Care amidst crisis: Advancing palliative care in the WHO Eastern Mediterranean Region

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Palliative care is a human right and a moral imperative, offering holistic relief for patients and families facing serious illness, yet in the World Health Organization (WHO) Eastern Mediterranean Region (EMR) millions are left without access to essential palliative care. In addition, the region hosts nearly half of the world's displaced population, with cancer and chronic disease rates rising rapidly, compounded by conflict-related psychosocial issues, injuries, and trauma.

The EMR Expert Network in Palliative Care is contributing to policy development and culturally sensitive capacity building on service models, including home-based care. The WHO/EMR office is taking great steps in involving Member States in order to integrate palliative care services within the different health systems.

Palliative care is a holistic approach to alleviating health-related suffering, regardless of a patient's disease stage or prognosis *(1)*. It represents a return to the core purpose of healthcare: person-centred care for patients and their families, addressing not only physical problems, but also emotional, social, and spiritual distress. Palliative care is recognized under the human right to health *(2)* and is a moral imperative in response to those grappling with tremendous burdens and suffering due to a serious illness.

Despite its universal relevance, the implementation of palliative care varies significantly across regions *(3)*, and particularly in the World Health Organization (WHO) Eastern Mediterranean Region (EMR), where complex challenges – namely humanitarian crises, fragile health systems, and limited resources – hinder its integration. While the principles of palliative care emphasize dignity, relief from suffering, and holistic support, these ideals are often difficult to uphold in settings marked by instability, scarcity, and unrecognition of palliative care. In the EMR, protracted conflicts, displacement, and strained healthcare infrastructures have exacerbated the need for palliative care, particularly for vulnerable populations facing life-limiting illnesses, trauma, and severe pain without adequate relief *(4)*. Despite gradual advances in palliative care over recent years, the disrupted health systems in many countries of the region have compromised substantial progress. This article aims to shed light on the situation and the need for palliative care in the EMR amid conflict settings.

The need for palliative care in the EMR

The EMR is experiencing one of the fastest increasing rates of cancer and other chronic diseases globally, with cancer projected to rise significantly over the next 15 years *(5)*. Most cancer cases are diagnosed late, resulting in poor survival rates and a high demand for palliative care services to manage advanced disease *(6-8)*. An estimated 2.4 million people in the EMR require palliative care annually; the majority suffering from advanced cancer, cardiovascular diseases, chronic respiratory conditions, inherited haemoglobinopathies, and progressive neurological and metablic disorders *(9)*. However, these numbers fail to capture the hidden toll of conflict-related injuries, burns, and trauma which have created a surge of patients with severe, long-term pain and disability. The intersection of chronic disease and conflict creates a detrimental situation: patients who might have managed their conditions with early intervention now face unmitigated suffering due to bombed hospitals, medication shortages, and hyperinflated prices.

Even before political instability and displacement shattered many countries of the region, limited palliative care services in the EMR were mainly due to ignorance of its importance and its impact, compounded by restrictive policies, cultural stigma, and institutional indifference. Governments failed to integrate palliative care into national health strategies, leaving more than 80% of patients without access to essential pain relief *(10)*. Opioid regulations can be overly restrictive: morphine was often exclusive to cancer patients, with prescriptions limited to 3-day supplies or permitted only in inpatient settings, forcing terminally ill patients to repeatedly travel for medication refills or get admitted to a hospital bed just to relieve pain *(11)*. Meanwhile, training in palliative care was virtually non-existent; many medical schools offered zero hours of formal palliative education, and misconceptions about morphine addiction overshadowed its medical necessity *(12)*. Meanwhile, funding ignored the cost-efficiencies of palliative care and its ability to reduce hospitalizations and optimize treatment, leaving services concentrated in urban hubs, if at all existent. This systematic abandonment created a vicious cycle: without recognition, there was no funding; without funding, there was no training; and without training, there was no advocacy. These multifaceted challenges require balancing immediate humanitarian needs with sustainable health system strengthening, reflecting the unique challenges and opportunities present in the EMR.

The EMR represents a critical area of unmet need for palliative care – marked by significant health disparities, and exacerbated by persistent conflict, economic instability, and sociocultural barriers (Figure 1). Although palliative care is essential for the millions facing terminal conditions across the region, access remains challenging *(13)*.

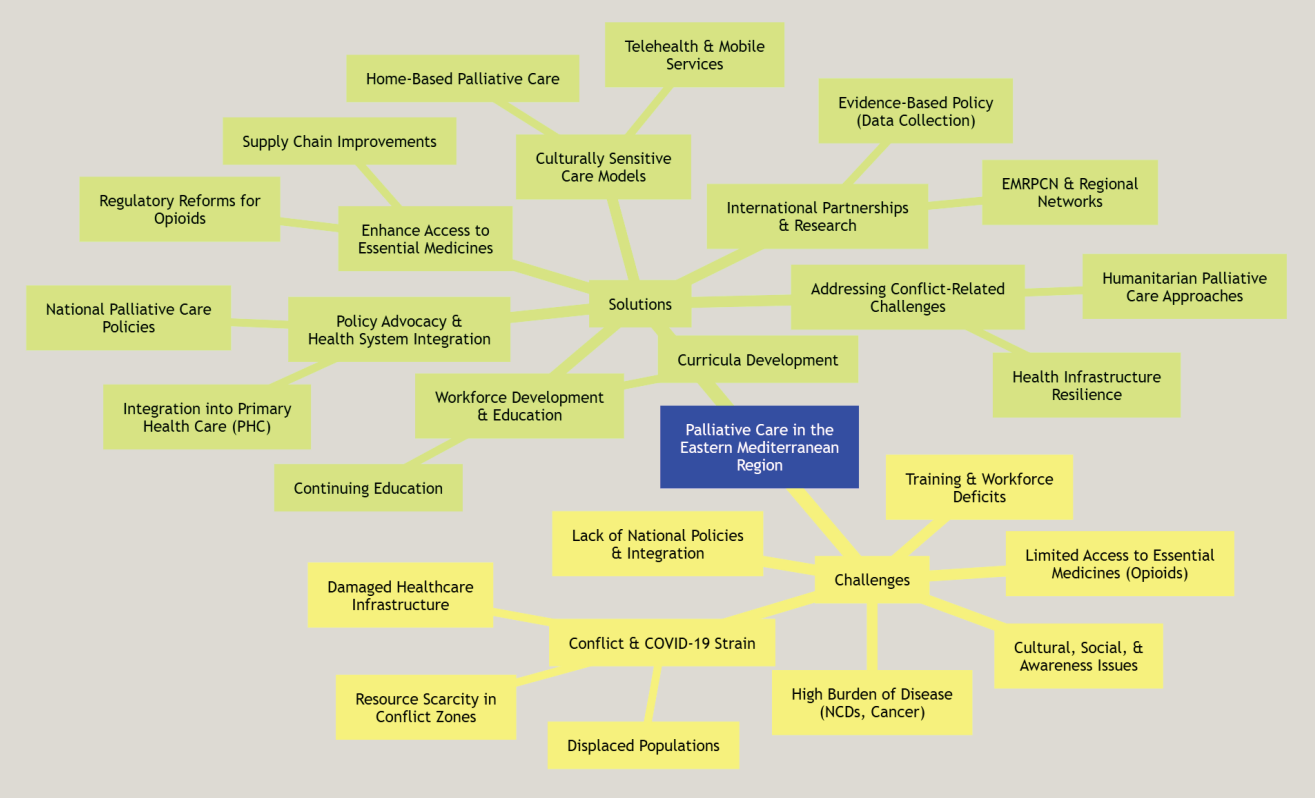
Addressing the palliative care imperative through timely provision

The wide range of systemic and contextual challenges collectively contribute to delayed referrals and limited palliative care service provision. The consequences of such late referrals include poor symptom control, increased emergency department visits and hospitalizations, and higher healthcare costs due to aggressive, futile treatments, notwithstanding the emotional distress for patients and families. Table 1 outlines the primary barriers to timely and effective palliative care, alongside actionable recommendations aimed at strengthening service delivery, enhancing integration into health systems, and improving patient outcomes. A fundamental goal is to reframe palliative care not as a service exclusive to the end of life, but as a core skill set for all healthcare professionals, integrated at all levels of practice – from generalist to specialist – and introduced early in the disease trajectory.

The EMR and conflict

The EMR is one of the world's most crisis-affected areas, with over 60% of its countries embroiled in armed conflict, political

Figure 1: A mind map illustrating the complex web of challenges (yellow) and interconnected solutions (green) for palliative care in the EMR



instability, or protracted humanitarian emergency *(14)*. In 2023, the region hosted nearly 30 million refugees and 40 million internally displaced persons, accounting for almost half of the global displaced population *(15)*. Countries including Syria, Yemen, Sudan, and Palestine-Gaza face catastrophic health system collapses, while host countries such as Egypt, Lebanon, Jordan, Libya, and Pakistan struggle with strained resources amid mass migration. This displacement crisis creates a double burden: fragile states cannot meet even basic healthcare needs, while host countries grapple with overcrowded facilities, exhausted staff, and funding deficits. For patients with chronic conditions this translates to unrelieved suffering.

Impact of conflict on healthcare systems, the healthcare workforce, and patients

Countries with armed conflicts have been witnessing detrimental effects on their healthcare systems, healthcare workforces, and patients with serious illnesses. The prevailing regional instability has been detrimental to the healthcare workforce, as documented in the WISH Report "In the Line of Fire: Protecting Health in Armed Conflict": targeted attacks, forced labour, and systemic collapse have decimated the medical workforce across conflict zones in the EMR. Those who remain face unimaginable risks; for example, a nurse kidnapped at gunpoint to treat a militia soldier, and a doctor executed after a commander died under his care. Even when they evade bullets and abduction, survival is a struggle, with salaries, if paid at all, rendered worthless by hyperinflation. Health professionals working in the public sector experience reduced wages during a crisis and after it *(16)*. Roads to clinics are either blocked or unsafe; pharmacies lack even basic antibiotics; and the psychological trauma of practicing "medicine without medicines" drives many to abandon their posts. Over 70% of Syrian healthcare workers fled the country after 2011, while in Sudan, 60% of hospitals lost staff within months due to direct violence and unsustainable conditions *(17)*. Within the first two weeks of the conflict, 26 hospitals in Khartoum were bombed, contributing to the war's catastrophic shutdown of 80% of Sudan's hospitals *(18)*, leaving cancer patients without access to basic care, let alone the sophisticated treatment modalities they desperately needed. Lebanon, which hosts the

Table 1: **Barriers to timely and effective palliative care, and recommendations for improvement**

Barriers to early palliative care	Recommendations for improvement
1. Education and awareness barriers - Many healthcare providers and patients/families associate palliative care only with end-of-life care, leading to delayed referrals	- Integrate palliative care principles and basics into the undergraduate and graduate education of healthcare disciplines (nursing, medicine, social work, psychology, pharmacy, etc.) - Train healthcare providers to assess palliative care needs, provide basic palliative care, and on referral to palliative care as early as possible - Integrate palliative care into orientation programmes and continuing education requirements - Public awareness programmes to destigmatize palliative care
2. Healthcare system barriers - Limited integration of palliative care into primary and secondary healthcare settings - Shortage of specialized palliative care teams and services	- Expand palliative care programmes to rural and underserved areas - Integrate palliative care into oncology, geriatrics, and chronic disease management - Ensure presence of palliative care teams at major hospitals, and their interaction with the different departments in terms of referral, training, and joint research - Build palliative care career pathways, compensations, and incentives for providing palliative care
3. Physician-related barriers - Some physicians hesitate to refer patients due to prognostic uncertainty, fear of taking away hope, and lack of training in palliative care communication	- Develop clear criteria for early palliative care referral for different conditions based on "need" and not based on "prognosis or disease progression" - Implement triggers in electronic health records for automatic palliative care consultations
4. Cultural and religious barriers - Families may resist palliative care due to misconceptions, preferring aggressive treatment until the very end - Cultural and religious beliefs may influence perceptions of death and dying, causing reluctance to discuss palliative care - Limited health literacy about the benefits of early palliative care	- Engage religious leaders (Ulama) to support discussions on palliative care within religious ethical frameworks - Design and integrate palliative care chaplaincy education into higher education systems - Encourage family meetings with palliative care teams to address concerns
5. Policy barriers - Lack of integration of early palliative care into national healthcare policies and funding schemes - Lack of standardized referral criteria across hospitals	- Government support for national palliative care policies and funding - More research on early integration of palliative care in health services in the EMRO region

highest refugee population per capita in the world, has endured several wars, conflicts, and crises, severely limiting access to essential medicines, healthcare facilities, and workforce, thereby burdening its fragile healthcare system *(19)*. The latest war on Lebanon resulted in 160 attacks on healthcare, 109 attacks on ambulances, 241 healthcare personnel killed and 295 injured, and the closure of three hospitals and 19 primary healthcare centres and dispensaries *(20)*. In Gaza, according to the latest situation update released by the WHO in August 2025, there have been 62,192 people killed and 157,114 injured. Only 50% of hospitals are partially functional and 39% of primary healthcare centres are functional. A total of 772 attacks on healthcare were documented, resulting in the killing of 929 peole, targeting 125 health facilities, including 29 hospitals damaged, and 197 ambulances. The malnutrition crisis remains dire and the infectious diseases threat persists. The ongoing attacks and resource shortages have severely weakened the health system – damaging or destroying 94% of hospitals, overwhelming the remaining partially functional ones, and disrupting essential health service delivery *(21)*.

Political instability and armed conflict have stalled cancer care across the EMR, transforming treatable malignancies into death sentences. Patients face significant treatment interruptions, whereby chemotherapy cycles are abandoned due to hospital shelling, radiation therapy halted by power outages, and life-saving surgeries cancelled due to fleeing medical staff *(22)*. In Syria alone, more than 11 years of war have left 1.5 million people living with permanent disabilities, many requiring ongoing palliative support *(23)*. Similarly, in Yemen, where healthcare systems have collapsed, the majority of cancer patients die without access to basic pain relief *(24)*. In Gaza, breast cancer survival rates have gone down and patients are suffering from a multitude of psychosocial issues *(25)*. In rural areas, a patient with multiple myeloma might endure a three-hour journey on the back of a cart, screaming in pain, only to reach an oncology centre with depleted morphine stocks. Radiotherapy, complex surgeries, and combined chemoradiotherapy (cornerstones of cancer management) require stable infrastructure, safe transportation, and precise timing, all obliterated by war *(26)*.

The consequences are dire: late-stage diagnoses surge as patients cannot reach functioning facilities, while those mid-treatment face relapses due to disrupted care. Another factor faced by the refugees and the displaced population is the psychological and social impact of the conflicts – loss of income, loss of housing, increased vulnerablility to sexual assault, loss of roles, grief and complicated grief, loss of country, being forced into a new society which might differ in culture and language. All these demand a holistic approach not only for individuals but for communities *(27)*. The result is a growing population of patients living – and dying – in agony from advanced disease, their suffering compounded by the near-total absence of pain management. This is where palliative care becomes not only an option, but a necessity.

The EMR Expert Network

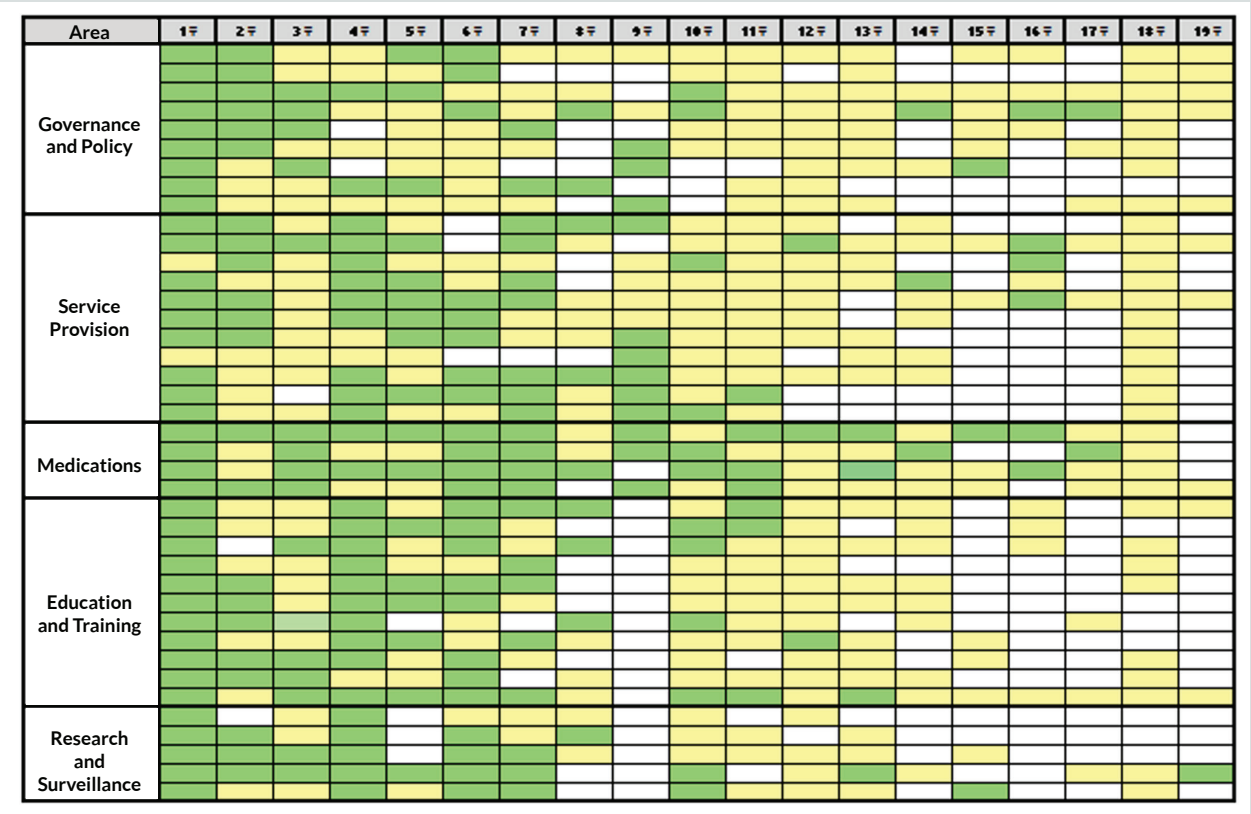
In 2019, the EMR Expert Network for Palliative Care (ENPC) was established by WHO/WHO Regional Office for the Eastern Mediterranean Region (EMRO) in collaboration with academic partners to create strategies for integrating palliative care into national systems. The network has developed a regional roadmap aligned with WHO guidelines aimed at policy development, workforce training, service implementation, and quality assurance *(28)*. Countries are encouraged to develop and adopt national palliative care policies to formally embed these services within health systems, including cancer control frameworks and primary care. This would ensure sustainable funding and coordination. Regulatory reforms are needed to improve the availability of opioid analgesics while ensuring safe and controlled use. Revising prescription laws and overcoming supply chain issues are priorities to expand pain relief access. Given the cultural and religious context in many EMR countries, home-based palliative care services are emphasized. These models facilitate care in patients' homes, respecting cultural values, and overcoming geographical and infrastructural barriers. The ENPC is also expanding palliative care training for physicians, nurses, and allied health professionals through curricula development and continuing education to support capacity building. Collaborations with international academic institutions and the WHO support facilitated knowledge exchange and the adaptation of global best practices. Ongoing research and monitoring help track progress and inform policy adjustments. The World Health Assembly Resolution 67.19 on palliative care *(29)*, the WISH report: How Can We Respond to 10 Years of Limited Progress? *(30)* and the Regional Framework for action addressing noncommunicable diseases in emergencies *(31)* provide guidance for the work of the ENPC.

Bridging the gaps: Advancing equitable access to palliative care in the EMR

The WHO Office for the Eastern Mediterranean Region is seeking to provide an overarching regional framework to guide its Member States towards strengthening palliative care. Priority actions that have been identified through the Member State consultations are shown in Table 2.

These priority interventions were identified based on an analysis of the prevailing situation in the region. Figure 2 provides a snapshot of the current status and feasibility of key strategic interventions across 19 countries that participated in a series of consultative stakeholder meetings that WHO EMRO conducted during the period May–June 2025.

Figure 2: Snapshot of the current status of palliative care in 19 EMR countries across five strategic areas in 2025. Columns represent Member States, and the shading reflects whether a strategic action is fully or partially available (green), or is considered implementable within 1–2 years (yellow), or needs more than two years to implement (white), according to the stakeholders in each country



The different rows indicate the following strategic actions respectively: a national palliative care policy; implement the palliative care strategy; appoint a dedicated focal person or taskforce within the Ministry of Health for palliative care development; include palliative care in cancer, NCD, HIV/AIDS, ageing, and UHC strategies; advocate for legal frameworks that support patient rights to palliative care and care choices; ensure palliative care services are defined within basic benefit packages and UHC; ensure dedicated budget lines for palliative care; promote public-private partnerships for palliative care services; and include palliative care in universal healthcare coverage plans.

Embed palliative care into primary healthcare, general hospitals, and tertiary-level services, ensuring consistent access; include palliative care in existing disease-specific programmes (e.g., oncology, HIV/AIDS, NCDs, geriatrics); develop comprehensive paediatric palliative care services within paediatric services; include children in adult palliative care programmes where appropriate; establish palliative care units or teams in tertiary and general hospitals; expand home-based and community palliative care services; develop national palliative care clinical guidelines; prepare health systems for palliative care in crises; identify and strengthen hospitals or institutions as model palliative care hubs and link them to academic institutions for capacity building and evidence generation; introduce referral and back-referral systems between institutes and homecare services; mobilize communities to support and be aware of palliative care.

Include essential palliative care medicines in national essential medical list; improve access to palliative care medicines, especially oral opioids; monitor national opioid consumption; revise laws and institutional regulations to enable safe and controlled access; include palliative care modules in undergraduate medicine, nursing, pharmacy, and social work education; develop postgraduate training and certification; regularly update practising health workers through CPD, short courses, and mentorship; build community and caregiver training capacity; train palliative care providers on home-based palliative care delivery; develop national standards and accreditation for palliative care training; recognize intermediate and specialist qualifications; support national professional development platforms; promote operational and implementation research in palliative care; integrate palliative care data into health information systems; and train physicians on proper pain management and safe opioid prescribing. Develop cost-effective models of care adapted to country context and health system infrastructure; establish patient-reported outcomes and feedback systems; conduct quality audits and service evaluations; track access to oral opioids and their consumption; and support participation in global and regional palliative care research collaborations.

Abbreviations: CPD, continuing professional development; NCD, noncommunicable disease; UHC, Universal Health Coverage.

Table 2: **Priority actions identified during Member State consultations for palliative care**

Area of Intervention	Challenges	Proposed solutions	Expected impact
Policy and governance	Lack of national policies, fragmented services, insufficient funding	Develop and adopt national palliative care policies; appoint a taskforce for palliative care development and avail funds	Formal recognition, sustainable funding, coordinated service delivery, equitable access
Medication access	Restrictive opioid regulations, supply chain barriers, stigma	Regulatory reforms for opioid availability; streamline supply chains; public awareness campaigns	Effective pain and symptom management, reduced suffering, improved quality of life
Workforce capacity	Shortage of trained professionals, limited educational opportunities	Expand training programmes (curricula, continuous education); recognize intermediate and advanced levels of palliative care training	Competent and compassionate healthcare providers, enhanced quality of care, increased number of staff providing palliative care
Service delivery models	Limited-service availability, inadequate infrastructure, geographical barriers	Promote culturally sensitive, home-based care; deploy mobile/telehealth services, especially in conflict zones; integrate palliative care in primary healthcare and in hospitals	Improved accessibility, continuity of care, patient-centred approaches; increased services at all levels of the health system
Public and cultural acceptance	Low awareness, stigma, cultural/religious sensitivities regarding end of life	Community engagement; education campaigns; involvement of religious leaders	Increased acceptance, earlier referrals, reduced psychological burden on families; increased social support

Conclusion

The EMR faces a critical and growing need for palliative care, exacerbated by intersecting crises of conflict, displacement, and fragmented health systems. Millions of patients with serious illnesses, trauma-related disabilities, and chronic conditions endure unrelieved suffering due to systemic barriers, including restrictive policies, workforce shortages, and cultural stigma. Yet, the region also presents opportunities for transformative change. By integrating palliative care into national health strategies, reforming opioid access laws, and prioritizing culturally sensitive service models, the EMR can uphold the fundamental right to relief from suffering, even amid instability.

Addressing these challenges requires a dual focus: immediate humanitarian action to deliver pain management and basic palliative services in conflict zones, and long-term system strengthening to embed palliative care into primary healthcare, oncology, and chronic disease programmes. Collaborative efforts, guided by WHO frameworks, regional networks like the ENPC, and community-led advocacy, can bridge gaps in awareness, training, and equity. The path forward demands political commitment, cross-sector partnerships, and innovative solutions tailored to the EMR's unique realities. Only then can the region ensure that no patient, whether in war-torn zone or an overcrowded refugee clinic, faces preventable suffering. ■

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