities may include elements of palliative care within courses such as oncology, internal medicine, or pain management. Informal exposure to palliative care may occur during clinical rotations in teaching hospitals, particularly within oncology or internal medicine departments.
11.2. The proportion of medical schools with OPTIONAL teaching in PC.	0/18	
11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).	0/9	
11.4. The proportion of nursing schools with OPTIONAL teaching in PC.	0/9	

Ind 12

Existence of an official specialization process in palliative medicine for physicians, recognized by the competent authority in the country.	1 ○ ○ ○ There is no process on specialization for palliative care physicians.	No evidence found.

EM Libya

Provision of PC / Specialized Services

Ind 13

13.1. There is a system of specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.	1 ○ ○ ○ No or minimal provision of palliative care specialized services or teams exist in the country.	A private centre specializing in palliative care is known to exist in the capital city; however, no publicly available information could be found regarding its structure, services, or scope of activity.
13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.	1 ○ ○ ○ Not at all.	
13.3. Free-standing HOSPICES (including hospices with inpatient beds).	1 ○ ○ ○ Not at all.	
13.4. HOME CARE teams (specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.	1 ○ ○ ○ Not at all.	
13.5. Total number of specialized PC services or teams in the country.	0	RATE OF SPECIALIZED PC SERVICES/100,000 INH MEDIAN RATE IN THE REGION 0.05 LIBYA 0 0 MINIMUM RATE IN THE REGION 1.60 MAXIMUM RATE IN THE REGION ← SPECIALIZED PALLIATIVE CARE SERVICES

Ind 14

14.1. There is a system of specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.	1 ○ ○ ○ No or minimal provision of palliative care specialized services or teams for children exists in country.	Currently, Libya does not have a fully developed system of specialized palliative care services or dedicated teams specifically for children. There is a lack of structured and specialized pediatric palliative care services across the country.
14.2. Number of pediatric specialized PC services or teams in the country.	N/A PPC TEAMS	

EM

General data

POPULATION, 2024
38,081,173

PHYSICIANS/1000 INH, 2020-2022
N/A

Socioeconomic data

COUNTRY INCOME LEVEL, 2022
Lower middle

HUMAN DEVELOPMENT INDEX RANKING, 2023
120

GDP PER CAPITA (US$), 2023
3,771.45

HEALTH EXPENDITURE, 2021
221.11

UNIVERSAL HEALTH COVERAGE, 2021
69

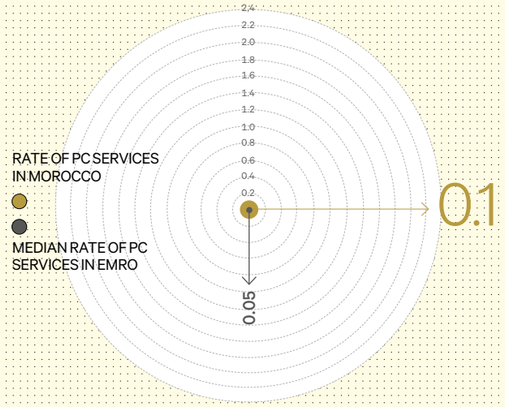
Morocco

Ⓕ Provision of PC (Specialized Services)

Total number of Specialized PC services: **37**

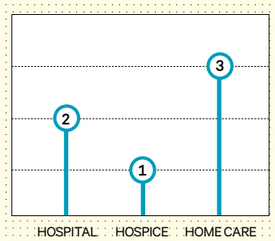
Rate of PC services per 100,000 inhabitants: **0.1**

Morocco in the context of EMRO



Geographic distribution and integration of PC services

Level of development of different types of PC services



Pediatric PC Services

GEOGRAPHIC DISTRIBUTION AND INTEGRATION: 1

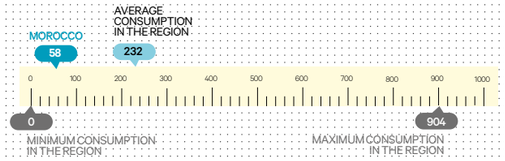
TOTAL NUMBER: **7**

EM Morocco

Ⓓ Use of essential medicines

Opioids consumption (excluding methadone): **58** S-DDD/MILL INHABITANTS/DAY

Morocco in the context of EMRO



Overall availability of essential medicines for pain and PC at the primary level

General availability of immediate-release oral morphine at the primary level

Ⓒ Research

PC-related research articles: 1

Existence of PC congresses or scientific meetings: 4

National Association: Société Marocaine des Soins Palliatifs et Traitement de la Douleur (SMSPTD) et Association Marocaine des Soins Palliatifs (AMSP).

Consultants: Awatef Belakhel; Berraho Mohamed; Elazhari Asmaa; Loubna Abousselham.

Data collected: July 2023.

Report validated by consultants: Yes

Endorsed by National PC Association: Yes

Report reviewed by the Ministry of Health

Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching: **18/18**

Nursing schools with mandatory PC teaching: **0/26**

Recognition of PC specialty: 3

Ⓑ Policies

National PC plan or strategy: 3

Responsible authority for PC in the Ministry of Health: 3

Inclusion of PC in the basic health package at the primary care level: 4

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients: 4

Advanced care planning-related policies: 1

EM Morocco

People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their caregivers, and disease survivors.

4

Strong national and sub-national presence of palliative care advocacy and promoting patient rights (as a professional association of Palliative Care, i.e.)

In Morocco, strong national and subnational advocacy for palliative care is led by two specialist associations: the Moroccan Society for Palliative Care and Pain Management (SMSPTD, founded in 1996) and the Moroccan Association for Palliative Care (AMSP, established in 2019). Both organizations support training, public engagement, and contribute to policy development. The Lalla Salma Foundation plays a key role in establishing palliative care units in oncology centers as part of the National Cancer Control Plan. The Association de Lutte Contre le Sida (ALCS) and the network of people living with HIV advocate for rights and community empowerment. Volunteer activities, coordinated through civil society networks, primarily provide socio-economic support. Public awareness and community acceptance of palliative care and opioid use are increasing, driven by patient and family demand for symptom relief and dignity at the end of life.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

1

There is no national policy or guideline on advance care planning.

In Morocco, the Official Bulletin No. 7002 (17 February 2022) provides legal provisions on end-of-life care. Article 44 states that physicians must relieve suffering and offer moral support to terminally ill patients, avoiding disproportionate or futile treatments that do not contribute to relief or dignity. Article 45 prohibits the use of outdated or unproven therapies and forbids exploitation of patient vulnerability. While these provisions establish ethical clinical conduct, there is no national policy or guideline on advance care planning (ACP), advance directives, or formal delegation of decision-making authority. The current legal framework addresses professional duties but does not empower patients to formally document or plan their future care preferences.

Policies

Ind 3

3.1. There is a current national PC plan, program, policy, or strategy.

3

Actualized in last 5 years, but not actively evaluated or audited.

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

3

There is a dedicated section on palliative care contained within another national plan such as for cancer, NC diseases or HIV.

In Morocco, palliative care is integrated into national health strategies, including the Multisectoral Strategy for Non-Communicable Diseases (2019–2029), the 2025 Health Plan, and the National Cancer Prevention and Control Plan. These frameworks include actions focused on pain management, social support, and the expansion of outpatient and home-based palliative care services. Specialized units have been established within oncology centers, and national psychosocial programs for people living with HIV incorporate palliative care components. However, there is no standalone national palliative care strategy, and funding remains limited—palliative care represents only 1% of the cancer plan's budget. Despite these challenges, the MoH recognizes palliative care as a priority, setting measurable targets and maintaining active partnerships, including with the WHO. Services for cancer patients are largely provided free of charge, supported by NGOs that offer financial, material, and training assistance. The overall strategy is nationally validated and coordinated, although certain key populations remain underserved.

EM Morocco

Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

4

The Indicators to monitor and evaluate progress are currently implemented.

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

4

Palliative care is included in the list of health services provided at the primary care level in the General Health Law.

In Morocco, palliative care is incorporated into the national minimum service package and the country's cancer control strategy. The second National Cancer Prevention and Control Plan (PNPCC) includes a strategic axis dedicated to palliative care, emphasizing pain management across hospital, outpatient, and home-based settings. Key measures focus on expanding access to pain relief, training healthcare providers, and developing regulations aligned with bioethical principles. The plan also promotes community-based palliative care, although currently this is largely limited to tertiary-level services and family involvement. These initiatives align with theWHO-EMRO strategies for cancer control, particularly in enhancing provider capacity and expanding community and home-based palliative care services. The plan outlines five core actions and eleven specific measures to improve pain relief and palliative care access across all levels of the health system.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

3

The coordinating entity but has an incomplete structure (lack of scientific or technical section).

5.2. The national authority has concrete functions, budget and staff.

4

Does not have concrete functions or resources (budget, staff, etc.)

Within the Ministry of Health and Social Protection in Morocco, palliative care is coordinated through the Division for Non-Communicable Diseases (DELM), by the cancer prevention and control service. This service is responsible for planning, supervising, and implementing palliative care activities in oncology at the national level. Their role includes defined functions and involvement of professional staff. However, these responsibilities are carried out within the broader framework of cancer control, and there is no separate organizational unit or allocated budget dedicated exclusively to palliative care across all conditions.

EM Morocco

Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC.

4

At least one national conference specifically dedicated to palliative care every 3 years.

In Morocco, two national scientific conferences exclusively focused on palliative care were held in 2022 and 2023 as international events. Palliative care was also addressed in other meetings, such as the 2017 ASCO multidisciplinary course in Marrakech on colorectal cancer. In 2021, five national webinars were organised for general practitioners and specialists, covering key topics like pain management, nutrition, symptom control, and communication.

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

1

Minimal or nonexistent number of articles published on the subject in that country.

In Morocco, there is no specific funding allocated to palliative care research. Most studies are oncology-related and supported by academic teams through external funding. Although the National Cancer Prevention and Control Plan identifies palliative care research as a priority, no dedicated budget has been established. By July 2023, 14 peer-reviewed articles had been published—ten indexed, including seven in Q1 journals. Additional outputs include national guidelines, technical reports, and medical theses on topics such as cancer pain, diagnosis disclosure, and quality of life.

Medicines

Ind 8

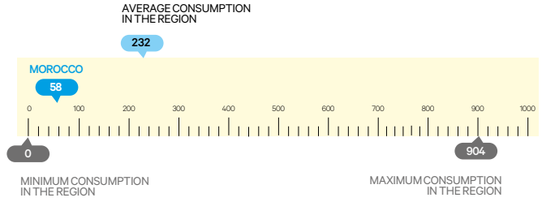
Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

Average consumption of opioids, in defined daily doses (S-DDD) for statistical purposes per million inhabitants per day, 2022.

58

S-DDD PER MILLION INHAB /DAY

COUNTRY VS REGION



EM Morocco

Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

4

Very good: Between 70% to 100%.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

4

Very good: Between 70% to 100%.

In Morocco, first-line analgesics on the WHO pain ladder are available throughout the health system. However, access to opioids remains limited. Although national regulations permit all physicians to prescribe opioids and community pharmacies to dispense them, in practice opioids are primarily restricted to regional oncology centers and selected urban pharmacies. Two opioids are available: morphine (oral immediate-release and sustained-release tablets, as well as injectable solution) and fentanyl (transdermal patches, oral tablets, and injectable solution). Transdermal and oral forms are rarely supplied by hospitals and are typically purchased by patients at considerable expense. Transmucosal fentanyl is occasionally available at two university hospitals, located in Fès and Oujda.

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

In Morocco, although legislation permits all community pharmacies to store and dispense opioids, in practice only a few—mostly located in urban areas near regional oncology centers—do so. Strict regulatory requirements and administrative burdens, alongside persistent concerns among prescribers and pharmacists, restrict access. All physicians are authorized to prescribe opioids; however, prescriptions are predominantly limited to oncologists and anaesthetists. Morphine is chiefly available within the public sector. Prescriptions must be issued on special prescription pads, with a validity of 28 days for oral forms and 10 days for injectables. No pediatric formulations exist, and oral liquid or powder morphine forms are not marketed. The Ministry of Health has recognized opioid access as a national priority, incorporating specific measures in the health strategy to train professionals and combat "morphinophobia." Despite legislative provisions, substantial practical barriers to access and prescribing persist.

EM Morocco

Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)	18/18	In Morocco, initial palliative care training within medical education remains limited. Following the 2015 reform of the medical curriculum, a basic 20-hour module on palliative care is provided during the fifth year of study, primarily concentrating on pain management. This module is predominantly delivered by anaesthetists and radiotherapists. Moreover, the Faculty of Medicine and Pharmacy in Marrakech has, over the past five years, implemented a four-day palliative care training programme for sixth-year medical students, which combines theoretical teaching with simulation-based practical sessions. Within the broader medical curriculum, palliative care is treated as a cross-cutting subject rather than as an independent discipline. Conversely, palliative care is not currently incorporated into undergraduate nursing education programmes in Morocco.
11.2. The proportion of medical schools with OPTIONAL teaching in PC.	0/18	
11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).	0/26	
11.4. The proportion of nursing schools with OPTIONAL teaching in PC.	0/26	

Ind 12

Existence of an official specialization process in palliative medicine for physicians, recognized by the competent authority in the country.	3 There is no process for specialization for palliative care physicians but exists other kinds of diplomas with official recognition (i.e., certification of the professional category or of the job position of palliative care physician).	In Morocco, specialization in palliative care is currently in development. Although accredited and certificated continuing education programs are available domestically, there is no formal national medical specialization in palliative care at present. Physicians practicing as palliative care specialists have generally completed their training abroad. Furthermore, specialized palliative care training for paramedical professionals is not yet established. While efforts to develop formalized training pathways are underway, the absence of an official specialization limits the local capacity to train and credential professionals comprehensively within this field. Consequently, Morocco relies on external training programs to prepare physicians who wish to specialize in palliative care. The development of national frameworks for specialist training, including for paramedical staff, remains a priority to enhance the quality and availability of palliative care services across the country.

EM Morocco

Provision of PC / Specialized Services

Ind 13

13.1. There is a system of specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.	1 No or minimal provision of palliative care specialized services or teams exist in the country.	In Morocco, palliative care services are available in 11 of the country's 12 administrative regions, with broad coverage in urban areas but limited access in rural regions. Public hospitals offer services through specialist teams, inpatient units, and mobile teams, whereas private sector availability remains minimal. Currently, there are 11 fixed palliative care units located within regional oncology centers in cities such as Casablanca, Rabat, Fès, and Marrakech, with an additional unit under development in Agadir. Alongside these, 26 mobile palliative care teams operate nationwide, primarily from tertiary hospitals or oncology centers, providing home visits and outpatient care for patients with advanced cancer. The Casablanca unit functions as a national referral and training center. Despite notable progress, the system continues to face challenges including shortages of trained professionals, limited specialized centers for general and end-of-life care, and inadequate follow-up for patients post-discharge.
13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.	2 Ad hoc/ in some parts of the country.	
13.3. Free-standing HOSPICES (including hospices with inpatient beds).	1 Not at all.	
13.4. HOME CARE teams (specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.	3 Found in many parts of the country.	
13.5. Total number of specialized PC services or teams in the country.	37	RATE OF SPECIALIZED PC SERVICES/100,000 INH MEDIAN RATE IN THE REGION 0.05 MOROCCO 0.1 0 MINIMUM RATE IN THE REGION 1.60 MAXIMUM RATE IN THE REGION ← SPECIALIZED PALLIATIVE CARE SERVICES

Ind 14

14.1. There is a system of specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.	1 No or minimal provision of palliative care specialized services or teams for children exists in country.	In Morocco, there are no dedicated pediatric palliative care units. However, one existing palliative care team also provides services for children. The country has six specialized pediatric oncology and hematology centers—two located in Casablanca, and one each in Rabat, Fès, Oujda, and Marrakech—all offering pediatric palliative care. Additionally, mobile palliative care teams have received training in pediatric palliative care and occasionally deliver services to children in community settings. Despite these provisions, formal pediatric palliative care remains limited, with care often integrated within broader oncology or adult services. Training and resource allocation for pediatric palliative care are still developing, and access outside major urban centers is minimal.
14.2. Number of pediatric specialized PC services or teams in the country.	7 PPC TEAMS	

EM

Occupied Palestinian Territory

General data

POPULATION, 2024
5,289,152

PHYSICIANS/1000 INH, 2020-2022
N/A

Socioeconomic data

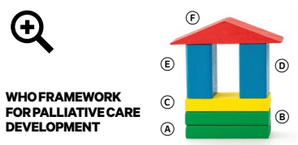
COUNTRY INCOME LEVEL, 2022
Lower middle

HUMAN DEVELOPMENT INDEX RANKING, 2023
133

GDP PER CAPITA (US$), 2023
3,372.35

HEALTH EXPENDITURE, 2021
N/A

UNIVERSAL HEALTH COVERAGE, 2021
N/A

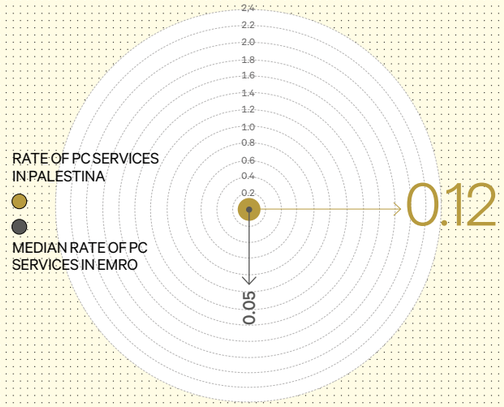


Ⓕ Provision of PC (Specialized Services)

Total number of Specialized PC services: **6**

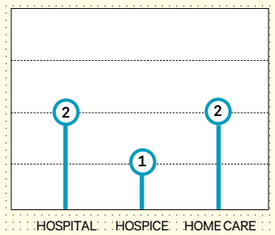
Rate of PC services per 100,000 inhabitants: **0.12**

Palestina in the context of EMRO



Geographic distribution and integration of PC services

Level of development of different types of PC services



Pediatric PC Services

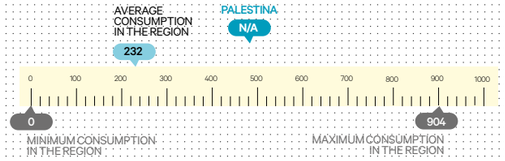
GEOGRAPHIC DISTRIBUTION AND INTEGRATION: 2

TOTAL NUMBER: 1

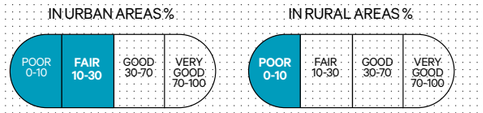
Ⓓ Use of essential medicines

Opioids consumption (excluding methadone): **N/A** S-DDD/MILL INHABITANTS/DAY

Palestina in the context of EMRO



Overall availability of essential medicines for pain and PC at the primary level



General availability of immediate-release oral morphine at the primary level

Ⓒ Research

PC-related research articles: 2

Existence of PC congresses or scientific meetings: 2

National Association: No.

Consultants: Khamis Elessi, Mhoira Leng, Abu-Odah Hammoda, Khadijah Abu Khader.

Data collected: January-June 2025.

Report validated by consultants: Yes

Endorsed by National PC Association: N/A

Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching: **1/2**

Nursing schools with mandatory PC teaching: **2/10**

Recognition of PC specialty: 2

Ⓑ Policies

National PC plan or strategy: 2

Responsible authority for PC in the Ministry of Health: 2

Inclusion of PC in the basic health package at the primary care level: 3

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients: 3

Advanced care planning-related policies: 1

EM Occupied Palestinian Territory

People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their caregivers, and disease survivors.

3

Existence of group(s) that cover palliative care in a more integrated way or over a wider range of disease/program areas.

While no formal groups in Palestina specifically advocate for the rights of palliative care patients, important efforts have been led by Dr Khamis Elessi and international collaborators. Since 2010, more than twenty workshops have been held for general and specialist doctors. In 2015, Dr Elessi, Dr Mhoira Leng, Dr Liz Grant, and colleagues developed a palliative care curriculum delivered to seven student cohorts. In 2023, the "Professional Diploma in Pain and Palliative Care" was launched in partnership with Cairdeas International, the Islamic University of Gaza, and the Turkish-Palestinian Friendship Hospital. In the West Bank, the Al-Sadeel Society has promoted awareness and caregiver education since 2008. Other key contributors include Medical Aid for Palestinians (MAP), Augusta Victoria Hospital, and Dr Hammoda Abu-Odah, a PhD nurse in Gaza, who has published over 15 articles on palliative care.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

1

There is no national policy or guideline on advance care planning.

Although Palestine does not yet have a national policy or guidelines on ACP, important initiatives have been undertaken. A national steering committee for palliative care and pain management was established in 2018 under the leadership of Dr. Khamis Elessi, with members from hospitals, NGOs, the PCRF, and WHO, aiming to integrate PC into the health system. Key actions include developing local clinical guidelines at the Turkish-Palestinian Friendship Hospital in 2023 and publishing essential drug lists for adults and children at this hospital and at Rantisi Pediatric Hospital. In the absence of national ACP regulation, efforts have focused on identifying unmet needs among cancer patients and assessing system and training requirements from healthcare professionals' perspectives.

Policies

Ind 3

3.1. There is a current national PC plan, program, policy, or strategy.

2

Developed over 5 years ago.

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

3

There is a dedicated section on palliative care contained within another national plan such as for cancer, NC diseases or HIV.

While Palestine lacks stand-alone health policies for palliative care, it has been integrated into pain management policies. In August 2023, the MoH requested a repeated situational analysis, conducted in Gaza and the West Bank. The Palestine Cancer Control Plan (National Cancer Control Strategy, 2024–2034), published in 2024, includes palliative care as a key priority under Section III and defines specific objectives in Section IV. Several Standard Operating Procedures with performance indicators have been developed, though implementation has been delayed due to ongoing conflict. In 2023, local guidelines for palliative care and pain management were created at the Turkish Palestinian Friendship Hospital (TPFH), alongside essential drug lists for adults and children at TPFH and Rantisi pediatric Hospital. Additionally, the Gaza Government established a palliative care policy committee to develop policies and guidelines for the Gaza Strip.

EM Occupied Palestinian Territory

Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

2

The indicators to monitor and evaluate progress with clear targets exist but have not been yet implemented.

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

3

Included in the essential list of services recognized by a government decree or law but not in the General Health Law.

Although palliative care services have not yet been explicitly introduced at the primary care level in Palestine, they became a priority in the MoH's strategic plans for 2022–2023. This shift reflects the growing importance of integrating palliative care within hospitals and ensuring representation on all relevant MoH palliative care committees. The MoH has agreed, in principle, to a development plan for integrating palliative care services, with a formal stakeholder meeting scheduled to finalize and implement the rollout. While services have not been fully integrated at the primary care level, these developments represent a significant step towards improving access to palliative care across healthcare facilities in Palestine.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

2

The authority for palliative care is defined but only at the political level (without a coordinating entity defined.

5.2. The national authority has concrete functions, budget and staff.

2

There are concrete functions but do not have a budget or staff.

Since 2018, a national steering committee for palliative care and pain management, chaired by Dr Khamis Elessi, has worked to integrate palliative care within hospitals and health NGOs across Palestine. The committee comprises members from various hospitals, NGOs, the Palestine Children's Relief Fund (PCRF), and the WHO. Dr Abdellatif El-Hajj, General Director of International Cooperation at the MoH, has also led capacity-building initiatives for medical staff, particularly at Gaza's Turkish Friendship Hospital. Despite these efforts, there is no specific coordinating authority for palliative care, and the MoH does not allocate a dedicated budget for its development, relying instead on NGO donations to support healthcare services, including palliative care.

EM Occupied Palestinian Territory

Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC .

2

Only sporadic or non-periodical conferences or meetings related to palliative care take place.

There is no annual national palliative care congress in Palestine; however, sporadic conferences on the subject are held regularly. A significant event was the first international conference titled "Pain Management & Palliative Care in Palestine," held on 25–26 October 2019. This conference attracted over 500 doctors and health professionals, including international experts from the USA, Norway, Britain, Japan, and Uganda, who shared knowledge with local practitioners. On the second day, two workshops took place: one on the use of opioids and strong analgesics in pain management, and another addressing the spiritual and psychosocial aspects of palliative care. Additionally, in 2018, the first Palestinian International Nursing Conference in Oncology and Palliative Care was organized.

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

2

Reflects a limited number of articles published.

Several articles published in the past five years in indexed journals have been identified, focusing on palliative care research. However, the number of such studies concerning the Palestinian population remains limited.

Medicines

Ind 8

Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

N/A

EM Occupied Palestinian Territory

Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

2

Fair: Between 10% to 30%.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

1

Poor: Between 0% to 10%.

The availability and access to opioids across the Gaza Strip are critically limited, with no access reported at the primary care level. Other essential medicines for pain and palliative care show inconsistent availability, though overall access remains generally poor throughout the region.

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

Over 50% of essential palliative care medicines were unavailable in Gaza before the current conflict due to the prolonged siege. Ongoing efforts to improve supply and local production have been disrupted, with repeated hospital displacements and destruction of pharmaceutical facilities worsening opioid shortages.

EM Occupied Palestinian Territory

Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)

1/2

11.2. The proportion of medical schools with OPTIONAL teaching in PC.

1/2

11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).

2/10

11.4. The proportion of nursing schools with OPTIONAL teaching in PC.

1/10

The Islamic University of Gaza (IUG) integrated a compulsory palliative care module into its medical curriculum and included the topic within its nursing program as part of an integrated approach. Al Azhar University, the only other medical school, offers an elective module, although formal training has not yet commenced. Since 2010, over 20 workshops on palliative care and pain management have been held for general and specialist doctors in Gaza. In 2015, an evidence-based curriculum on palliative care and pain management was developed with international partners and delivered to seven consecutive cohorts of medical students. In 2022, a postgraduate Diploma in Palliative Care was launched through collaboration between IUG, the Turkish-Palestinian Friendship Hospital, Cairdeas International Palliative Care Trust, and other partners. In 2023, the "Professional Diploma in Pain and Palliative Care" began, involving senior healthcare professionals from four hospitals, with measurable improvements in knowledge, skills, and performance across ten comprehensive modules.

Ind 12

Existence of an official specialization process in palliative medicine for physicians, recognized by the competent authority in the country.

2

There is no process on specialization for palliative care physicians but exists other type of professional training diplomas without official and national recognition (i.e., advanced training courses or masters in some universities of institutions).

There is currently no formal specialization process in palliative medicine for physicians in the Gaza Strip. However, alternative professional training opportunities exist, including the "Professional Diploma in Pain and Palliative Care." Additionally, while the Arab Board and Palestinian Board processes are present in the region, they do not yet include palliative care specialization. In response, a postgraduate Diploma in Palliative Care was established through collaboration among the Islamic University of Gaza (IUG), the Turkish-Palestinian Friendship Hospital, Cairdeas International Palliative Care Trust, and other partners, providing structured training for healthcare professionals in this field.

EM Occupied Palestinian Territory

Provision of PC / Specialized Services

Ind 13

13.1. There is a system of specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.

2

Isolated provision: Exists but only in some geographic areas.

13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.

2

Ad hoc/ in some parts of the country.

13.3. Free-standing HOSPICES (including hospices with inpatient beds).

1

Not at all.

13.4. HOME CARE teams (specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.

2

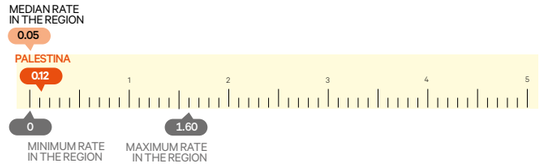
Ad hoc/ in some parts of the country.

13.5. Total number of specialized PC services or teams in the country.

6

Specialized palliative care services are officially available in two hospitals: Augusta Victoria Hospital in East Jerusalem, which also operates home-based care services in Bethlehem and Ramallah, and Rantisi pediatric Hospital in Gaza, which has a small team providing care for children with chronic and terminal illnesses. In addition, the Al-Sadeel Society, a non-governmental organization in Bethlehem, offers palliative care consultations for cancer patients and their families through a team composed of a nurse and a social worker trained in palliative care. The Turkish-Palestinian Friendship Hospital in Gaza also has a trained palliative care team, with plans to expand its services.

RATE OF SPECIALIZED PC SERVICES/100,000 INH



← SPECIALIZED PALLIATIVE CARE SERVICES

Ind 14

14.1. There is a system of specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.

2

Isolated provision: palliative care specialized services or teams for children exist but only in some geographic areas.

14.2. Number of pediatric specialized PC services or teams in the country.

1

PPC TEAMS

The Rantisi pediatric Hospital, located in Gaza, has a small team providing palliative care for children with chronic and terminal illnesses.

EM

Oman

General data

POPULATION, 2024
5,281,538

PHYSICIANS/1000 INH, 2020-2022
2.09

Socioeconomic data

COUNTRY INCOME LEVEL, 2022
High

HUMAN DEVELOPMENT INDEX RANKING, 2023
50

GDP PER CAPITA (US$), 2023
21,549.84

HEALTH EXPENDITURE, 2021
852.62

UNIVERSAL HEALTH COVERAGE, 2021
70

WHO FRAMEWORK FOR PALLIATIVE CARE DEVELOPMENT

Ⓐ EMPOWERMENT OF PEOPLE AND COMMUNITIES
Ⓑ POLICIES
Ⓒ RESEARCH
Ⓓ USE OF ESSENTIAL MEDICINES
Ⓔ EDUCATION AND TRAINING
Ⓕ PROVISION OF PC

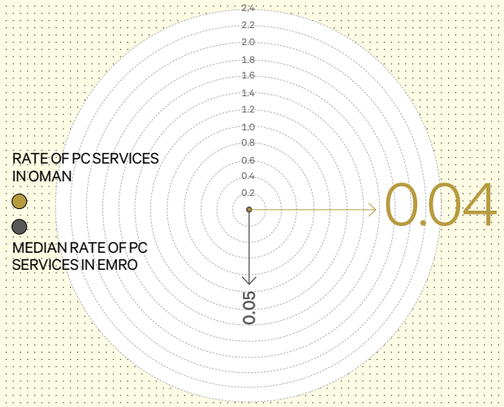
LEVEL OF DEVELOPMENT: 1 EMERGING · 2 PROGRESSING · 3 ESTABLISHED · 4 ADVANCED

Ⓕ Provision of PC (Specialized Services)

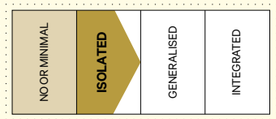
Total number of Specialized PC services: **2**

Rate of PC services per 100,000 inhabitants: **0.04**

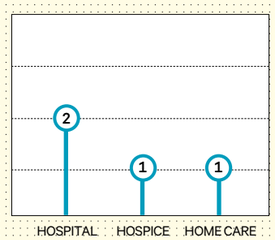
Oman in the context of EMRO



Geographic distribution and integration of PC services



Level of development of different types of PC services



Pediatric PC Services

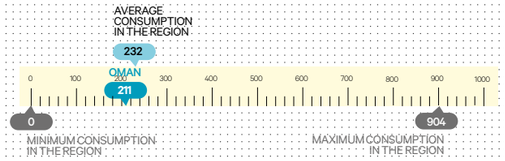
GEOGRAPHIC DISTRIBUTION AND INTEGRATION: 1 ○ ○ ○

TOTAL NUMBER: 0

Ⓓ Use of essential medicines

Opioids consumption (excluding methadone): **211** S-DDD/MILL INHABITANTS/DAY

Oman in the context of EMRO



Overall availability of essential medicines for pain and PC at the primary level

General availability of immediate-release oral morphine at the primary level

Ⓒ Research

PC-related research articles: 2 ○ ○

Existence of PC congresses or scientific meetings: 1 ○ ○ ○

National Association: No.
Consultants: Atika Al Musalami.

Data collected: January-June 2025.
Report validated by consultants: Yes
Endorsed by National PC Association: N/A.
Report reviewed by the Ministry of Health
Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching: **0/2**

Nursing schools with mandatory PC teaching: **0/12**

Recognition of PC specialty: 1 ○ ○ ○

Ⓑ Policies

National PC plan or strategy: 1 ○ ○ ○

Responsible authority for PC in the Ministry of Health: 2 ○ ○

Inclusion of PC in the basic health package at the primary care level: 1 ○ ○ ○

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients: ○ ○ 3 ○

Advanced care planning-related policies: ○ 2 ○ ○

EM Oman

People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their caregivers, and disease survivors.

3

Existence of group(s) that cover palliative care in a more integrated way or over a wider range of disease/ program areas.

The Oman Palliative Care (OPC) group advocates for the rights of patients requiring palliative care, their caregivers, and disease survivors. OPC focuses on education, community awareness, and fostering international connections. In Oman, physicians and community members have actively promoted the development of palliative care, organizing seminars with stakeholders and the MoH to highlight its importance and integration into healthcare. Although OPC's activities were particularly active until 2020, there is a lack of recent published reports on its endeavours.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

2

There is/are national policies or guidelines on surrogate decision-makers.

Currently, a policy regarding Do Not Resuscitate (DNR) orders exists, outlining the roles of decision-makers and substitute decision-makers. However, there is no established legal process for obtaining a living will or advance directive.

Policies

Ind 3

3.1. There is a current national PC plan, program, policy, or strategy.

1

Do not know or does not exist.

Oman does not have a national palliative care plan, program, policy, or strategy with a defined implementation framework. Furthermore, there is no dedicated section for palliative care in the current National Health Plans.

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

1

A national palliative care plan is in preparation.

EM Oman

Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

1

Do not know or does not exist.

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

1

Not at all.

Despite a few publications indicating that palliative care is generally available for specific populations in primary healthcare facilities, Oman has no decree or law explicitly mentioning palliative care. Furthermore, the most recent Primary healthcare costing report, published in 2023, does not include any expenditure on palliative care.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

2

The authority for palliative care is defined but only at the political level (without a coordinating entity defined.

Oman has recently established a dedicated section for palliative care at the ministerial level, situated within the rehabilitation division.

5.2. The national authority has concrete functions, budget and staff.

1

Does not have concrete functions or resources (budget, staff, etc.).

EM Oman

Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC.

1

There are no national congresses or scientific meetings related to palliative care.

No evidence found.

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

2

Reflects a limited number of articles published.

A search of PubMed Central for peer-reviewed articles on palliative care in Oman reveals a limited number of studies. Using the MeSH terms 'palliative care' and 'Oman', and covering the period from 2019 to 2024, the search yielded five results.

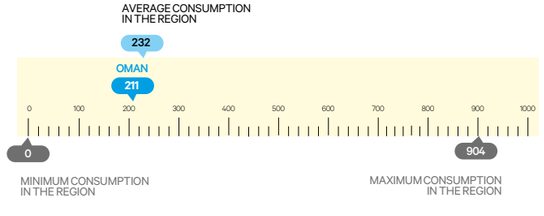
Medicines

Ind 8

Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

Average consumption of opioids, in defined daily doses (S-DDD) for statistical purposes per million inhabitants per day, 2022.

COUNTRY VS REGION



EM Oman

Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

2

Fair: Between 10% to 30%.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

1

Poor: Between 0% to 10%.

The availability of essential medicines for pain and palliative care at the primary level largely aligns with international recommendations. The consultant's list includes key opioid analgesics such as morphine, fentanyl, and codeine, alongside adjuvant medications for symptom management, including amitriptyline, dexamethasone, diazepam, metoclopramide, and ondansetron. However, comparison with the WHO Model List of Essential Medicines reveals some gaps, notably the absence of non-opioid analgesics such as aspirin, ibuprofen, and methadone, as well as essential antiemetics like cyclizine. Additionally, medications including loperamide and hyoscine hydrobromide, important for symptom control in palliative care, are not listed. Conversely, the consultant's list contains additional drugs such as pregabalin, gabapentin, and quetiapine, which may improve symptom management but are not included in the WHO's essential list.

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

At the primary care level, only injectable morphine is available. However, morphine in injectable, tablet, and syrup formulations is accessible at all cancer centers.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

EM Oman

Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)	0/2	Currently, no medical or nursing schools in the country have integrated palliative care into their undergraduate curricula. However, the Oman Medical Specialties Board (OMSB), the official body responsible for postgraduate medical training, has introduced palliative care education within selected specialization programs. This includes lectures in general medicine and general surgery, as well as a one-month rotation with the palliative care team for oncology trainees. These initiatives represent a significant step towards incorporating palliative care into medical education, although further integration at the undergraduate level remains essential.
11.2. The proportion of medical schools with OPTIONAL teaching in PC.	0/2	
11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).	0/12	
11.4. The proportion of nursing schools with OPTIONAL teaching in PC.	0/12	

Ind 12

Existence of an official specialization process in palliative medicine for physicians, recognized by the competent authority in the country.	1 ○ ○ ○ There is no process on specialization for palliative care physicians.	In Oman, there is currently no formal specialization in palliative medicine for physicians within the country. However, three physicians have received specialized training in palliative care abroad. The absence of a local training program underscores the need to develop a structured specialization pathway to strengthen palliative care services and build capacity within the healthcare system.

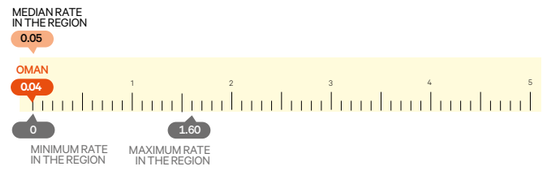
EM Oman

Provision of PC / Specialized Services

Ind 13

13.1. There is a system of specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.	● 2 ○ ○ Isolated provision: Exists but only in some geographic areas.	The country currently has two specialized palliative care teams, both operating at the tertiary level. One is based at the National Oncology Center, Royal Hospital, and the other at the Sultan Qaboos Comprehensive Cancer Center. At present, there are no dedicated palliative home care services; however, general community nursing services are available.
13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.	● 2 ○ ○ Ad hoc/ in some parts of the country.	
13.3. Free-standing HOSPICES (including hospices with inpatient beds).	1 ○ ○ ○ Not at all.	
13.4. HOME CARE teams (specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.	1 ○ ○ ○ Not at all.	
13.5. Total number of specialized PC services or teams in the country.	2 ← SPECIALIZED PALLIATIVE CARE SERVICES	

RATE OF SPECIALIZED PC SERVICES/100,000 INH



Ind 14

14.1. There is a system of specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.	1 ○ ○ ○ No or minimal provision of palliative care specialized services or teams for children exists in country.	There are currently no specialized palliative care services or teams dedicated to children in the country.
14.2. Number of pediatric specialized PC services or teams in the country.	0 PPC TEAMS	

EM

Pakistan

General data

POPULATION, 2024
251,269,164

PHYSICIANS/1000 INH, 2020-2022
1.08

Socioeconomic data

COUNTRY INCOME LEVEL, 2022
Lower middle

HUMAN DEVELOPMENT INDEX RANKING, 2023
168

GDP PER CAPITA (US$), 2023
1,365.28

HEALTH EXPENDITURE, 2021
43.09

UNIVERSAL HEALTH COVERAGE, 2021
45

WHO FRAMEWORK FOR PALLIATIVE CARE DEVELOPMENT

Ⓐ EMPOWERMENT OF PEOPLE AND COMMUNITIES
Ⓑ POLICIES
Ⓒ RESEARCH
Ⓓ USE OF ESSENTIAL MEDICINES
Ⓔ EDUCATION AND TRAINING
Ⓕ PROVISION OF PC

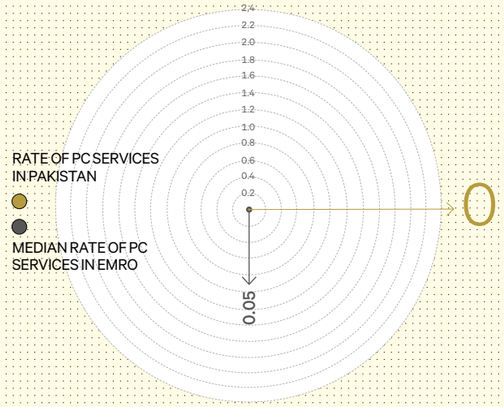
LEVEL OF DEVELOPMENT
1 EMERGING
2 PROGRESSING
3 ESTABLISHED
4 ADVANCED

Ⓕ Provision of PC (Specialized Services)

Total number of Specialized PC services: **5**

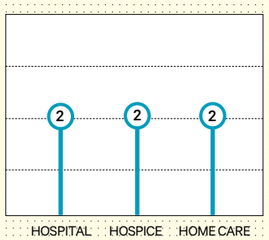
Rate of PC services per 100,000 inhabitants: **0**

Pakistan in the context of EMRO



Geographic distribution and integration of PC services

Level of development of different types of PC services



Pediatric PC Services

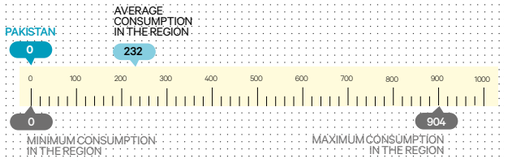
GEOGRAPHIC DISTRIBUTION AND INTEGRATION: 2

TOTAL NUMBER: **3**

Ⓓ Use of essential medicines

Opiods consumption (excluding methadone): **0** S-DDD/MILL INHABITANTS/DAY

Pakistan in the context of EMRO



Overall availability of essential medicines for pain and PC at the primary level

General availability of immediate-release oral morphine at the primary level

Ⓒ Research

PC-related research articles: 2

Existence of PC congresses or scientific meetings: 3

National Association: No.
Consultants: Atif Waqar.

Data collected: January-June 2025.
Report validated by consultants: Yes
Endorsed by National PC Association: N/A.
Report reviewed by the Ministry of Health
Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching: **10/114**

Nursing schools with mandatory PC teaching: **5/125**

Recognition of PC specialty: 4

Ⓑ Policies

National PC plan or strategy: 1

Responsible authority for PC in the Ministry of Health: 1

Inclusion of PC in the basic health package at the primary care level: 1

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients: 2

Advanced care planning-related policies: 1

EM Pakistan

People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their care-givers, and disease survivors.

2

Pioneers, champions, or advocators of palliative care can be identified, but without a formal organization constituted.

No evidence found.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

1

There is no national policy or guideline on advance care planning.

At present, there are no national policies or guidelines established for advance care planning or surrogate decision-making.

Policies

Ind 3

3.1. There is a current national PC plan, program, policy, or strategy.

1

Do not know or does not exist.

Currently, there is no national palliative care law, program, policy, or strategy established. Although a National Cancer Control program exists, it only briefly references palliative care without offering specific guidance on its delivery, available resources, or responsible providers.

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

1

A national palliative care plan is in preparation.

EM Pakistan

Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

1

Do not know or does not exist.

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

1

Not at all.

Palliative care is neither integrated nor provided at the primary care level within the national health system. Palliative care services are not included in the list of priority services for UHC.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

1

There is no authority defined.

At present, the MoH does not have a dedicated branch or department responsible for coordinating palliative care at the national level.

5.2. The national authority has concrete functions, budget and staff.

1

Does not have concrete functions or resources (budget, staff, etc.).

EM Pakistan

Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC .

3

At least one non-palliative care congress or conference (cancer, HIV, chronic diseases, etc.) that regularly has a track or section on palliative care, each 1-2 years (and no national conference specifically dedicated to palliative care)

The Shaukat Khanum Cancer Symposium is held annually, featuring both international and national speakers. Each year, the symposium includes two dedicated sessions on palliative care, along with a specialized session on pediatric palliative care.

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

2

Reflects a limited number of articles published.

Palliative care research in Pakistan is limited and primarily conducted in university hospitals, academic centers, and cancer centers in major urban areas. Over the past five years, 178 peer-reviewed articles with at least one author from Pakistan have been identified in PubMed.

Medicines

Ind 8

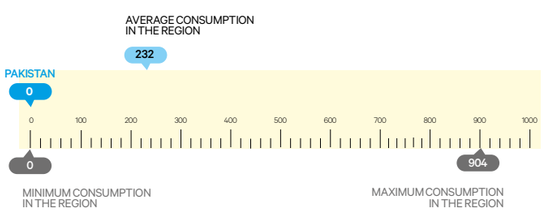
Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

Average consumption of opioids, in defined daily doses (S-DDD) for statistical purposes per million inhabitants per day, 2022.

0

S-DDD PER MILLION INHAB /DAY

COUNTRY VS REGION



EM Pakistan

Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

2

Fair: Between 10% to 30%.

No evidence found.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

2

Fair: Between 10% to 30%

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

No evidence found.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

EM Pakistan

Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)	10/114	Out of 114 medical schools, 10 have a dedicated mandatory palliative care subject, while 5 out of 125 nursing schools include palliative care as a required subject in their curriculum.
11.2. The proportion of medical schools with OPTIONAL teaching in PC.	N/A	
11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).	5/125	
11.4. The proportion of nursing schools with OPTIONAL teaching in PC.	N/A	

Ind 12

Existence of an official specialization process in palliative medicine for physicians, recognized by the competent authority in the country.	●●●● 4 Palliative medicine is a specialty or subspeciality (another denomination equivalent) recognized by competent national authorities.	Palliative Medicine is recognized as a subspecialty in Pakistan. Training consists of a two-year postgraduate clinical fellowship, which can be pursued after completing a four-year residency in either Internal Medicine or Family Medicine. The fellowship is accredited by the College of Physicians & Surgeons Pakistan (CPSP) and is currently available only at Aga Khan University in Karachi and Shaukat Khanum Cancer Hospital in Lahore. Additionally, a six-month diploma course in Palliative Care is offered at four universities nationwide.

EM Pakistan

Provision of PC / Specialized Services

Ind 13

13.1. There is a system of specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.	●●○○ 2 Isolated provision: Exists but only in some geographic areas.	In Pakistan, specialized palliative care services are limited to a few major urban centers, with no nationwide system ensuring geographic reach or multiple service delivery platforms. Palliative care is provided at Aga Khan University Hospital in Karachi, Shaukat Khanum Cancer Hospital in Lahore and Peshawar, and Shifa International Hospital in Islamabad. A total of five palliative care teams, linked to these hospitals, are offering both inpatient services and home-based care. However, access remains restricted to urban areas, and there is no formal integration of palliative care into a comprehensive national healthcare framework.
13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.	●●○○ 2 Ad hoc/ in some parts of the country.	
13.3. Free-standing HOSPICES (including hospices with inpatient beds).	●●○○ 2 Ad hoc/ in some parts of the country.	
13.4. HOME CARE teams (specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.	●●○○ 2 Ad hoc/ in some parts of the country.	RATE OF SPECIALIZED PC SERVICES/100,000 INH MEDIAN RATE IN THE REGION 0.05 PAKISTAN 0 0 MINIMUM RATE IN THE REGION 1.60 MAXIMUM RATE IN THE REGION 5 ← SPECIALIZED PALLIATIVE CARE SERVICES
13.5. Total number of specialized PC services or teams in the country.		

Ind 14

14.1. There is a system of specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.	●●○○ 2 Isolated provision: palliative care specialized services or teams for children exist but only in some geographic areas.	Pediatric palliative care services are provided at Aga Khan University Hospital in Karachi, Indus Health Network in Karachi, and Children's Cancer Hospital in Lahore.
14.2. Number of pediatric specialized PC services or teams in the country.	3 PPC TEAMS	

COUNTRY REPORTS

EM

Qatar

General data

POPULATION, 2024
2,857,822

PHYSICIANS/1000 INH, 2020-2022
N/A

Socioeconomic data

COUNTRY INCOME LEVEL, 2022
High

HUMAN DEVELOPMENT INDEX RANKING, 2023
43

GDP PER CAPITA (US$), 2023
80,195.87

HEALTH EXPENDITURE, 2021
1,934.08

UNIVERSAL HEALTH COVERAGE, 2021
76

WHO FRAMEWORK FOR PALLIATIVE CARE DEVELOPMENT

Ⓐ EMPOWERMENT OF PEOPLE AND COMMUNITIES
Ⓑ POLICIES
Ⓒ RESEARCH
Ⓓ USE OF ESSENTIAL MEDICINES
Ⓔ EDUCATION AND TRAINING
Ⓕ PROVISION OF PC

LEVEL OF DEVELOPMENT

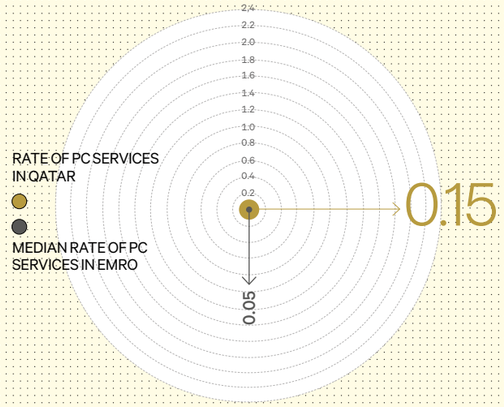
1	2	3	4
EMERGING	PROGRESSING	ESTABLISHED	ADVANCED

Ⓕ Provision of PC (Specialized Services)

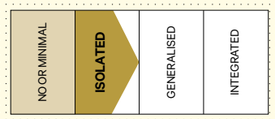
Total number of Specialized PC services **4**

Rate of PC services per 100,000 inhabitants **0.15**

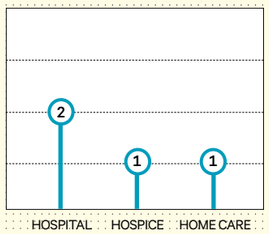
Qatar in the context of EMRO



Geographic distribution and integration of PC services



Level of development of different types of PC services



Pediatric PC Services

GEOGRAPHIC DISTRIBUTION AND INTEGRATION: 1

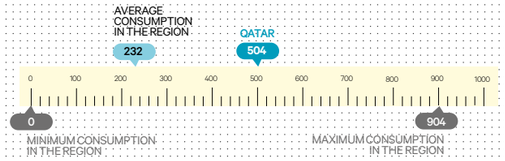
TOTAL NUMBER: 1

EM Qatar

Ⓓ Use of essential medicines

Opiods consumption (excluding methadone) **504** S-DDD/MILL INHABITANTS/DAY

Qatar in the context of EMRO



Overall availability of essential medicines for pain and PC at the primary level

General availability of immediate-release oral morphine at the primary level

Ⓒ Research

PC-related research articles: 2

Existence of PC congresses or scientific meetings: 3

National Association: No.

Consultants: Amrita Sarpal; Ayman Saleh.

Data collected: January-June 2025.

Report validated by consultants: No

Endorsed by National PC Association: N/A.

Reviewed by Ministry of Health: No

Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching **0/2**

Nursing schools with mandatory PC teaching **0/1**

Recognition of PC specialty: 4

Ⓑ Policies

National PC plan or strategy: 1

Responsible authority for PC in the Ministry of Health: 1

Inclusion of PC in the basic health package at the primary care level: 1

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients: 1

Advanced care planning-related policies: 1

EM Qatar

People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their caregivers, and disease survivors.

1 ○ ○ ○

Only isolated activity can be detected.

As of now, there are no formal groups in Qatar dedicated to advocating for the rights of palliative care patients, their caregivers, or disease survivors. Although a declaration to expand palliative care beyond oncology—covering areas such as geriatrics and dementia—was signed in November 2021 by Hamad Medical Corporation, with support from the World Innovation Summit for Health (WISH) and Alzheimer's Disease International, no advocacy groups have been established. An informal group, the Palliative Care Network – Qatar, was formed two years ago but faced significant challenges, including limited stakeholder engagement, and was ultimately unsuccessful. National laws restrict the formation of associations, particularly those involved in advocacy, hindering such efforts. Existing patient support is confined to social media-based grief support, which remains limited in scope.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

1 ○ ○ ○

There is no national policy or guideline on advance care planning.

Qatar does not have a national policy or guidelines on advance care planning, living wills, or the use of life-sustaining treatment at the end of life. However, individual health institutions may implement their own internal policies. Sidra Medicine has established guidelines addressing palliative care, end-of-life care, withdrawal and withholding of life support, Do Not Attempt Resuscitation (DNAR), and brain stem death. Hamad Medical Corporation (HMC) is also reported to have similar internal policies, though these are not publicly accessible. Institutional differences exist; for example, DNAR patients are admitted to the Palliative Intensive Care Unit at Sidra Medicine but not at HMC.

Policies

Ind 3

3.1. There is a current national PC plan, program, policy, or strategy.

1 ○ ○ ○

Do not know or does not exist.

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

1 ○ ○ ○

A national palliative care plan is in preparation.

Qatar currently lacks a specific national palliative care plan, program, policy, or strategy with a defined implementation framework. Palliative care is not addressed by any dedicated national law or integrated meaningfully into broader health strategies. The National Qatar Cancer Plan 2023–2026 includes only a brief mention of palliative care without treating it as a core component. Similarly, the National Health Strategy 2022–2024 includes only a minor reference to enhancing end-of-life services among its objectives. The upcoming National Health Strategy 2024–2030 does not prioritise palliative care or allocate a dedicated section to it.

EM Qatar

Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

1 ○ ○ ○

Do not know or does not exist.

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

1 ○ ○ ○

Not at all.

Palliative care is not included in the basic package of health services provided at the primary care level in Qatar, nor is it supported by specific or general legislation. The healthcare system is predominantly private, with palliative care mainly covered under Hamad Medical Corporation's insurance. Access to community-based services is influenced by nationality; Qatari nationals may receive private in-home nursing, while expatriates generally require private insurance for similar care. Current legal frameworks do not support home-based end-of-life care or access to essential palliative medications in outpatient settings. Additionally, the country lacks a strong primary care system, with no designated family physicians or pediatricians, resulting in palliative care being primarily delivered by specialized teams in tertiary care facilities.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

1 ○ ○ ○

There is no authority defined.

There is no designated unit, branch, or department within the MoH in Qatar specifically responsible for palliative care. However, the MoH plays a broader role in overseeing healthcare services and policy formulation, including matters related to palliative care. Collaborative efforts have occurred sporadically between the Ministry, Hamad Medical Corporation (HMC), and other stakeholders, as reflected in initiatives such as the Doha Declaration on the Development of Palliative Care in Qatar, indicating some level of involvement in advancing palliative care services.

5.2. The national authority has concrete functions, budget and staff.

1 ○ ○ ○

Does not have concrete functions or resources (budget, staff, etc.).

EM Qatar

Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC .

3

At least one non-palliative care congress or conference (cancer, HIV, chronic diseases, etc.) that regularly has a track or section on palliative care, each 1-2 years (and no national conference specifically dedicated toPC).

Qatar does not host dedicated or periodic national conferences specifically focused on palliative care. However, the World Innovation Summit for Health (WISH) Congress, held biennially, has included discussions on palliative care among its broader health topics. In addition, a limited number of dedicated talks on palliative care have taken place over the past two years.

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

2

Reflects a limited number of articles published.

Palliative care research in Qatar is limited, with most peer-reviewed academic work led by Dr Azza Adel Hassan and her colleagues at the National Center for Cancer Care and Research (NCCCR). Although not a Qatari national, Dr Hassan has resided and worked in Qatar for several years and was instrumental in establishing the adult palliative care service for cancer patients in 2008.

Medicines

Ind 8

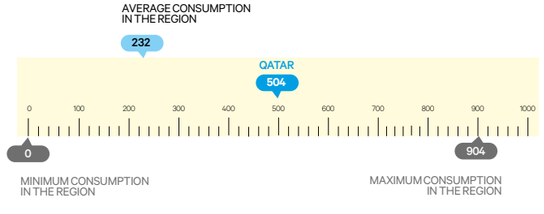
Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

Average consumption of opioids, in defined daily doses (S-DDD) for statistical purposes per million inhabitants per day, 2022.

504

S-DDD PER MILLION INHAB /DAY

COUNTRY VS REGION



EM Qatar

Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

3

Good: Between 30% to 70%.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

1

Poor: Between 0% to 10%.

The availability of essential medications for pain and palliative care in Qatar is generally good in urban health centers, particularly in Doha, where most facilities are located. However, in rural areas, access may be limited due to the scarcity of primary health centers and the concentration of the population in major cities. The prescription of controlled medications, including opioids, is strictly regulated, while other essential medications are typically accessible.

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

The availability of essential medications in Qatar appears to be generally good in urban health centers, particularly in Doha, where most facilities are located. However, in rural areas, availability may be limited due to a lack of primary health centers and the concentration of the population in major cities. The prescription of controlled medications, such as opioids, including oral morphine, is strictly regulated, while other essential medications are generally available.

EM Qatar

Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)

0/2

11.2. The proportion of medical schools with OPTIONAL teaching in PC.

1/2

11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).

0/1

11.4. The proportion of nursing schools with OPTIONAL teaching in PC.

0/1

In Qatar, there are two medical schools: Weill Cornell Medicine–Qatar (WCM-Q) and Qatar University College of Medicine. WCM-Q provides an elective clinical course in palliative care, focusing on pain management, symptom palliation, and opioid prescribing, with evaluation based on participation and presentations. Qatar University College of Medicine, though offering a comprehensive MD curriculum, does not include a dedicated palliative care subject in its published study plans. The University of Calgary in Qatar (UCQ) is the primary institution offering undergraduate and postgraduate nursing education. However, research indicates that nursing curricula in Qatar do not typically include dedicated or elective palliative care courses; instead, palliative care content is integrated into broader nursing education modules.

Ind 12

Existence of an official specialization process in palliative medicine for physicians, recognized by the competent authority in the country.

4

Palliative medicine is a specialty or subspeciality (another denomination equivalent) recognized by competent national authorities.

Palliative care is officially recognized as a sub-specialty in Qatar, with a postgraduate training program for adult palliative care. This program, designed as a fellowship sub-specialty, offers advanced training for physicians in pain management, symptom control, and holistic care for patients with life-limiting illnesses. The process of official specialization in palliative medicine for physicians was recognized by the competent authority in Qatar as of 2021. The recognition of palliative care as a sub-specialty is supported by the MoH and reflected in national health strategies and policy documents. Currently, there are an estimated 50 palliative medicine specialists practicing in the country.

EM Qatar

Provision of PC / Specialized Services

Ind 13

13.1. There is a system of specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.

2

Isolated provision: Exists but only in some geographic areas.

13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.

2

Ad hoc/ in some parts of the country.

13.3. Free-standing HOSPICES (including hospices with inpatient beds).

1

Not at all.

13.4. HOME CARE teams (specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.

1

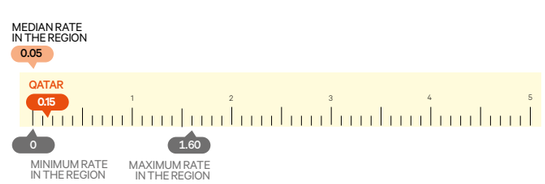
Not at all.

13.5. Total number of specialized PC services or teams in the country.

4

In Qatar, specialized palliative care services are primarily provided by the Hamad Medical Corporation (HMC), particularly through the National Center for Cancer Care and Research (NCCCR). The NCCCR offers comprehensive palliative care as part of its oncology program, utilising a multidisciplinary team and operating a 10-bed unit since 2008, which has since been expanded. Private providers, such as Clear Diamond Care, also offer palliative care focused on symptom management and emotional support. The current focus is primarily on oncology-related palliative care, with ongoing efforts to gradually extend services to address non-oncologic needs.

RATE OF SPECIALIZED PC SERVICES/100,000 INH



Ind 14

14.1. There is a system of specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.

1

No or minimal provision of palliative care specialized services or teams for children exists in country.

14.2. Number of pediatric specialized PC services or teams in the country.

1

PPC TEAMS

In Qatar, the only specialized palliative care service for children is limited to inpatient care, with a primary focus on end-of-life care. The service consists of a small team, typically including a nurse and a physician. The physician primarily serves as a liaison and administrative director, rather than providing direct patient care. This service is constrained in both scope and resources, with no broader pediatric palliative care provisions currently available.

EM

Saudi Arabia

General data

POPULATION, 2024
33,264,292

PHYSICIANS/1000 INH, 2020-2022
2.63

Socioeconomic data

COUNTRY INCOME LEVEL, 2022
High

HUMAN DEVELOPMENT INDEX RANKING, 2023
37

GDP PER CAPITA (US$), 2023
32,093.96

HEALTH EXPENDITURE, 2021
1,442

UNIVERSAL HEALTH COVERAGE, 2021
74

WHO FRAMEWORK FOR PALLIATIVE CARE DEVELOPMENT

Ⓐ EMPOWERMENT OF PEOPLE AND COMMUNITIES
Ⓑ POLICIES
Ⓒ RESEARCH
Ⓓ USE OF ESSENTIAL MEDICINES
Ⓔ EDUCATION AND TRAINING
Ⓕ PROVISION OF PC

LEVEL OF DEVELOPMENT

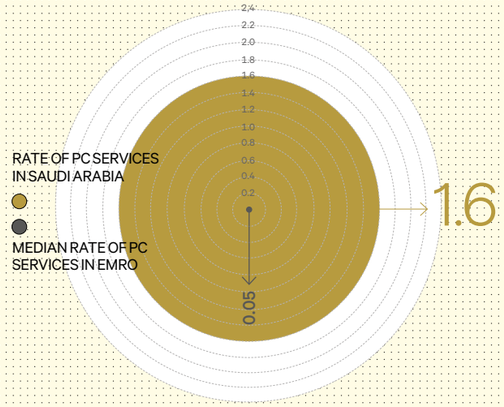
1 EMERGING · 2 PROGRESSING · 3 ESTABLISHED · 4 ADVANCED

Ⓕ Provision of PC (Specialized Services)

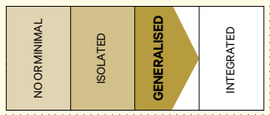
Total number of Specialized PC services **55**

Rate of PC services per 100,000 inhabitants **1.6**

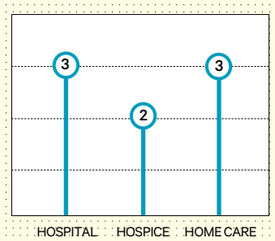
Saudi Arabia in the context of EMRO



Geographic distribution and integration of PC services



Level of development of different types of PC services



Pediatric PC Services

GEOGRAPHIC DISTRIBUTION AND INTEGRATION: 2

TOTAL NUMBER: 4

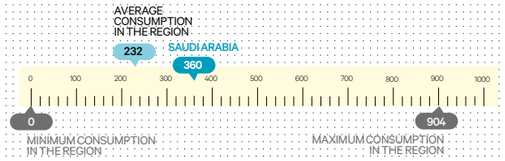
EM

Saudi Arabia

Ⓓ Use of essential medicines

Opioids consumption (excluding methadone) **360** S-DDD/MILL INHABITANTS/DAY

Saudi Arabia in the context of EMRO



Overall availability of essential medicines for pain and PC at the primary level

General availability of immediate-release oral morphine at the primary level

Ⓒ Research

PC-related research articles: 3

Existence of PC congresses or scientific meetings: 4

National Association: Saudi Society for Palliative Care.
Consultants: Mohammad Zafir Al-Shahri; Sami Alshammary.

Data collected: January-June 2025.
Report validated by consultants: Yes
Endorsed by National PC Association: Yes
Reviewed by Ministry of Health: No
Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching **1/41**

Nursing schools with mandatory PC teaching **1/39**

Recognition of PC specialty: 4

Ⓑ Policies

National PC plan or strategy: 3

Responsible authority for PC in the Ministry of Health: 3

Inclusion of PC in the basic health package at the primary care level: 2

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients: 4

Advanced care planning-related policies: 3

EM Saudi Arabia

People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their caregivers, and disease survivors.

4

Strong national and sub-national presence of palliative care advocacy and promoting patient rights (as a professional association of Palliative Care, i.e.).

The Saudi Society for Palliative Care (SSPC) is a scientific society under the umbrella of the Saudi Commission for Health Specialties. It aims to introduce palliative medicine in society in the right context and to unify the efforts of palliative medicine specialists to improve the services available to patients. Efforts to raise community awareness about palliative care include writing in local newspapers, participating in media (TV and radio), and giving talks during awareness campaigns. Recently, a new society, "The Society of Religious and Spiritual Support of Palliative Care Patients," was officially approved, focusing on one aspect of palliative care while aiming to promote the concept more broadly. The activities of this society may pave the way for establishing a public palliative care society with a broader scope.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

3

There is/are national policies or guidelines on living wills and/or on advanced directives.

Saudi Arabia has had national guidelines on DNR orders since 2017, but no official policies exist on advance directives, and surrogate decision-making lacks standardized protocols. Medical decisions are usually authorised by next of kin. While there is no stand-alone ACP policy, it is integrated into broader frameworks. The 2019 National Palliative Care Guidelines recommend family meetings to discuss goals of care and advance directives, particularly in oncology. The Home-Based Palliative Care program also promotes patient-centred decision-making. Although patient wishes are not legally binding, providers are encouraged to document and respect them, reflecting a structured, though non-legislated, approach to ACP.

Policies

Ind 3

3.1. There is a current national PC plan, program, policy, or strategy.

3

Actualized in last 5 years, but not actively evaluated or audited.

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

3

There is a dedicated section on palliative care contained within another national plan such as for cancer, NC diseases or HIV.

Saudi Arabia has established a national framework for palliative care integrated within its Vision 2030 health transformation strategy. Although a standalone comprehensive strategy has not been published, palliative care is addressed through multiple coordinated instruments. These include the National Palliative Care Guidelines—first issued in 2018 and updated in 2025—the National Palliative Care Standards (2021), and dedicated funding from the MoH since 2016. The Saudi Society for Palliative Care and the MoH jointly oversee implementation across health clusters. National efforts are supported by defined benchmarks in training, opioid availability, and service distribution. Palliative and end-of-life care are formally recognized as priorities within Vision 2030, and while no singular policy document exists, the collective measures in place function as a national strategy with structured operational components and mechanisms for monitoring progress.

EM Saudi Arabia

Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

3

The indicators exist, but have not been updated (implemented out of the determined period).

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

2

Decree or law to include palliative care in the list of health services provided at the primary care level in preparation.

Although palliative care is not explicitly included in Saudi Arabia's General Health Law, it has been progressively integrated into primary healthcare through MoH initiatives. Since the early 2000s, pilot programs have introduced palliative services at the primary care level. A Proactive Identification and Screening Guide is currently in use to support early detection of palliative needs. In 2004, a formal proposal to establish palliative care within primary care was developed by a ministerial committee; however, administrative changes delayed its approval. More recently, end-of-life care has been incorporated into the Vision 2030 national health strategy, reinforcing its strategic relevance. Despite these developments, the absence of formal legal recognition within the national package of essential health services under universal health coverage indicates that systematic inclusion remains incomplete.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

3

There is a coordinating entity but has an incomplete structure (lack of scientific or technical section).

5.2. The national authority has concrete functions, budget and staff.

3

There are concrete functions and staff, but do not have a budget.

Saudi Arabia has a clearly defined coordinating entity for palliative care within the MoH. The Department of Palliative Care at the MoH is responsible for service implementation, strategic planning, and coordination with the SSPC. It leads national initiatives, guides service expansion across all health clusters, and collaborates on training and standards development. However, while the entity has defined functions and a structured mandate, it lacks a dedicated and permanent national budget line. Staff and technical capacities are in place, but resources are often drawn from broader healthcare allocations rather than earmarked specifically for palliative care.

EM Saudi Arabia

Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC.

4

At least one national conference specifically dedicated to palliative care every 3 years.

Saudi Arabia hosts regular national scientific congresses dedicated exclusively to palliative care. The SSPC organizes national conferences every 2–3 years with participation from all MoH health clusters, academic institutions, and international experts. These meetings serve as key platforms for professional development, dissemination of research, and policy advocacy. In addition to standalone congresses, palliative care is routinely represented in broader national health conferences—such as oncology and primary care—through dedicated tracks or symposia. The sustained organization and institutionalization of these events across the country reflects a mature scientific culture around palliative care and positions Saudi Arabia at the advanced level. The last major event was the Pan Arab Palliative Care Conference in 2019, which took place at the King Faisal Specialist Hospital and Research center in Riyadh.

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

3

Represents a considerable amount of articles published.

Saudi Arabia has shown growing engagement in palliative care research, with a notable increase in peer-reviewed publications over the past five years. Topics include clinical practice, opioid accessibility, end-of-life models, and cultural aspects. Leading institutions such as King Fahad Medical City and King Faisal Specialist Hospital, in collaboration with universities and the SSPC, have been central to this progress. Research is formally integrated into the national palliative medicine fellowship curriculum as a mandatory component of training, reflecting a strengthened national research capacity in the field.

Medicines

Ind 8

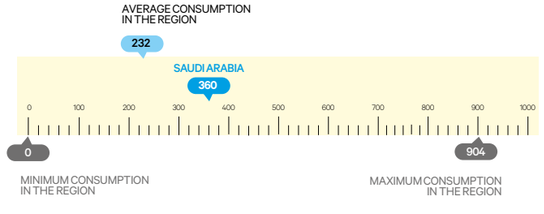
Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

Average consumption of opioids, in defined daily doses (S-DDD) for statistical purposes per million inhabitants per day, 2022.

360

S-DDD PER MILLION INHAB /DAY

COUNTRY VS REGION



EM Saudi Arabia

Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

4

Very good: Between 70% to 100%.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

2

Fair: Between 10% to 30%.

A 2024 study assessing palliative care in Saudi Arabia following Vision 2030 reforms reported significant advancements, including expanded palliative care units, community home services, outpatient care, and consultation availability. However, disparities persist in the geographical distribution of services, resource allocation, and opioid availability. The study emphasised the need to address both cancer and noncancer patient populations. By 2025, essential palliative care medicines—such as morphine, fentanyl, and oxycodone—are available in all Ministry of Health hospitals and in most primary care centers in urban areas. This improvement has been driven by national policy reforms and centralised procurement systems. In rural regions, access remains variable, though efforts through decentralised pharmaceutical distribution and mobile care teams continue to strengthen availability. The MoH has also prioritized professional training to support equitable access, contributing to improved symptom management at the primary care level nationwide.

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

3

Good: Between 30% to 70%.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

3

Good: Between 30% to 70%.

The MoH in Saudi Arabia has established a regulatory system for controlled medicines, enabling all hospitals, including those in rural areas, to request opioids in compliance with national protocols. As a result of MoH reforms in supply chains, policy support, and clinical education, morphine, oxycodone, and fentanyl are now routinely available across MoH facilities, reflecting expanded capacity for pain relief. Primary care centers primarily manage acute and chronic conditions, antenatal care, and immunisations, with a structured referral system ensuring comprehensive coverage, including remote areas. While oral immediate-release morphine is available for acute pain crises, its routine use at the primary care level remains limited. Palliative care has been increasingly integrated into the national health strategy and Vision 2030 initiatives, supported by trained teams, early identification tools, and home-based programs coordinated from primary care centers, though uniform access to oral morphine at this level is not yet fully achieved.

EM Saudi Arabia

Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)

1/41

11.2. The proportion of medical schools with OPTIONAL teaching in PC.

40/41

11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).

1/39

11.4. The proportion of nursing schools with OPTIONAL teaching in PC.

N/A

At Alfaisal University, final-year medical students receive mandatory lectures on palliative care during their oncology block. The Ministry of Education in Saudi Arabia announced that over 19,000 students are studying nursing in Saudi universities through supportive initiatives and programs. According to Vision 2030, the aim is to nationalize 67% of nursing practitioners in the Kingdom. The Ministry also reported 14,681 students in government colleges and 4,474 in private colleges, with 25 government colleges and 14 private colleges. Most of these institutions include palliative care blocks in their curricula.

Ind 12

Existence of an official specialization process in palliative medicine for physicians, recognized by the competent authority in the country.

4

Palliative medicine is a specialty or subspeciality (another denomination equivalent) recognized by competent national authorities.

Since 2012, Saudi Arabia has recognized palliative medicine as a medical subspecialty. The Saudi Commission for Health Specialties (SCFHS) formally accredits a two-year national fellowship program in palliative medicine, established in 2013 and based on the CanMEDS competency framework. The program is open to physicians holding board certifications in internal medicine, family medicine, or anaesthesia. As of 2025, a total of 27 specialists have completed the fellowship, with 31 additional fellows expected to graduate. Training is conducted at major national institutions, including King Fahad Medical City and King Faisal Specialist Hospital. The curriculum includes multidisciplinary clinical rotations, research components, and practical experience across primary, secondary, and tertiary healthcare levels. Multiple fellowship programs are currently active, contributing to the development of a formally trained palliative care workforce.

EM Saudi Arabia

Provision of PC / Specialized Services

Ind 13

13.1. There is a system of specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.

3

Generalized provision: Exists in many parts of the country but with some gaps.

13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.

3

In a growing number of private hospitals.

13.3. Free-standing HOSPICES (including hospices with inpatient beds).

2

Ad hoc/ in some parts of the country.

13.4. HOME CARE teams (specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.

3

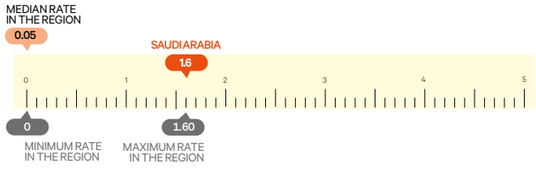
Found in many parts of the country.

13.5. Total number of specialized PC services or teams in the country.

55

Palliative care services are widely available in major hospitals nationwide, with primary care centers able to refer patients to hospitals with such services. Government hospitals have palliative care teams, with or without dedicated beds, but private hospitals lag in this area. Including end-of-life care in the country's 2030 vision will drive improvements in private hospital services. Free-standing hospices are rare, though some hospitals allocate buildings or parts of buildings for long-term and palliative care patients. Typically, palliative care units are integrated within hospital wards or have scattered beds in oncology or medical units. Many hospitals also offer home healthcare (HHC) services covering palliative and other home care aspects. Palliative care services are accessible in all regions but are more established and developed in major cities. For instance, in the capital city, Riyadh, there are well-established palliative care programs at: King Faisal Specialist Hospital and Research center, King Abdulaziz Medical City for National Guard, Prince Sultan Military Medical City, First Health Cluster, and Second Health Cluster.

RATE OF SPECIALIZED PC SERVICES/100,000 INH



← SPECIALIZED PALLIATIVE CARE SERVICES

Ind 14

14.1. There is a system of specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.

2

Isolated provision: palliative care specialized services or teams for children exist but only in some geographic areas.

14.2. Number of pediatric specialized PC services or teams in the country.

4

PPC TEAMS

Pediatric palliative care in Saudi Arabia is progressively expanding, with dedicated teams operating in three major tertiary hospitals: King Faisal Specialist Hospital and Research Center (KFSH-RC), National Guard hospitals, and, more recently, King Fahad Medical City (KFMC). The country's first pediatric hospice, Alyamamh, was established in 2019 under the MoH. PPC training is included in the national palliative medicine fellowship. While these developments reflect clear national commitment, the service-to-population ratio remains below international benchmarks, placing Saudi Arabia at a progressing level with partial but insufficient implementation to meet population needs.

EM

Somalia

General data

POPULATION, 2024
19,009,151

PHYSICIANS/1000 INH, 2020-2022
N/A

Socioeconomic data

COUNTRY INCOME LEVEL, 2022
Low

HUMAN DEVELOPMENT INDEX RANKING, 2023
192

GDP PER CAPITA (US$), 2023
597.46

HEALTH EXPENDITURE, 2021
N/A

UNIVERSAL HEALTH COVERAGE, 2021
27

WHO FRAMEWORK FOR PALLIATIVE CARE DEVELOPMENT

Ⓐ EMPOWERMENT OF PEOPLE AND COMMUNITIES
Ⓑ POLICIES
Ⓒ RESEARCH
Ⓓ USE OF ESSENTIAL MEDICINES
Ⓔ EDUCATION AND TRAINING
Ⓕ PROVISION OF PC

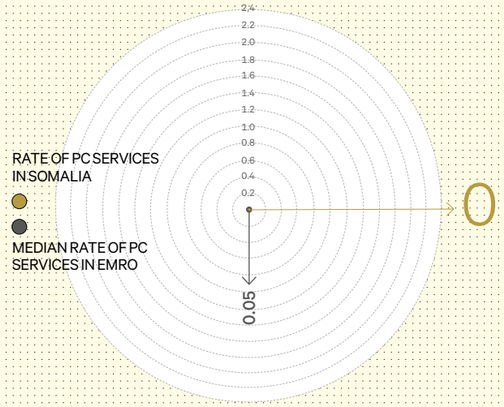
LEVEL OF DEVELOPMENT: 1 EMERGING · 2 PROGRESSING · 3 ESTABLISHED · 4 ADVANCED

Ⓕ Provision of PC (Specialized Services)

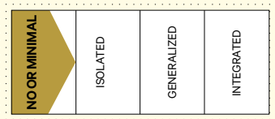
Total number of Specialized PC services: **0**

Rate of PC services per 100,000 inhabitants: **0**

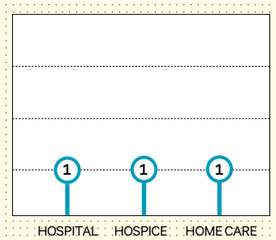
Somalia in the context of EMRO



Geographic distribution and integration of PC services



Level of development of different types of PC services



Pediatric PC Services

GEOGRAPHIC DISTRIBUTION AND INTEGRATION: 1 ○ ○ ○

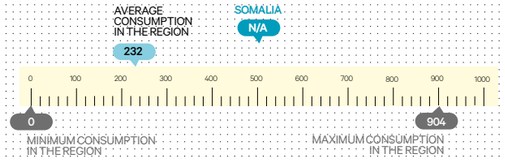
TOTAL NUMBER: 0

EM Somalia

Ⓓ Use of essential medicines

Opioids consumption (excluding methadone): **N/A** S-DDD/MILL INHABITANTS/DAY

Somalia in the context of EMRO



Overall availability of essential medicines for pain and PC at the primary level

General availability of immediate-release oral morphine at the primary level

Ⓒ Research

PC-related research articles: 1 ○ ○ ○

Existence of PC congresses or scientific meetings: 1 ○ ○ ○

National Association: No.
Consultants: Confidential.

Data collected: December 2023-March 2024.
Report validated by consultants: No
Endorsed by National PC Association: N/A.
Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching: **0/31**

Nursing schools with mandatory PC teaching: **0/6**

Recognition of PC specialty: 1 ○ ○ ○

Ⓑ Policies

National PC plan or strategy: 1 ○ ○ ○

Responsible authority for PC in the Ministry of Health: 1 ○ ○ ○

Inclusion of PC in the basic health package at the primary care level: 1 ○ ○ ○

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients: ● ● 3 ○

Advanced care planning-related policies: 1 ○ ○ ○

EM Somalia

People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their caregivers, and disease survivors.

3

Existence of group(s) that cover palliative care in a more integrated way or over a wider range of disease/ program areas.

There are various groups and organizations dedicated to promoting the rights of patients requiring palliative care, their caregivers, and disease survivors. These groups work towards advocating for the needs and rights of these individuals, raising awareness of palliative care, and improving the quality of life for those facing serious illnesses.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

1

There is no national policy or guideline on advance care planning.

Somalia does not have a national policy or guideline addressing advance care planning, surrogate decision-making, or living wills related to end-of-life care. Unlike other countries that have developed frameworks to support individuals in expressing their preferences regarding life-sustaining treatments and to guide healthcare professionals accordingly, Somalia has not established such provisions. Key national health documents, including the 2022–2027 Somali Health Sector Investment Case and the Essential Package of Health Services (EPHS), do not reference any policies related to advance care planning or end-of-life decision-making.

Policies

Ind 3

3.1. There is a current national PC plan, program, policy, or strategy.

1

Do not know or does not exist.

The Somalia Health Sector Strategic Plan 2022–2026 (HSSP III) and the Somali National Development Plan 2020–2024 do not explicitly mention palliative care as a key focus. However, palliative care is briefly referenced in the Essential Package of Health Services as a proposed intervention related to cancer management. This includes essential palliative care and pain control measures, such as oral immediate-release morphine and medications for managing associated symptoms.

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

1

Not known or does not exist neither standalone nor is included in another national plan.

EM Somalia

Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

1

Do not know or does not exist.

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

1

Not at all.

Palliative care is briefly referenced in the Essential Package of Health Services as a proposed intervention related to cancer management. This includes essential palliative care and pain control measures, such as oral immediate-release morphine and medications for managing associated symptoms. While primary health units are not currently included within this scope, the documents note that extending palliative care services to lower levels of care would be an optimal goal, resources permitting.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

1

There is no coordinating entity.

There is no authority defined.

5.2. The national authority has concrete functions, budget and staff.

1

Does not have concrete functions or resources (budget, staff, etc.).

EM Somalia

Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC.

1

There are no national congresses or scientific meetings related to palliative care.

In Somalia, palliative care remains at a very early stage of development. Consequently, no national congresses or scientific meetings dedicated specifically to palliative care have been recorded to date. The field has yet to gain sufficient recognition or momentum as a specialized area within the national health agenda to justify the organization of such events.

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

1

Minimal or nonexistent number of articles published on the subject in that country.

The average consultant perceives that the number of published articles is minimal or non-existent.

Medicines

Ind 8

Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

N/A.

EM Somalia

Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

3

Good: Between 30% to 70%.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

2

Fair: Between 10% to 30%

The Somali Essential Medicines List (2019), endorsed by the Federal Ministry of Health and WHO, includes a comprehensive section on medicines for pain and palliative care. It features core analgesics such as paracetamol and ibuprofen, alongside opioids including morphine (immediate and slow-release), codeine, and transdermal fentanyl. Importantly, the list also includes a broad range of adjuvant medicines essential for palliative care: antiemetics (ondansetron, metoclopramide), anxiolytics (midazolam, diazepam), antipsychotics (haloperidol), antidepressants (amitriptyline), anticholinergics (hyoscine), corticosteroids (dexamethasone), and laxatives (lactulose, senna). This demonstrates policy-level recognition of comprehensive symptom management. However, the document does not specify whether these medicines are routinely available in primary care settings, whether urban or rural. Thus, while the regulatory framework is in place, the practical accessibility of these essential medicines at the facility level remains uncertain.

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

In the country, oral or liquid morphine is unavailable; only injectable morphine is provided. Its use is primarily restricted to cancer patients and limited to specific clinical situations.

EM Somalia

Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)	0/31	In Somalia, palliative care is not included in the medical or nursing school curricula, either as a compulsory subject or an optional course.
11.2. The proportion of medical schools with OPTIONAL teaching in PC.	0/31	
11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).	0/6	
11.4. The proportion of nursing schools with OPTIONAL teaching in PC.	0/6	

Ind 12

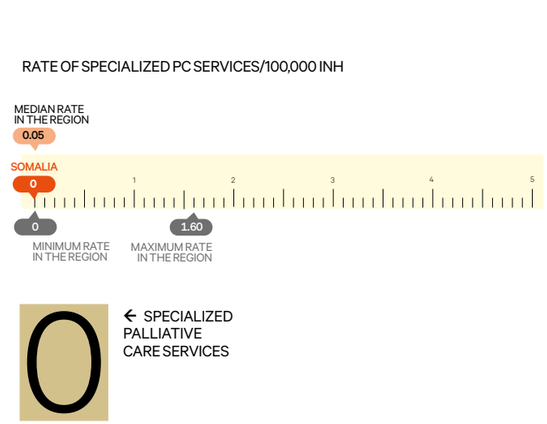
Existence of an official specialization process in palliative medicine for physicians, recognized by the competent authority in the country.	1 ○ ○ ○ There is no process on specialization for palliative care physicians.	No evidence found.

EM Somalia

Provision of PC / Specialized Services

Ind 13

13.1. There is a system of specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.	1 ○ ○ ○ No or minimal provision of palliative care specialized services or teams exist in the country.	The availability of specialized palliative care in Somalia is severely limited, primarily due to challenges such as a fragile healthcare system and resource constraints. Although the healthcare system is developing and striving for improvement, no dedicated or specialized palliative care services currently exist. Occasionally, healthcare staff may provide care for patients with severe illnesses; however, these efforts are minimal and lack a structured or specialized framework.
13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.	1 ○ ○ ○ Not at all.	
13.3. Free-standing HOSPICES (including hospices with inpatient beds).	1 ○ ○ ○ Not at all.	
13.4. HOME CARE teams (specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.	1 ○ ○ ○ Not at all.	
13.5. Total number of specialized PC services or teams in the country.		



Ind 14

14.1. There is a system of specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.	1 ○ ○ ○ No or minimal provision of palliative care specialized services or teams for children exists in country.	There is no evidence of specialized pediatric palliative care services or of trained professionals in Somalia.
14.2. Number of pediatric specialized PC services or teams in the country.	0 PPC TEAMS	

COUNTRY REPORTS

EM

Sudan

General data

POPULATION, 2024
50,448,963

PHYSICIANS/1000 INH, 2020-2022
N/A

Socioeconomic data

COUNTRY INCOME LEVEL, 2022
Low

HUMAN DEVELOPMENT INDEX RANKING, 2023
176

GDP PER CAPITA (US$), 2023
2,183.44

HEALTH EXPENDITURE, 2021
21.58

UNIVERSAL HEALTH COVERAGE, 2021
44

WHO FRAMEWORK FOR PALLIATIVE CARE DEVELOPMENT

Ⓐ EMPOWERMENT OF PEOPLE AND COMMUNITIES
Ⓑ POLICIES
Ⓒ RESEARCH
Ⓓ USE OF ESSENTIAL MEDICINES
Ⓔ EDUCATION AND TRAINING
Ⓕ PROVISION OF PC

LEVEL OF DEVELOPMENT

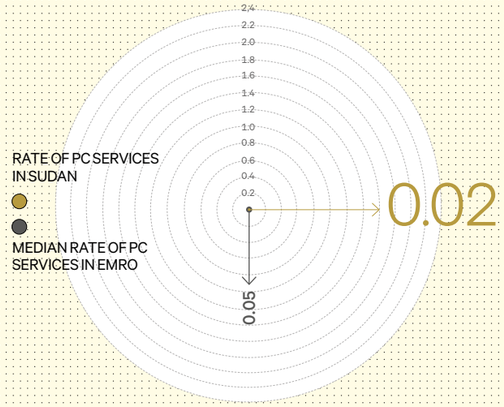
1 EMERGING · 2 PROGRESSING · 3 ESTABLISHED · 4 ADVANCED

Ⓕ Provision of PC (Specialized Services)

Total number of Specialized PC services: **5**

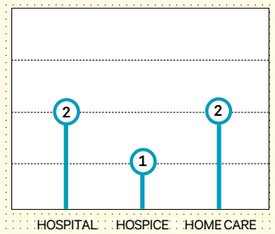
Rate of PC services per 100,000 inhabitants: **0.02**

Sudan in the context of EMRO



Geographic distribution and integration of PC services

Level of development of different types of PC services



Pediatric PC Services

GEOGRAPHIC DISTRIBUTION AND INTEGRATION: 1

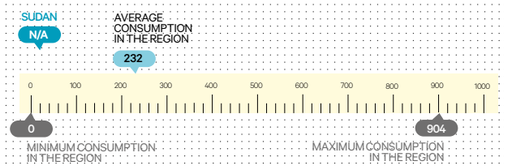
TOTAL NUMBER: 1

Sudan

Ⓓ Use of essential medicines

Opiods consumption (excluding methadone): **N/A** S-DDD/MILL INHABITANTS/DAY

Sudan in the context of EMRO



Overall availability of essential medicines for pain and PC at the primary level

General availability of immediate-release oral morphine at the primary level

Ⓒ Research

PC-related research articles: 2

Existence of PC congresses or scientific meetings: 2

National Association: No.

Consultants: Halima Ibrahim Malik Ali; Nahla Gafer; Confidential.

Data collected: December 2023-March 2024.

Report validated by consultants: Yes

Endorsed by National PC Association: N/A

Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching: **0/27**

Nursing schools with mandatory PC teaching: **1/10**

Recognition of PC specialty: 2

Ⓑ Policies

National PC plan or strategy: 3

Responsible authority for PC in the Ministry of Health: 1

Inclusion of PC in the basic health package at the primary care level: 1

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients: 3

Advanced care planning-related policies: 1

EM Sudan

People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their caregivers, and disease survivors.

3

Existence of group(s) that cover palliative care in a more integrated way or over a wider range of disease/ program areas.

Since 2010, several champions have emerged in the field of palliative care in Sudan. The Palliative Care Unit at Khartoum Oncology Hospital, in collaboration with the Federal Ministry of Health, plays an active role in promoting palliative care nationally. Additionally, the Comboni Palliative Care Volunteers, based at a higher education institution, engage directly with communities to support awareness and care initiatives.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

1

There is no national policy or guideline on advance care planning.

Sudan does not have a standalone policy or guideline specifically addressing advance care planning for life-sustaining treatment or end-of-life decisions, nor is it explicitly incorporated into broader frameworks such as the National Cancer Control program.

Policies

Ind 3

3.1. There is a current national PC plan, program, policy, or strategy.

3

Actualized in last 5 years, but not actively evaluated or audited.

Palliative care is incorporated as a strategic component in Sudan's National Cancer Control Strategies (2012–2016 and 2023–2030) and is also referenced in Non-Communicable Disease surveillance documents, which include several related indicators. However, Sudan lacks a standalone national palliative care policy, plan, or program with a clearly defined implementation framework.

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

3

There is a dedicated section on palliative care contained within another national plan such as for cancer, NC diseases or HIV.

EM Sudan

Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

2

The indicators to monitor and evaluate progress with clear targets exist but have not been yet implemented.

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

1

Not at all.

No evidence found.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

1

There is no coordinating entity.

Sudan does not currently have a national authority—such as a unit or department within the MoH—responsible for palliative care. Although the Palliative Care Unit at Khartoum Oncology Hospital has initiated dialog with the Ministry to establish an official coordinating body, the process remains incomplete and has been further impeded by the ongoing conflict.

5.2. The national authority has concrete functions, budget and staff.

1

Does not have concrete functions or resources (budget, staff, etc.).

EM Sudan

Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC.

2

Only sporadic or non-periodical conferences or meetings related to palliative care take place.

Sudan does not hold congresses or scientific meetings exclusively dedicated to palliative care. Nonetheless, palliative care activities have gradually increased. Notable events include a 2016 workshop by the Arab Association for Palliative Care Medicine under the "Awareness Without Borders" program, and the first pediatric palliative care workshop by ICPCN in 2013. In 2018, a two-week workshop was conducted in collaboration with the University of Edinburgh. More recently, palliative care has been featured in broader forums such as the 2022 Khartoum Cancer Workshop and the Gastrointestinal Surgical Conference. However, these inclusions remain occasional and lack regularity.

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

2

Reflects a limited number of articles published.

A comprehensive scoping review conducted in March 2023, covering publications from 2017 onwards, identified 14 peer-reviewed articles on palliative care in Sudan that met the inclusion criteria for this indicator.

Medicines

Ind 8

Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

N/A.

EM Sudan

Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

2

Fair: Between 10% to 30%.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

1

Poor: Between 0% to 10%.

The availability of essential medicines for pain and palliative care at the primary level in Sudan faces considerable challenges. Only 30% of the population is covered by public health services, insurance, or sickness funds, and 78% of essential medicines are primarily supplied to state hospitals through centralised procurement. Sudan relies entirely on imported medicines, with local manufacturers producing only 5% of essential medication needs. A study in Khartoum—home to 25% of PHC facilities but not representative of rural areas, where 67% of the population reside—reported an overall availability of essential medicines at 36.8%, significantly below the 48.6% national average in 2018 and the WHO's 80% target. Analgesics, critical for pain management, were available in only one-third of surveyed facilities. Affordability is also a major barrier, with medicine costs often exceeding daily wages.

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

In Sudan, oral morphine is available only at three cancer centers: the Radiation and Isotope center Khartoum (RICK), Soba University Hospital (SUH), and the National Cancer Institute at the University of Gezira (NCI-UG). Access is restricted to official working hours and is unavailable outside these institutions. Regulatory restrictions and licensing laws limit the broader distribution of strong opioids. Prescriptions are issued for a maximum of one month, necessitating monthly travel to obtain medication. Outside Khartoum and Wad Medani, availability is absent, posing significant barriers for patients in rural areas. Tramadol is more widely accessible due to its lower regulatory classification but does not substitute morphine for managing severe pain. Recent efforts to import ready-made liquid morphine have not resulted in wider distribution. Oral morphine remains free of charge for cancer patients at the designated centers.

EM Sudan

Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)

0/27

11.2. The proportion of medical schools with OPTIONAL teaching in PC.

1/27

11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).

1/10

11.4. The proportion of nursing schools with OPTIONAL teaching in PC.

1/10

Sudan has 95 medical and health colleges, including 27 medical and 10 nursing schools. Formal palliative care education remains limited, with minimal integration into undergraduate curricula. At the University of Khartoum, the Faculty of Medicine offers an optional palliative care course to fourth-year medical students, providing some exposure. In nursing, Comboni College is the sole institution with a dedicated program, introducing a fifth-year specialization in palliative care nursing in June 2022. At the University of Gezira, palliative care is briefly addressed within oncology lectures for BSc nursing students but is not formally integrated into the curriculum.

Ind 12

Existence of an official specialization process in palliative medicine for physicians, recognized by the competent authority in the country.

2

There is no process for specialization for palliative care physicians but exists other types of professional training diplomas without official and national recognition (i.e., advanced training courses or masters in some universities or institutions).

Palliative medicine is not formally recognized as a standalone specialty or subspecialty by national health authorities in Sudan. However, it is integrated into the oncology specialization for physicians through the Medical Specialization Board. Oncology registrars receive introductory training and clinical rotations at the palliative care unit. In parallel, Dr Nahla Gafer, in collaboration with international partners, has led efforts to establish a national diploma in palliative care for all health professionals.

EM Sudan

Provision of PC / Specialized Services

Ind 13

13.1. There is a system of specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.

2

Isolated provision: Exists but only in some geographic areas.

13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.

2

Ad hoc/ in some parts of the country.

13.3. Free-standing HOSPICES (including hospices with inpatient beds).

1

Not at all.

13.4. HOME CARE teams (specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.

2

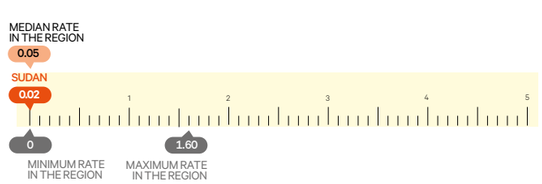
Ad hoc/ in some parts of the country.

13.5. Total number of specialized PC services or teams in the country.

5

In Sudan, palliative care services are primarily delivered through hospital-based programs within oncology centers. The Radiation Isotopic center Khartoum (RICK) and the National Cancer Institute offer comprehensive care, including outpatient, inpatient, and home-based support. Soba Hospital focuses on inpatient care, while Oncology East Hospital provides outpatient services. A hospice initiative is currently under development in Port-Sudan, with plans to offer both outpatient and home-based care.

RATE OF SPECIALIZED PC SERVICES/100,000 INH



← SPECIALIZED PALLIATIVE CARE SERVICES

Ind 14

14.1. There is a system of specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.

1

No or minimal provision of palliative care specialized services or teams for children exists in country.

14.2. Number of pediatric specialized PC services or teams in the country.

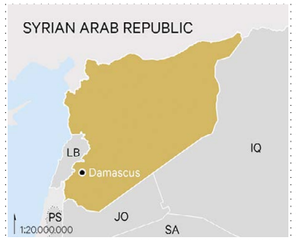
1

PPC TEAMS

Palliative care services in Sudan are primarily provided for adults. However, one nurse at Khartoum Oncology Hospital has completed a diploma in pediatric palliative care in Uganda and is currently employed at the facility.

EM

Syrian Arab Republic



General data

POPULATION, 2024
24,672,760

PHYSICIANS/1000 INH, 2020-2022
N/A

Socioeconomic data

COUNTRY INCOME LEVEL, 2022
Low

HUMAN DEVELOPMENT INDEX RANKING, 2023
162

GDP PER CAPITA (US$), 2022
N/A

HEALTH EXPENDITURE, 2021
N/A

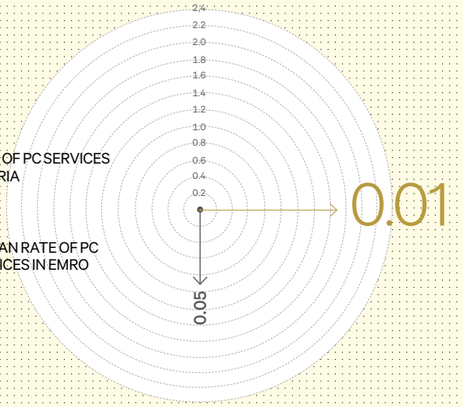
UNIVERSAL HEALTH COVERAGE, 2021
64

Ⓕ Provision of PC (Specialized Services)

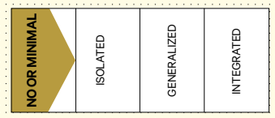
Total number of Specialized PC services: **2**

Rate of PC services per 100,000 inhabitants: **0.01**

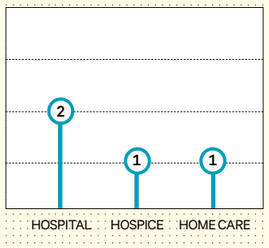
Syria in the context of EMRO



Geographic distribution and integration of PC services



Level of development of different types of PC services



Pediatric PC Services

GEOGRAPHIC DISTRIBUTION AND INTEGRATION: 1

TOTAL NUMBER: 1

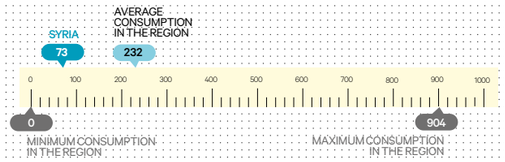
EM

Syria

Ⓓ Use of essential medicines

Opiods consumption (excluding methadone): **73** S-DDD/MILL INHABITANTS/DAY

Syria in the context of EMRO



Overall availability of essential medicines for pain and PC at the primary level

General availability of immediate-release oral morphine at the primary level

Ⓒ Research

PC-related research articles: 2

Existence of PC congresses or scientific meetings: 2

National Association: No.
Consultants: Maha Manachi.

Data collected: January-June 2025.
Report validated by consultants: No
Endorsed by National PC Association: N/A
Report reviewed by the Ministry of Health
Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching: 0/9

Nursing schools with mandatory PC teaching: 0/10

Recognition of PC specialty: 1

Ⓑ Policies

National PC plan or strategy: 1

Responsible authority for PC in the Ministry of Health: 1

Inclusion of PC in the basic health package at the primary care level: 1

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients: 1

Advanced care planning-related policies: 1

EM Syria

People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their caregivers, and disease survivors.

1

Only isolated activity can be detected.

There is no evidence of formal groups in Syria specifically advocating for the rights of palliative care patients, caregivers, or survivors. Ongoing conflict has further limited the development of civil society organizations in this field, and existing efforts are primarily embedded within hospital-based initiatives and cancer care committees, often led by the MoH or carried out in collaboration with international agencies.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

1

There is no national policy or guideline on advance care planning.

Syria lacks a national policy or guideline on advance care planning related to life-sustaining treatment or end-of-life care. Although recommendations exist to incorporate such measures within broader cancer and palliative care strategies, no formal frameworks have been adopted.

Policies

Ind 3

3.1. There is a current national PC plan, program, policy, or strategy.

1

Do not know or does not exist.

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

1

Not known or does not exist neither standalone nor is included in another national plan.

Syria does not have a national palliative care plan, program, policy, or strategy with a defined implementation framework. Although the National Cancer Control Committee, established in 2019, is responsible for developing a National Cancer Control Plan that includes recommendations for palliative care, no dedicated or operational framework currently exists. Palliative care programs remain rarely implemented, and care is principally provided by treating physicians, mainly oncologists.

EM Syria

Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

1

Not known or does not exist.

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

1

Not at all.

Palliative care is not included among Syria's priority health services under Universal Health Coverage. It is neither explicitly listed nor integrated into national health service planning, despite ongoing efforts to strengthen primary care.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

1

There is no coordinating entity.

Syria lacks a dedicated authority within the MoH for palliative care. While the National Cancer Control Committee addresses related policy, there is no evidence of dedicated roles, staff, or budget for palliative care. The specialty is not yet formally recognized, although efforts are underway. Services remain limited to a few major government hospitals.

5.2. The national authority has concrete functions, budget and staff.

1

Does not have concrete functions or resources (budget, staff, etc.).

EM Syria

Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC.

2

Only sporadic or non-periodical conferences or meetings related to palliative care take place.

There are no documented national congresses or scientific meetings in Syria specifically dedicated to palliative care. The ongoing conflict has constrained opportunities for professional gatherings, and educational content related to palliative care is instead occasionally integrated into broader medical society activities, most often under the theme of pain management.

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

2

Reflects a limited number of articles published.

Research on palliative care in Syria is limited, with at least four peer-reviewed studies over the past five years addressing provider knowledge, attitudes, community engagement, and refugee needs. These studies highlight low awareness among healthcare professionals and infrequent implementation of palliative care programs. No national research initiatives or dedicated funding have been identified, compounded by ongoing post-conflict recovery challenges.

Medicines

Ind 8

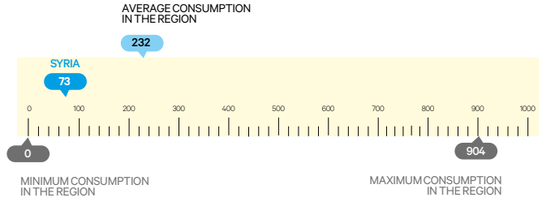
Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

Average consumption of opioids, in defined daily doses (S-DDD) for statistical purposes per million inhabitants per day, 2022.

73

S-DDD PER MILLION INHAB /DAY

COUNTRY VS REGION



EM Syria

Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

1

Poor: Between 0% to 10%.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

1

Poor: Between 0% to 10%.

Essential medicines for pain and palliative care, including immediate-release oral morphine, are not widely available in Syria, particularly at the primary care level, and the country lacks guidelines or a structured system to support access. Regional analyses highlight opioid phobia and restrictive regulations as key barriers, compounded in Syria by supply challenges and disruptions linked to the ongoing conflict. In this context, the absence of organized palliative care may lead patients to resort to unsafe or unregulated alternatives, thereby increasing the risk of misuse and addiction, especially in conflict situations.

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

Immediate-release oral morphine is not widely available at the primary care level in Syria. Although the MoH has indicated plans to consider its inclusion, current access remains limited. The literature does not provide detailed national data, but regional analyses identify restrictive regulations, opioid-related stigma, and supply challenges as significant barriers. Broader access to opioids is further hindered by the ongoing conflict and systemic disruptions within the healthcare infrastructure.

EM Syria

Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)

0/9

11.2. The proportion of medical schools with OPTIONAL teaching in PC.

0/9

11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).

0/10

11.4. The proportion of nursing schools with OPTIONAL teaching in PC.

0/10

Syria has at least nine official medical schools, including six public universities—Damascus, Aleppo, Tishreen, Al-Baath, Al-Furat, and Hama—and four private institutions: Syrian Private University, Al-Kalamoon University, Arab International University, and Al-Andalus University for Medical Sciences. A review of official university sources and academic literature reveals no evidence that palliative care is offered as a stand-alone course, either compulsory or elective, in the undergraduate curricula of any of these medical schools.

Ind 12

Existence of an official specialization process in palliative medicine for physicians, recognized by the competent authority in the country.

1 ○ ○ ○

There is no process on specialization for palliative care physicians.

Palliative medicine is not recognized as an official medical specialization in Syria, and there are no formal training programs or structured educational pathways in this field. While pain management may be briefly covered in anaesthesiology courses, comprehensive palliative care education is absent. Official lists from the MoH and Ministry of Higher Education do not include it among specialties or subspecialties eligible for postgraduate training or board certification.

EM Syria

Provision of PC / Specialized Services

Ind 13

13.1. There is a system of specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.

1 ○ ○ ○

No or minimal provision of palliative care specialized services or teams exist in the country.

13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.

● 2 ○ ○

Ad hoc/ in some parts of the country.

13.3. Free-standing HOSPICES (including hospices with inpatient beds).

1 ○ ○ ○

Not at all.

13.4. HOME CARE teams (specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.

1 ○ ○ ○

Not at all.

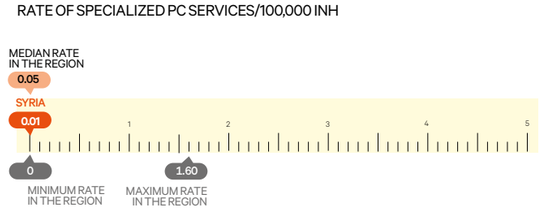
13.5. Total number of specialized PC services or teams in the country.

2

← SPECIALIZED PALLIATIVE CARE SERVICES

A regional assessment confirmed the absence of documented palliative care providers. Limited services exist within three major government hospitals, primarily in oncology or internal medicine departments, but these are not comprehensive. Humanitarian organizations provide the only known specialized services: Médecins Sans Frontières supports six hospitals in northwest Syria, including a burns facility offering palliative care as part of a multidisciplinary approach.

RATE OF SPECIALIZED PC SERVICES/100,000 INH



Ind 14

14.1. There is a system of specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.

1 ○ ○ ○

No or minimal provision of palliative care specialized services or teams for children exists in country.

Sources show that pediatric palliative care is only available at Jabel al Zawiyah Children's Hospital in Idlib, supported by Malteser International and Hand in Hand for Syria.

14.2. Number of pediatric specialized PC services or teams in the country.

1

PPC TEAMS

EM

Tunisia

General data

POPULATION, 2024
12,277,109

PHYSICIANS/1000 INH, 2020-2022
1.28

Socioeconomic data

COUNTRY INCOME LEVEL, 2022
Lower middle

HUMAN DEVELOPMENT INDEX RANKING, 2023
105

GDP PER CAPITA (US$), 2023
3,977.7

HEALTH EXPENDITURE, 2021
265.47

UNIVERSAL HEALTH COVERAGE, 2021
67

WHO FRAMEWORK FOR PALLIATIVE CARE DEVELOPMENT

Ⓐ EMPOWERMENT OF PEOPLE AND COMMUNITIES
Ⓑ POLICIES
Ⓒ RESEARCH
Ⓓ USE OF ESSENTIAL MEDICINES
Ⓔ EDUCATION AND TRAINING
Ⓕ PROVISION OF PC

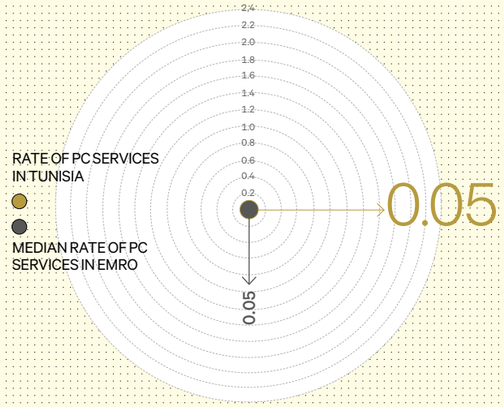
LEVEL OF DEVELOPMENT: 1 EMERGING · 2 PROGRESSING · 3 ESTABLISHED · 4 ADVANCED

Ⓕ Provision of PC (Specialized Services)

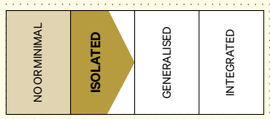
Total number of Specialized PC services: **5**

Rate of PC services per 100,000 inhabitants: **0.05**

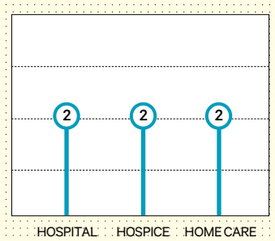
Tunisia in the context of EMRO



Geographic distribution and integration of PC services



Level of development of different types of PC services



Pediatric PC Services

GEOGRAPHIC DISTRIBUTION AND INTEGRATION: 1

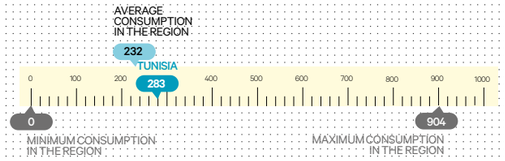
TOTAL NUMBER: 0

EM Tunisia

Ⓓ Use of essential medicines

Opioids consumption (excluding methadone): **283** S-DDD/MILL INHABITANTS/DAY

Tunisia in the context of EMRO



Overall availability of essential medicines for pain and PC at the primary level

General availability of immediate-release oral morphine at the primary level

Ⓒ Research

PC-related research articles: 2

Existence of PC congresses or scientific meetings: 2

National Association: Association Tunisienne de Soins Palliatifs.

Consultants: Henda Rais; Nesrine Mejri.

Data collected: December 2023-March 2024.

Report validated by consultants: Yes

Endorsed by National PC Association: Yes

Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching: 0/3

Nursing schools with mandatory PC teaching: 0/43

Recognition of PC specialty: 2

Ⓑ Policies

National PC plan or strategy: 2

Responsible authority for PC in the Ministry of Health: 1

Inclusion of PC in the basic health package at the primary care level: 1

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients: 3

Advanced care planning-related policies: 1

EM Tunisia

People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their care-givers, and disease survivors.

3

Existence of group(s) that cover palliative care in a more integrated way or over a wider range of disease/ program areas.

The Tunisian Association for Palliative Care (ATSP), founded in 2001, previously played a significant role in advancing the field. It established a regional branch in Gabès and collaborated with the Salah Azaiez Institute in supporting patients in the palliative phase. While no public activities have been documented since 2019, some ATSP members continue to be active in the palliative care field. Meanwhile, the Tunisian Association for the Fight Against Cancer remains active and has led awareness campaigns that may indirectly support people with palliative care needs.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

1

There is no national policy or guideline on advance care planning.

Tunisia does not have a national policy or legal framework governing advance directives (ADs) for end-of-life care. Public awareness remains limited, with only 27.1% of the targeted population familiar with ADs, although nearly half have considered their preferences for palliative care. Among surveyed physicians, 86.96% have never proposed ADs to their patients, despite 90.22% expressing willingness to do so. The lack of legal recognition is a major barrier to clinical implementation and contributes to low awareness. Nevertheless, both healthcare professionals and the public show significant conceptual support for ADs, suggesting strong potential for adoption if legislative and educational structures are established. Systemic reforms could enable the integration of ADs into Tunisia's healthcare system.

Policies

Ind 3

3.1. There is a current national PC plan, program, policy, or strategy.

2

Developed over 5 years ago.

There is currently no standalone palliative care plan or strategy. However, the 2015–2019 National Cancer Plan addressed some palliative care needs, including an estimate of 250 required palliative care beds in Tunisia. It also introduced a five-year long-term leave entitlement for cancer patients and established a dedicated annual palliative care budget line of 30,000 TND.

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

3

There is a dedicated section on palliative care contained within another national plan such as for cancer, NC diseases or HIV.

EM Tunisia

Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

3

The indicators exist, but have not been updated (implemented out of the determined period).

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

1

Not at all.

In Tunisia, palliative care is not included in the package of health services provided at the primary care level or among prioritized essential services. Current national health strategies and essential service packages focus primarily on maternal, neonatal, and other basic healthcare, without integrating palliative care into primary care structures. As a result, access to palliative care remains limited, and patients with advanced illnesses are often managed without systematic support at the community or primary care level. The absence of palliative care in national service packages highlights a significant gap in comprehensive health coverage in Tunisia.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

1

There is no coordinating entity..

There is no national coordinating authority for palliative care—such as a unit, service, or department—within Tunisia's MoH or any equivalent body responsible for this field. Hospital services are characterized by compartmentalization and a lack of coordination, with no dedicated national structure overseeing or integrating palliative care at either the policy or operational level. This absence of central leadership contributes to fragmented service provision and impedes the development and implementation of comprehensive palliative care strategies across the country.

5.2. The national authority has concrete functions, budget and staff.

1

Does not have concrete functions or resources (budget, staff, etc.).

EM Tunisia

Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC.

2

Only sporadic or non-periodical conferences or meetings related to palliative care take place.

Palliative care development in Tunisia began in 1993 with support from Douleur Sans Frontière and French experts including Prof. Philippe Poulain, Prof. Michèle Salamagne, Prof. Alain Serrie, and Prof. Bernard Calvino. British experts also contributed to the activation of the ATSP branch in Gabès. At the national level, the Tunisian Association for the Fight Against Cancer (ATCC) organizes an annual congress dedicated to palliative care. The 2024 edition focused on early palliative care and featured international experts. Regular scientific meetings in Sfax and Sousse further contribute to continuous professional development.

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

2

Reflects a limited number of articles published.

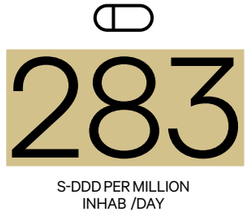
A comprehensive scoping review conducted in March 2023, covering publications from 2017 onwards, identified nine peer-reviewed articles on palliative care in Tunisia that met the inclusion criteria for this indicator. Additionally, several studies have been published in local or regional journals, addressing topics such as access to opioids for cancer pain, communication of diagnosis in oncology, national pain management strategies, and opioid dispensing by pharmacists. Further research explores patient preferences, the role of non-governmental organizations in palliative care development, challenges related to prolonged care, and preferred place of death. Recent publications also examine trends in opioid consumption and attitudes towards advance directives.

Medicines

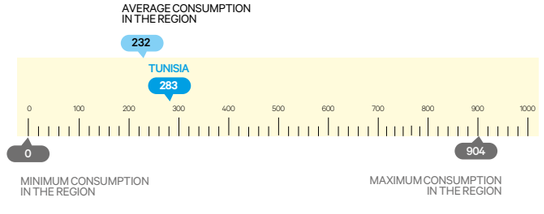
Ind 8

Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

Average consumption of opioids, in defined daily doses (S-DDD) for statistical purposes per million inhabitants per day, 2022.



COUNTRY VS REGION



EM Tunisia

Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

2

Fair: Between 10% to 30%.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

1

Poor: Between 0% to 10%.

In Tunisia, essential medicines for pain management and palliative care are available at various levels according to their category. First-step medications, such as paracetamol and anti-inflammatories, are widely accessible in hospitals, primary health centers, and private pharmacies. Second-step drugs, including codeine and tramadol, are generally available, although their use depends on price and marketing authorization. Strong third-step opioids are not accessible in primary care and are limited to certain university, regional, and private hospitals, requiring a special prescription. Although regulations permit 28-day prescriptions, these medicines are typically dispensed for only 14 days. Oral Moscontin is administered for 14 days in hospital settings and dispensed every 28 days in private pharmacies, in accordance with legal provisions. Immediate-release oral morphine is not available in hospitals but can be obtained from private pharmacies, where a minimum opioid stock is legally mandated.

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

3

Good: Between 30% to 70%.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

In Tunisia, immediate-release oral morphine, such as Oxynorm (5 mg, 10 mg, and 20 mg), is available only in private pharmacies and is primarily purchased directly by cancer patients, with higher doses imposing a substantial financial burden. In hospitals, rapid-acting morphine is administered as morphine hydrochloride, either subcutaneously or orally—often as a syrup prepared by the pharmacy for both children and adults. Access to rapid-acting morphine in university and regional hospitals is generally free for patients covered by the national health insurance (CNAM) or those with low income, with approximately 70% of these patients receiving it. However, rural areas lack access at the primary care level; patients must travel to regional hospitals to obtain morphine hydrochloride, as immediate-release tablets are unavailable in primary care settings.

EM Tunisia

Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)

0/3

11.2. The proportion of medical schools with OPTIONAL teaching in PC.

3/3

11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).

0/43

11.4. The proportion of nursing schools with OPTIONAL teaching in PC.

1/43

In Tunisia, none of the three medical faculties—located in Tunis, Sousse, and Sfax—include compulsory palliative care education within their undergraduate programs. Palliative care is offered only as an optional course through Certificates of Complementary Studies (CEC). Similarly, palliative care is not a mandatory subject in the curricula of either public or private nursing schools. Although some private nursing schools incorporate palliative care into their core curricula, participation remains optional. Despite the presence of 21 public and 22 private nursing schools in the country, none require formal palliative care training at the basic education level. This underscores a significant gap in the integration of palliative care within foundational medical and nursing education in Tunisia.

Ind 12

Existence of an official specialization process in palliative medicine for physicians, recognized by the competent authority in the country.

2

There is no process for specialization for palliative care physicians but exists other types of professional training diplomas without official and national recognition (i.e., advanced training courses or masters in some universities or institutions).

In Tunisia, physician specialization in palliative medicine is available through Certificates of Complementary Studies (CEC) and master's programs offered by several medical faculties. The Faculty of Medicine of Tunis has provided a CEC in chronic pain management since 1997, training approximately 1,250 physicians. The Faculty of Medicine of Sousse has offered a CEC in palliative care and cancer prevention since 2005, with 570 practitioners trained, including general practitioners and oncology residents. The Faculty of Medicine of Sfax offers a Master's in palliative care, with 150 graduates across four cohorts. Since 2021, an inter-university CEC in palliative care in Tunis has trained 30 physicians, some of whom have pursued further training in France. Additionally, a professional Master's in palliative care for nurses has been available in Sousse since 2010. Although palliative care is not integrated into the core medical curricula, targeted initiatives such as "La mort, parlons-en" have contributed to enriching student training.

EM Tunisia

Provision of PC / Specialized Services

Ind 13

13.1. There is a system of specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.

2

Ad hoc/ in some parts of the country.

13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.

2

Ad hoc/ in some parts of the country.

13.3. Free-standing HOSPICES (including hospices with inpatient beds).

2

Ad hoc/ in some parts of the country.

13.4. HOME CARE teams (specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.

2

Ad hoc/ in some parts of the country.

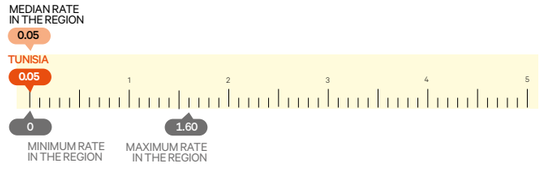
13.5. Total number of specialized PC services or teams in the country.

5

← SPECIALIZED PALLIATIVE CARE SERVICES

Specialized palliative care services in Tunisia are primarily concentrated in major regions such as Tunis, Sousse, Sfax, and Gabès. However, their availability remains inadequate for a population of approximately 12 million as of 2021. The sole dedicated palliative care unit in the country is situated at the Salah Azaiez Institute of Medical Oncology in Tunis. Established in 2008, this unit comprises eight beds and a multidisciplinary team, including a psychologist, a physiotherapist, and two nurses. Although some physicians and nurses trained in palliative care actively provide services within the community, Tunisia lacks a well-structured national network of specialized palliative care services. This limited distribution results in many regions and patients lacking adequate access to specialized palliative care, underscoring a significant gap in coverage relative to national needs.

RATE OF SPECIALIZED PC SERVICES/100,000 INH



Ind 14

14.1. There is a system of specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.

1

No or minimal provision of palliative care specialized services or teams for children exists in country.

14.2. Number of pediatric specialized PC services or teams in the country.

0

PPC TEAMS

In Tunisia, pediatric palliative care (PPC) services remain limited and are not part of any national program. Most care for children is delivered by adult oncology teams rather than specialized pediatric services. At the Salah Azaiez Institute in Tunis, the palliative care team includes children in its activities, offering pain relief and supportive care. The pediatric oncology team at Tunis Children's Hospital also provides care during the palliative phase. Similar support is available in cancer centers in Sousse, Sfax, and Gabès, though none have dedicated PPC teams or programs. As a result, children requiring palliative care are often managed within adult-oriented services.

EM

United Arab Emirates

General data

POPULATION, 2024
10,876,981

PHYSICIANS/1000 INH, 2020-2022
2.76

Socioeconomic data

COUNTRY INCOME LEVEL, 2022
High

HUMAN DEVELOPMENT INDEX RANKING, 2023
15

GDP PER CAPITA (US$), 2023
49,040.69

HEALTH EXPENDITURE, 2021
2,351.81

UNIVERSAL HEALTH COVERAGE, 2021
82

WHO FRAMEWORK FOR PALLIATIVE CARE DEVELOPMENT

Ⓐ EMPOWERMENT OF PEOPLE AND COMMUNITIES
Ⓑ POLICIES
Ⓒ RESEARCH
Ⓓ USE OF ESSENTIAL MEDICINES
Ⓔ EDUCATION AND TRAINING
Ⓕ PROVISION OF PC

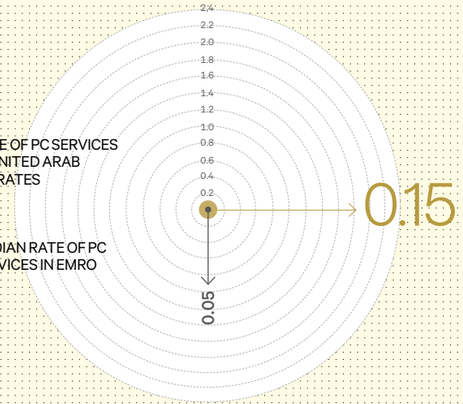
LEVEL OF DEVELOPMENT: 1 EMERGING · 2 PROGRESSING · 3 ESTABLISHED · 4 ADVANCED

Ⓕ Provision of PC (Specialized Services)

Total number of Specialized PC services: **16**

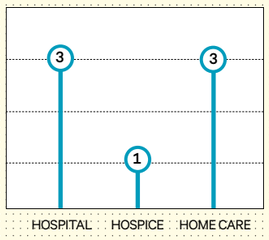
Rate of PC services per 100,000 inhabitants: **0.15**

United Arab Emirates in the context of EMRO



Geographic distribution and integration of PC services: NO OR MINIMAL · **ISOLATED** · GENERALISED · INTEGRATED

Level of development of different types of PC services



Pediatric PC Services

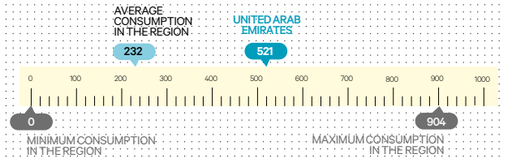
GEOGRAPHIC DISTRIBUTION AND INTEGRATION: 1

TOTAL NUMBER: **1**

Ⓓ Use of essential medicines

Opiods consumption (excluding methadone): **521** S-DDD/MILL INHABITANTS/DAY

United Arab Emirates in the context of EMRO



Overall availability of essential medicines for pain and PC at the primary level

IN URBAN AREAS %	IN RURAL AREAS %
MUY POCO 0-10 · POCO 10-30 · BIEN 30-70 · **MUY BIEN 70-100**	N/A

General availability of immediate-release oral morphine at the primary level

IN URBAN AREAS %	IN RURAL AREAS %
POOR 0-10 · FAIR 10-30 · **GOOD 30-70** · VERY GOOD 70-100	N/A

Ⓒ Research

PC-related research articles: 2

Existence of PC congresses or scientific meetings: 3

National Association: No.
Consultants: Neil Nijhawan.

Data collected: January-June 2025.
Report validated by consultants: Yes
Endorsed by National PC Association: N/A
Report reviewed by the Ministry of Health
Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching: **1/8**

Nursing schools with mandatory PC teaching: **0/6**

Recognition of PC specialty: 1

Ⓑ Policies

National PC plan or strategy: 3

Responsible authority for PC in the Ministry of Health: 2

Inclusion of PC in the basic health package at the primary care level: 2

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients: 3

Advanced care planning-related policies: 1

EM United Arab Emirates

People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their caregivers, and disease survivors.

3

Existence of group(s) that cover palliative care in a more integrated way or over a wider range of disease/ program areas.

In the UAE, no formal national organizations are exclusively dedicated to palliative care advocacy. Instead, cancer-focused initiatives partly address this role. A Palliative Care Working Group operates under the Emirates Oncology Society, and groups such as Friends of Cancer Patients (FOCP), Cancer Patient Care Society (RAHMA), Emirates Cancer Society, and Brest Friends provide psychosocial and financial support. Majlis Al Amal and The Cancer Majlis offer psychological assistance, especially for women with cancer. Home healthcare providers, including Lifecare Home Health and JPR Home healthcare, support caregivers. The Patients' Rights Charter (2021) reinforces patient engagement.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

1

There is no national policy or guideline on advance care planning.

In the UAE, there is no comprehensive national policy on ACP. Article 11 of Federal Decree-Law No. 4 of 2016 on Medical Liability permits the non-application of cardiopulmonary resuscitation in terminal cases under specific conditions without requiring patient or family consent. This provides a legal basis for certain end-of-life decisions but does not establish a complete ACP framework with patient-centered discussions, formally recognized advance directives, or standardized documentation. Some hospitals apply do-not-attempt-resuscitation (DNAR) orders institutionally. Cultural and religious values influence decision-making. Awareness is growing, with recommendations to update the Allow Natural Death (AND) policy.

Policies

Ind 3

3.1. There is a current national PC plan, program, policy, or strategy.

3

Actualized in last 5 years, but not actively evaluated or audited.

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

3

There is a dedicated section on palliative care contained within another national plan such as for cancer, NC diseases or HIV.

In the UAE, palliative care is integrated as a key pillar within the National Cancer Control Plan 2022–2026. In 2019, the Department of Health, Abu Dhabi issued subnational guidelines that serve as a regulatory reference for service provision, including symptom management, multidisciplinary care, and quality standards. The National Cancer Control Committee, under the Ministry of Health and Prevention (MoHP), also addresses palliative care as part of broader cancer control efforts. The palliative care program at Tawam Hospital, launched in 2007, remains the only government-funded service, while other specialized programs operate within the private sector. A Palliative and Supportive Care Working Group has been approved by the Emirates Medical Association. The National Cancer Control Committee has acknowledged the need to develop a comprehensive, nationwide palliative care strategy to further integrate services across the health system.

EM United Arab Emirates

Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

2

The indicators to monitor and evaluate progress with clear targets exist but have not been yet implemented.

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

2

Decree or law to include palliative care in the list of health services provided at the primary care level in preparation.

Palliative care is incorporated into the list of services within the UAE's recently developed UHC framework, though this framework has yet to be formally endorsed and applied consistently across all Emirates. At present, access is concentrated in specialized facilities, primarily in Abu Dhabi and Dubai, often within oncology departments. Health insurance coverage varies; comprehensive plans such as Thiqa 1 and 2 include long-term and palliative care services. Recent progress includes the introduction of DRG codes for inpatient and outpatient palliative care consultations, supporting service recognition and reimbursement. While a dedicated national funding model has not yet been established, these developments, alongside inclusion in the UHC framework, represent important steps toward broader integration. Continued efforts toward harmonized regulation and funding could further strengthen service availability and alignment across the health system.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

2

The authority for palliative care is defined but only at the political level (without a coordinating entity defined.

5.2. The national authority has concrete functions, budget and staff.

2

There are concrete functions but do not have a budget or staff.

The UAE Ministry of Health and Prevention holds overall responsibility for palliative care; however, there is currently no dedicated national unit. Instead, palliative care is integrated within the National Cancer Control Plan, as part of the broader cancer program under the NCD framework. The Emirates Medical Association has recently approved a Palliative and Supportive Care Working Group under the Emirates Oncology Society to promote awareness and support implementation efforts. Additionally, UAE-based experts actively contribute to the WHO Eastern Mediterranean Regional Palliative Care Expert Network, although this does not constitute a formal national authority. The establishment of a dedicated national agency for palliative care has been identified as a priority, with an anticipated development timeline of one to two years.

EM United Arab Emirates

Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC.

3

At least one non-palliative care congress or conference (cancer, HIV, chronic diseases, etc.) that regularly has a track or section on palliative care, each 1-2 years.

The UAE hosted its first national Palliative Care Conference in October 2024, with a second edition planned for 2026. Although there is no recurring national congress exclusively dedicated to palliative care, the topic features regularly in broader medical conferences such as the Emirates International Oncology Congress (EIOC), which includes consistent palliative care sessions. Additional tracks appear in events like the International Pediatric Conference and the International Conference on Global Healthcare and Medicine, typically linked to oncology or chronic illness. Pediatric palliative care was included in Al Qassimi Hospital's 2023 agenda. The Emirates Medical Association has approved a dedicated palliative and supportive care working group.

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

2

Reflects a limited number of articles published.

Palliative care research in the UAE is still developing. The current output, with 10 peer-reviewed publications, remains limited and has primarily examined systemic challenges and implementation barriers. Recent studies, including evaluations of outreach programs for advanced cancer patients, reflect growing interest in the field. At present, palliative care is not a prominent area in national research funding schemes or strategic priorities. Nevertheless, institutions such as the United Arab Emirates University, Tawam Hospital, and the Mohammed Bin Rashid Medical Research Institute have built strong oncology research foundations, offering a platform to expand into palliative care and strengthen evidence-based practice.

Medicines

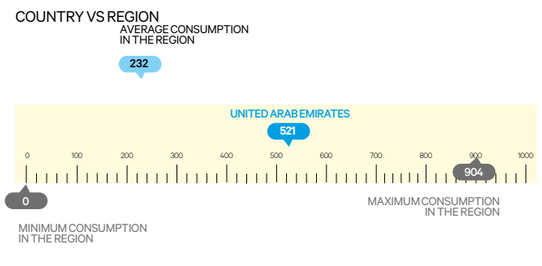
Ind 8

Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

Average consumption of opioids, in defined daily doses (S-DDD) for statistical purposes per million inhabitants per day, 2022.

521

S-DDD PER MILLION INHAB /DAY



EM United Arab Emirates

Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

4

Very good: Between 70% to 100%.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

Not applicable.

According to the National Responsible Authority for Drugs in the UAE, essential medicines for pain and palliative care, including those listed by the IAHPC, are available in accredited hospitals across all Emirates within a centralized and regulated healthcare system. These facilities provide morphine, midazolam, haloperidol, and oral methadone (5 mg tablets), ensuring consistent access for the population. Immediate-release oral morphine is included in the UAE National Essential Medicines List, developed in coordination with federal and local health authorities. National opioid consumption reflects rational prescribing policies aimed at balancing appropriate use and prevention of misuse. The Unified Electronic Platform for controlled substances supports prescribing and dispensing, including after-hours access through caregivers, thereby ensuring continuity of care across hospital and licensed pharmacy settings.

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

3

Good: Between 30% to 70%.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

Not applicable.

Immediate-release (IR) oral morphine, in both liquid and tablet form, is not routinely available at the primary care level in the UAE. Access is generally concentrated in hospitals and clinics providing oncology services, with no evidence of regular stocking or dispensing in primary care facilities. At this level, codeine and codeine–paracetamol combinations are prescribed, though these are not equivalent substitutes for morphine in palliative care. While there have been some advances in opioid availability, access remains focused on tertiary and specialist centers, with limited provision in community-based settings. The WHO classifies the UAE as having limited morphine availability, influenced by existing regulatory requirements. These factors present challenges for outpatient and home-based end-of-life care, with national availability still below global adequacy benchmarks.

EM United Arab Emirates

Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)

1/8

11.2. The proportion of medical schools with OPTIONAL teaching in PC.

0/8

11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).

0/6

11.4. The proportion of nursing schools with OPTIONAL teaching in PC.

0/6

As of 2025, one private medical school includes a dedicated standalone course in palliative care within its curriculum. In most cases, palliative care topics are integrated into broader courses through lectures or clinical case discussions rather than taught as distinct modules. The number of hours allocated to palliative care education varies widely and is difficult to quantify, particularly when content is embedded within other subjects. Elective opportunities in palliative care exist in some institutions but are inconsistently available. In nursing education, accredited institutions do not offer compulsory standalone modules on palliative care in their BSN programs, although some include relevant content within general nursing subjects.

Ind 12

Existence of an official specialization process in palliative medicine for physicians, recognized by the competent authority in the country.

1

There is no process on specialization for palliative care physicians.

In recent years, the MoHP has taken steps toward the formal recognition of palliative care as a medical specialty. Early discussions are in progress to establish a national fellowship program, with preparatory work aimed at future accreditation of palliative medicine within the country's medical education system. As of 2025, an officially accredited specialization or fellowship for physicians has not yet been implemented. Structured postgraduate curricula, formal training pathways, and designated faculty in palliative care are in development. Current training opportunities are primarily offered through non-mandatory lectures or elective modules within broader residency programs, such as internal medicine or emergency medicine. Many teaching hospitals do not yet have dedicated palliative care services to support comprehensive clinical training. Physicians seeking advanced specialization frequently pursue it abroad.

EM United Arab Emirates

Provision of PC / Specialized Services

Ind 13

13.1. There is a system of specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.

2

Ad hoc/ in some parts of the country.

13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.

3

In a growing number of private hospitals.

13.3. Free-standing HOSPICES (including hospices with inpatient beds).

1

Not at all.

13.4. HOME CARE teams (specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.

3

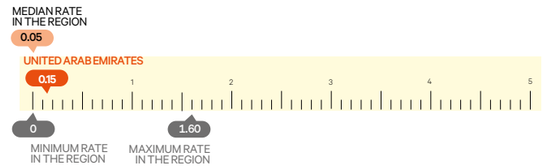
Found in many parts of the country.

13.5. Total number of specialized PC services or teams in the country.

16

As of 2025, the UAE has 16 specialized palliative care services, including hospital-based teams and home-based providers. Tawam Hospital in Al Ain remains the only public palliative care unit, offering inpatient and outpatient services for adults and children, dedicated beds, nurse-led outreach, and interventional pain management. Additional programs have developed in both public and private hospitals between 2014 and 2020, with services available at institutions such as Burjeel Medical City, American Hospital Dubai, Mediclinic City Hospital, and Cleveland Clinic Abu Dhabi, often linked to oncology. Pediatric-specific services remain limited. Home-based providers—such as LifeCare, JPR, Nightingale, and Aims Healthcare—operate in major emirates, though coverage and insurance reimbursement vary. In Abu Dhabi, the Department of Health has implemented an updated home care model to improve quality and integration. Regulatory barriers to prescribing injectable opioids in the community continue to limit home-based end-of-life care. No standalone hospices currently exist.

RATE OF SPECIALIZED PC SERVICES/100,000 INH



← SPECIALIZED PALLIATIVE CARE SERVICES

Ind 14

14.1. There is a system of specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.

1

No or minimal provision of palliative care specialized services or teams for children exists in country.

14.2. Number of pediatric specialized PC services or teams in the country.

1

PPC TEAMS

Specialized pediatric palliative care in the UAE is very limited. The American Hospital Dubai hosts the only dedicated program, affiliated with the Mayo Clinic's ComPASS initiative, offering inpatient and outpatient care. Al Qassimi Women's and Children's Hospital provides some pediatric-focused services but lacks a structured team, while other hospitals may include children within general programs. No formal home-based pediatric palliative care services exist.

COUNTRY REPORTS

EM

Yemen

General data

POPULATION, 2024
40,583,164

PHYSICIANS/1000 INH, 2020-2022
N/A

Socioeconomic data

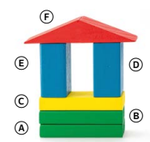
COUNTRY INCOME LEVEL, 2022
Low

HUMAN DEVELOPMENT INDEX RANKING, 2023
184

GDP PER CAPITA (US$), 2023
477.41

HEALTH EXPENDITURE, 2021
N/A

UNIVERSAL HEALTH COVERAGE, 2021
42



WHO FRAMEWORK FOR PALLIATIVE CARE DEVELOPMENT

Ⓐ EMPOWERMENT OF PEOPLE AND COMMUNITIES
Ⓑ POLICIES
Ⓒ RESEARCH
Ⓓ USE OF ESSENTIAL MEDICINES
Ⓔ EDUCATION AND TRAINING
Ⓕ PROVISION OF PC

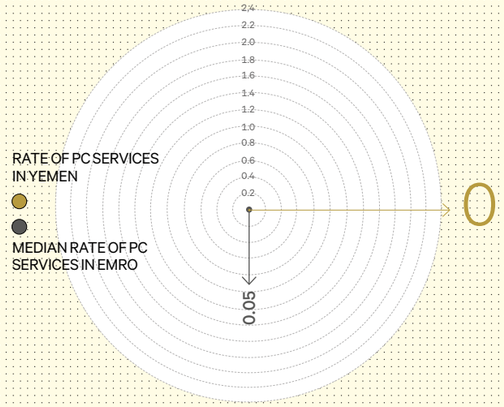
LEVEL OF DEVELOPMENT: 1 EMERGING · 2 PROGRESSING · 3 ESTABLISHED · 4 ADVANCED

Ⓕ Provision of PC (Specialized Services)

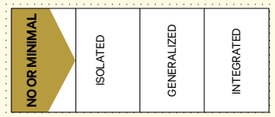
Total number of Specialized PC services: **0**

Rate of PC services per 100,000 inhabitants: **0**

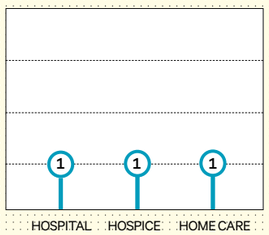
Yemen in the context of EMRO



Geographic distribution and integration of PC services



Level of development of different types of PC services



Pediatric PC Services

GEOGRAPHIC DISTRIBUTION AND INTEGRATION: 1 ○ ○ ○

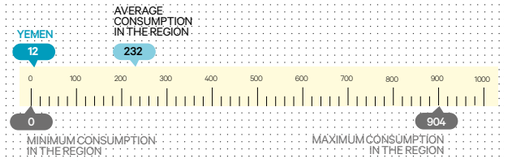
TOTAL NUMBER: 0

EM Yemen

Ⓓ Use of essential medicines

Opiods consumption (excluding methadone): **12** S-DDD/MILL INHABITANTS/DAY

Yemen in the context of EMRO



Overall availability of essential medicines for pain and PC at the primary level

General availability of immediate-release oral morphine at the primary level

Ⓒ Research

PC-related research articles: 1 ○ ○ ○

Existence of PC congresses or scientific meetings: 1 ○ ○ ○

National Association: No.

Consultants: Anghman Al-Akwaa; Confidential.

Data collected: January-June 2025.

Report validated by consultants: Yes

Endorsed by National PC Association: N/A

Report reviewed by the Ministry of Health

Edition: Edited by Atlantes Research Team (University of Navarra, Spain).

Ⓔ Education & Training

Medical schools with mandatory PC teaching: **0**

Nursing schools with mandatory PC teaching: **0**

Recognition of PC specialty: 1 ○ ○ ○

Ⓑ Policies

National PC plan or strategy: 1 ○ ○ ○

Responsible authority for PC in the Ministry of Health: 1 ○ ○ ○

Inclusion of PC in the basic health package at the primary care level: 1 ○ ○ ○

Ⓐ Empowerment of people and communities

Groups promoting the rights of PC patients: 1 ○ ○ ○

Advanced care planning-related policies: 1 ○ ○ ○

EM Yemen

People & Communities

Ind 1

Existence of groups dedicated to promoting the rights of patients in need of PC, their caregivers, and disease survivors.

1 ○ ○ ○

Only isolated activity can be detected.

In Yemen, there is no formally established palliative care department, unit, or specialized group dedicated to promoting the rights of patients in need of palliative care, their caregivers, or disease survivors. Only isolated activities can be detected, and palliative care remains largely unstructured within the healthcare system. However, a national program in collaboration with WHO took place in November 2024, focusing on the need to support and develop palliative care. Despite this initiative, there are no advocacy groups or professional associations actively working on integrating palliative care into the health system or advancing patient rights in this area.

Ind 2

Is there a national policy or guideline on advance directives or advance care planning?

1 ○ ○ ○

There is no national policy or guideline on advance care planning.

There is no national policy or guideline on advance directives or advance care planning. Palliative care remains underdeveloped and is still in the process of being addressed, with no existing legal framework governing its implementation. Furthermore, there are no established regulations to guide healthcare professionals or patients in making advance care decisions.

Policies

Ind 3

3.1. There is a current national PC plan, program, policy, or strategy.

1 ○ ○ ○

Do not know or does not exist.

3.2. The national palliative care plan (or program or strategy or legislation) is a standalone.

2 ○ ○ ○

A national palliative care plan is in preparation.

Yemen does not have a standalone national palliative care plan, program, policy, or strategy. However, in November 2024, discussions within the National Cancer Control Strategy (2025–2030) recognized palliative care as a key component for cancer patients. As part of this, a plan was proposed to establish a palliative care unit at the National Oncology Center (NOC) in Aden Governorate. Despite these discussions, there is no dedicated national framework for palliative care, nor any independent legislation or structured program. Additionally, there are no indicators to monitor or evaluate progress in palliative care. Recent WHO training sessions indicate efforts to build awareness and strengthen capacity in this area. While these steps mark progress, Yemen still lacks a structured system to ensure the integration and development of palliative care services at a national level.

EM Yemen

Policies

3.3. There are indicators in the national plan to monitor and evaluate progress, with measurable targets.

1 ○ ○ ○

Not known or does not exist.

Ind 4

PC services are included in the list of priority services for Universal Health Coverage at the primary care level in the national health system.

1 ○ ○ ○

Not at all.

Palliative care services are not included in the list of priority services for UHC at the primary care level in Yemen's national health system. Although palliative care was mentioned as a component of the National Cancer Control program, it remains under discussion and has not been formally integrated into primary healthcare services. Furthermore, access to essential palliative care resources, such as opioid medications, is severely limited due to the ongoing conflict.

Ind 5

5.1. Is there a national authority for palliative care within the government or the Ministry of Health?

1 ○ ○ ○

There is no coordinating entity.

5.2. The national authority has concrete functions, budget and staff.

1 ○ ○ ○

Does not have concrete functions or resources (budget, staff, etc.).

Yemen does not have a national authority for palliative care within the government or the MoH. Although palliative care was included in the National Cancer Control program this year, it remains under discussion and has not been integrated into other health services. There is no coordinating entity overseeing palliative care development. The country also lacks a dedicated palliative care unit, and there are no concrete functions, budget, or staff allocated to this area. Limited services, a shortage of trained healthcare personnel, and insufficient financial resources further hinder palliative care development. However, a pharmacist serving as Deputy Director of the National Cancer Center is participating in a WHO training course, marking a small step toward capacity building. Despite these discussions and training efforts, Yemen still lacks a structured framework or leadership to advance palliative care at a national level.

EM Yemen

Research

Ind 6

Existence of congresses or scientific meetings at the national level specifically related to PC.

1

There are no national congresses or scientific meetings related to palliative care.

There are no national congresses or scientific meetings specifically dedicated to palliative care in Yemen. In 2014, a one-week training course in palliative care was conducted; however, following the outbreak of war in 2015, all activities related to palliative care ceased. Since then, no conferences or scientific meetings on this topic have taken place. While there have been recent general health conferences in Yemen, none have focused specifically on palliative care.

Ind 7

Estimation of the level of peer-reviewed articles focusing on PC research published in any language in the past 5 years with at least one author from the country.

1

Indicates a minimal or nonexistent number of articles published on the subject in that country.

Research on palliative care in Yemen is extremely limited, with only a few known studies addressing the topic. One of the few contributions is a study on cancer pain management in developing countries, led by Professor Dr Gamal Abdel Hamid in 2020–2021. While regional analyses highlight the significant unmet need for palliative care across the Eastern Mediterranean, including Yemen, there remains a notable absence of country-specific research output and published studies focused exclusively on Yemen's context.

Medicines

Ind 8

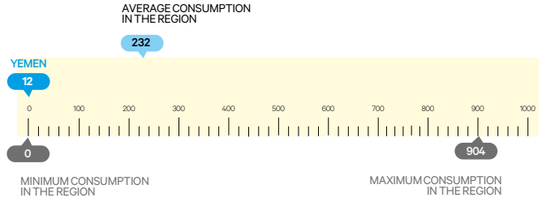
Reported annual opioid consumption –excluding methadone– in S-DDD per million inhabitants per day.

Average consumption of opioids, in defined daily doses (S-DDD) for statistical purposes per million inhabitants per day, 2022.

12

S-DDD PER MILLION INHAB /DAY

COUNTRY VS REGION



EM Yemen

Medicines

Ind 9

9.1. Percentage of health facilities at the primary care level in Urban areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

1

Poor: Between 0% to 10%.

9.2. Percentage of health facilities at the primary care level in rural areas that have pain and palliative care medications as defined in the WHO Model List of Essential Medicines.

1

Poor: Between 0% to 10%.

Yemen's morphine consumption in 2020 was just 0.03 mg per capita, far below global averages and reflecting critically low availability of essential opioids. The absence of a palliative care unit or dedicated team complicates the tracking and reporting of opioid use. Estimates suggest that opioid consumption meets only 10% to 30% of expected needs, leaving many patients without adequate pain relief. Political instability disrupts supply chains, while stigma and regulatory barriers further restrict access to essential medications. At the primary care level, the availability of pain and palliative care medications is extremely limited, with only 0% to 10% of urban health facilities stocking these essential drugs. There is no official data on rural access, but most cancer patients experiencing pain must travel to urban centers, particularly the National Oncology Center in Aden Governorate, for treatment. This highlights a severe gap in pain management at the primary care level across the country.

Ind 10

10.1. Percentage of health facilities at the primary care level in urban areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

10.2. Percentage of health facilities at the primary care level in rural areas that have immediate-release oral morphine (liquid or tablet).

1

Poor: Between 0% to 10%.

The availability of pain and palliative care medications in primary care facilities across Yemen is critically low. In rural areas, access ranges from 0% to 10%, with no official documentation on availability. Although morphine is technically available, its supply is highly irregular due to the ongoing war crisis, as reported by the National Oncology program. In urban areas, the situation is similarly dire; only 0% to 10% of primary care facilities stock immediate-release oral morphine (liquid or tablet). When available, morphine is typically concentrated in city centers, while most rural areas lack healthcare centers or tumour units, making access to pain relief even more challenging. The combination of supply chain disruptions, conflict, and inadequate infrastructure leaves a significant portion of the population without essential pain management.

EM Yemen

Education & Training

Ind 11

11.1. The proportion of medical schools with COMPULSORY teaching in PC (with or without other optional teaching)

0

11.2. The proportion of medical schools with OPTIONAL teaching in PC.

0

11.3. The proportion of nursing schools with COMPULSORY teaching in PC (with or without other optional teaching).

0

11.4. The proportion of nursing schools with OPTIONAL teaching in PC.

0

In Yemen, there is no formal education in palliative care within the undergraduate curricula of medical or nursing schools, either as a compulsory or optional subject. Universities and institutes of medicine, nursing, and pharmacy, such as those in Aden Governorate, provide general medical and healthcare education but do not include palliative care training in their programs. Additionally, there are no dedicated palliative care schools in the country.

Ind 12

Existence of an official specialization process in palliative medicine for physicians, recognized by the competent authority in the country.

1 ○ ○ ○

There is no process on specialization for palliative care physicians.

In Yemen, there is no specialization process for palliative care physicians. The country does not offer primary or secondary specialties in palliative care, and there are no formal training pathways for healthcare professionals to specialize in this field. The Ministry of Public Health does not recognize palliative care as a distinct specialty, and there are no residency or fellowship programs dedicated to palliative care. As a result, physicians and other healthcare workers lack structured opportunities for advanced training or certification in palliative care.

EM Yemen

Provision of PC / Specialized Services

Ind 13

13.1. There is a system of specialized PC services or teams in the country that has a GEOGRAPHIC reach and is delivered through different service delivery platforms.

1 ○ ○ ○

No or minimal provision of palliative care specialized services or teams exist in the country.

13.2. Are available in HOSPITALS (public or private), such as hospital PC teams (consultation teams), and PC units (with beds), to name a few examples.

1 ○ ○ ○

Not at all.

13.3. Free-standing HOSPICES (including hospices with inpatient beds).

1 ○ ○ ○

Not at all.

13.4. HOME CARE teams (specialized in PC) are available in the community (or at the primary Healthcare level), as independent services or linked with hospitals or hospices.

1 ○ ○ ○

Not at all.

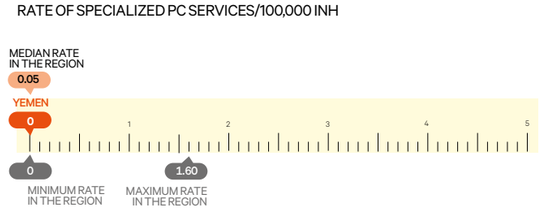
13.5. Total number of specialized PC services or teams in the country.

0

PPC TEAMS

Palliative care in Yemen remains in an early phase, with no structured services or multidisciplinary teams in place. The National Cancer Control Program, in collaboration with WHO, is exploring the launch of a palliative care initiative at the National Oncology Centre in Aden. A five-bed pilot unit once operated there but closed in 2015 due to conflict. Efforts to reactivate the unit are ongoing, though specialized services remain minimal. There are no hospices, and oncology clinics offer only general follow-up without a structured palliative approach. Around 50% of cancer patients present at advanced stages and receive home care via phone or WhatsApp. Formal training in palliative care is absent, and challenges include lack of support, limited trained staff, and insufficient space for admissions.

RATE OF SPECIALIZED PC SERVICES/100,000 INH



0 ← SPECIALIZED PALLIATIVE CARE SERVICES

Ind 14

14.1. There is a system of specialized PC services or teams for children in the country that has geographic reach and is delivered through different service delivery platforms.

1 ○ ○ ○

No or minimal provision of palliative care specialized services or teams for children exists in country.

14.2. Number of pediatric specialized PC services or teams in the country.

0

PPC TEAMS

Palliative care for children in Yemen remains at an early stage, with no specialized services or dedicated teams currently available. The National Cancer Control Program, in collaboration with the WHO, has recognized the need to develop pediatric palliative care and is actively discussing its implementation. In November 2024, palliative care was formally addressed, and an agreement was made to support its development, including the training and qualification of a dedicated team for pediatric palliative care. However, at present, these efforts remain at the discussion stage, and no structured pediatric palliative care services have been established in the country.

The way forward

Recommendations for the Future Development of Palliative Care in the Eastern Mediterranean Region

The findings of this Atlas underscore both the urgency and the opportunity to advance palliative care across the Eastern Mediterranean Region. Despite persistent inequities, fragile health systems, and the compounded challenges of conflict, displacement, and humanitarian crises, the region also demonstrates resilience and promising developments that can guide collective action.

Future progress will depend on consolidating health policies and implementation frameworks. Countries should adopt or update national PC strategies, ensuring realistic plans, measurable indicators, and alignment with UHC benefit packages. The establishment of dedicated coordination units within Ministries of Health can help guarantee continuity, accountability, and intersectoral collaboration.

Access to essential medicines, particularly opioids, remains a critical priority. Regional and national strategies are needed to harmonize regulatory frameworks, reduce unjustified barriers, and ensure the availability of affordable, quality-assured pain relief medications in both urban and rural settings. Efforts must also focus on rational prescribing practices and professional training in evidence-based pain management.

Service provision should expand beyond hospitals, strengthening community and home-based care models, especially for populations in vulnerable contexts such as refugees, internally displaced people, and those living in rural or conflict-affected areas. Integration of PC into primary health care and humanitarian health responses is essential to ensure continuity of care and equity.

Education and workforce development are fundamental pillars. Mandating PC training in undergraduate curricula for medicine, nursing, and allied health fields will create a baseline of competence, while advanced training programs and formal recognition of PC as a medical specialty can consolidate expertise. Innovative regional training initiatives and online platforms may bridge capacity gaps, particularly in settings with limited academic infrastructure.

Research and knowledge exchange must be strengthened. Building regional research networks, supporting contextually relevant studies, and ensuring the dissemination of findings can foster innovation and accelerate translation into practice. Centers of excellence emerging in some countries should be leveraged as regional hubs for clinical care, training, and research.

Finally, empowering communities and civil society is crucial. Community engagement fosters culturally appropriate models of care, raises awareness, and promotes advocacy for patient rights. Supporting national and regional associations, as well as grassroots initiatives, will reinforce sustainability and legitimacy.

By pursuing these integrated strategies—anchored in primary health care, responsive to humanitarian realities, and grounded in collaboration—the Eastern Mediterranean Region can move decisively toward equitable, high-quality palliative care. Progress will require not only political commitment and professional leadership, but also the solidarity of a regional movement that ensures no person is left behind in the face of serious illness. ●

THE ATLANTES RESEARCH TEAM

ATLANTES GLOBAL OBSERVATORY OF PALLIATIVE CARE
Institute for Culture and Society (ICS)
Campus Universitario
31009 Pamplona, Spain
www.unav.edu/web/atlantes-global-observatory-of-palliative-care

AUTHORS

ics Universidad de Navarra | ATLANTES GLOBAL OBSERVATORY OF PALLIATIVE CARE | WHO Collaborating Centre for the Global Monitoring of Palliative Care Development

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