Worldwide Hospice Palliative Care Alliance
London, UK 2026

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Global atlas of palliative care

Third edition



World Health Organization

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The World Health Organization (WHO) provided technical input and review in the development of this publication. The findings, interpretations, and conclusions expressed herein do not necessarily reflect the views of the World Health Organization.

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Suggested citation

Connor, S.R., & Rosa, W.E. (Eds.). (2026). *Global atlas of palliative Care* (3rd ed.). London, United Kingdom: Worldwide Hospice Palliative Care Alliance.

Acknowledgements

Ricardo Martinez, WHO Mapping Consultant / Design by Theresa Wilds / Howard Kinyua Communications

This publication was supported in part by a grant from **St Jude Research Hospital**
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Registered Office: Hospice House, 34-44 Britannia Street, London WC1X 9JG
ISBN: 978-0-9928277-3-1

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CONTENTS

Forward by WHPCA Chair, Dr James Cleary

Chapter 1 Introduction

What is palliative care for adults, for children?
- The WHO Definitions of Palliative care for adults and children
- The relationship between curative and palliative care

Global mandate for expanding palliative care
1. Palliative care and human rights
2. The World Health Organization World Health Assembly resolution WHA67.19 "Strengthening of palliative care as a component of comprehensive care throughout the life course"
3. Overview of palliative care economics case for support

Palliative care as part of Universal Health Coverage under the UN SDG #3

Chapter 2 How many adults and children need palliative care worldwide?

Executive summary & Introduction
Summary of methodological updates
Overall need for palliative care worldwide
Figures describing the need for palliative care for adults
Figures describing the need for palliative care for children

Chapter 3 What are the main barriers to palliative care?

Based on WHO Public Health Policy
- Policy, Education, Medication, Research, Empowerment, Implementation

Maps on opioid use by country
Health workforce need
Barriers to children's palliative care
Psychological, social, cultural, and financial barriers
- Essential and expanded palliative care packages for adults and children

Palliative care for special populations
- Humanitarian emergencies
- Stroke
- Serious respiratory illness

Chapter 4 How are palliative care services developing Worldwide to address the unmet need for care?

Results of palliative care findings from the WHO Country Capacity Survey (2019)
Maps showing levels of palliative care development by country from "Mapping Levels of Palliative Care Development" (2017)
Estimated number of specialized palliative care services and patients receiving care. Maps showing numbers of palliative care-specific providers to base population.
Primary palliative care development
Children's palliative care development
Family caregiving in palliative care
Provision of bereavement support to families
Map showing the availability of children's palliative care services

Chapter 5 What are existing models of palliative care (including financial mechanisms) in different resource settings?

Case studies of different models of care for adults and children

- (SEARO) Adults: Nepal Children: India
- (AFRO) Adults: Ethiopia Children: South Africa
- (EURO) Adults: UK Children: Uzbekistan
- (AMRO) Adults: Brazil Children: Canada
- (WPRO) Adults: China Children: Australia
- (EMRO) Adults: KSA Children: Lebanon

Stories from a Direct Stakeholder needing palliative care and parent of a child

Chapter 6 What is the way forward to advance palliative care in the health and human rights agendas at global/regional/country levels?

Advocacy Recommendations

References

Appendices

Appendix 1
Methodology for the Global Atlas of Palliative Care

Appendix 2
Organizational resources, journals, and collaborating centres

Appendix 3
WISH Report analysis of progress in Palliative Care against the WHO Resolution

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List of figures

1. UHC service coverage map SDG 3.8.1
2. UHC Service Coverage Index -SDG 3.8.1- by WHO Region (y=2023)
3. UHC Service Coverage Index -SDG 3.8.1- by WB income category (y=2023)
4. Financial hardship in health and components Map -SDG 3.8.2
5. Financial hardship in health and components -SDG 3.8.2- by WHO Region (% population; y=2022)
6. Financial hardship in health and components -SDG 3.8.2- by WB income category (% population; y=2022)
7. Major causes of death worldwide for all ages, all sexes (2023)
8. Need for palliative care for decedents and non-decedents (2023)
9. Worldwide need of palliative care by age group (2023)
10. Worldwide need for palliative care for adults, by major diagnostic group (20+ years, 2023)
11. Worldwide need for palliative care for adults, by disease groups (20+ years, 2023)
12. Worldwide need for palliative care for adults, by age and disease groups (20+ years, 2023)
13. Worldwide need for palliative care for adults, by WHO region (20+ years, 2023)
14. Worldwide need for palliative care for adults, by WHO region and per 100,000 population (20+ years; 183 countries; 2023)
15. Worldwide need for palliative care for adults, by WHO region and disease categories (20 + years; 183 countries; 2023)
16. Worldwide need for palliative care for adults by World Bank income category (20+ years; 2023)
17. Worldwide need for palliative care for adults per 100,000 population by World Bank income category (20+ years; 2023)
18. Worldwide need for palliative care for adult decedents and non-decedents by major disease categories in LMICs. (20+ years; 2023)
19. Worldwide need for palliative care for adult decedents and non-decedents by major disease categories in HICs. (20+ years; 2023)
20. Worldwide need for palliative care for children by WHO region (20+ years, 2023)
21. Worldwide need for palliative care for children per 100,000 population by WHO Region (0-19 years; 2023)
22. Worldwide need for palliative care for children by disease groups (0-19 years; 2023)
23. Worldwide need for palliative care for children (0-19) by WHO regions and disease categories (183 countries; 2023)
24. Worldwide need for palliative care for children (0-19) by income group (183 countries; 2023)
25. Worldwide need for palliative care for children per 100,000 population by World Bank income category (0-19 years; 2023)
26. Worldwide need for palliative care for children (0-19), decedents and non-decedents, by major disease categories* in LMICs (2023)
27. Worldwide need for palliative care for children (0-19), decedents and non-decedents, by major disease categories* in HICs (2023)
28. Public Health Model for Palliative Care Development
29. Global map of morphine consumption worldwide per capita
30. Global Map of Total Opioid Consumption in Morphine Equivalents (minus methadone) Per Capita
31. Barriers to children's palliative care
32. What is the essential package of palliative care services for adults?
33. What is the essential package of palliative care services for children?
34. Integrating Palliative Care and Symptom Relief into Humanitarian Emergencies
35. Palliative care model of "Total pain" adapted for Stroke
36. Primary and Specialty Palliative Care Integration in Serious Respiratory Illness
37. Percentage of Countries with Funding for Palliative Care by WHO Region
38. Percentage of countries with palliative care in primary care
39. Percentage of countries with palliative care in home care
40. Percentage of countries with Oral morphine reported as generally available in public health sector primary care facilities, by WHO region and World Bank income group
41. Levels of palliative care development in all countries
42. Rates of Specialised Palliative Care Services per 1 million Population
43. Rates of patients receiving specialised palliative care per million population
44. Proposed Primary Palliative Care Indicators
45. Proportion of patients with a Key Information Summary (KIS) in place before death
46. Global map of the levels of children's palliative care development per country in 2023.
47. Percentage of countries at the different levels of children's palliative care development in 2018 and 2023
48. Global state of caregiving
49. Transitional Bereavement Care Conceptual Model
50. Canuck Hospice Needs Based Approach

Tables

1. 2021 Global Opioid consumption data vs 2017
2. Relationship between the sets of indicators and the palliative care development conceptual framework (WHO, 2021)
3. Proposed Correspondence Between the 2020 Global Map Categories and the 2025 Classification Levels
4. Group 1 countries with minimal or absent palliative care development
5. Group 2 Countries with initial or uneven development
6. Group 3 countries with consistent development across dimensions
7. Group 4 countries with high levels of integration across dimensions
8. Number of Services and the Patients Served by Income Group and Region
9. Comparison of Services from 2017 to 2025 by Income Group & Region
10. Comparison of Patients Served from 2017 to 2025 by Income Group & Region
11. Levels of children's palliative care development
12. Levels of children's palliative care development in 2023
13. Levels of children's palliative care development across WHO regions in 2023
14. Levels of children's palliative care development in 2023

Acronyms

This list is confined to acronyms used more than once, and in more than one place, within the main chapters of this book.

AFRO	African Region of the World Health Organization
AMRO	Regional Office for the Americas of the World Health Organization
CESCR	Committee on Economic, Social and Cultural Rights
DR-TB	Drug Resistant Tuberculosis
EMRO	Eastern Mediterranean Region of the World Health Organization
EURO	European Region of the World Health Organization
ICESCR	International Covenant on Economic, Social and Cultural Rights
INCB	International Narcotics Control Board
INESCR	UN Committee on Economic, Social, and Cultural Rights
IOELC	International Observatory on End-of-Life Care
inh	Inhabitants
LICs	Low-Income Countries
LMICs	Low and Middle-Income Countries
NCD	Non-communicable disease
PC	Palliative Care
SEARO	Southeast Asian Region of the World Health Organization
SHS	Serious Health-related Suffering
UHC	Universal Health Coverage
UN	United Nations
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WHA	World Health Assembly
WHPCA	Worldwide Hospice Palliative Care Alliance
WISH	World Innovation Summit on Health
WPRO	Western Pacific Region of the World Health Organization

Foreword

The publication of this third edition of the Global Atlas of Palliative Care is a continuation of our efforts, in cooperation with the World Health Organisation, to monitor the progress of palliative care worldwide. In the past six years since the last edition was published, we have seen significant growth in the delivery of specialised palliative care, up more than 35% in the number of providers and over 50% in the number of patients served.

Along with this growth the need for palliative care for adults and children is also increasing to now over 73 million, though most of this new growth is for those with serious health related suffering before their last year of life. We are heartened by the creativity of colleagues around the world to find new and innovative ways to deliver palliative care and to integrate palliative care into mainstream health care systems **(See chapter 5)**.

Many challenges remain including continuing lack of access to essential palliative care medicines, education on palliative care for millions of health care workers, volunteers, and community members, policy and political will, research and increased compassionate community support. Fortunately, we have the tools to meet these challenges if we have the resources needed. Palliative care champions have always risen to the occasion to meet these challenges with our shared sense of mission and purpose.

Palliative care is a model fit for the future of health care. With the unparalleled ageing of the world's population and the rise in noncommunicable disease palliative care is the best model of cost-effective people centred care in the healthcare system.

Serious human suffering from illness and injury have been with us since the beginning. We now have the tools to ease this suffering and to provide compassionate whole person care that improves quality of life and dignity for the most seriously ill in our communities worldwide. It's time to embrace palliative care and join us in achieving universal access to palliative care for all.



Dr James Cleary
Board Chair, WHPCA

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Chapter 1

Introduction

Stephen Connor, William E. Rosa, Frank Brennan, Megan Doherty, Julia Downing, Elizabeth Gwyther, Michael McNeil



London, UK 2026
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This third edition of the Global Atlas of Palliative Care updates the current situation of global palliative care development since the original version was published in 2014 and revised in 2020. A lot has happened in the intervening years including the passage of the World Health Assembly's resolution on palliative care (WHA67.19). While progress is being made to meet the unmet need for palliative care globally the remaining gap in access to care continues to be unacceptable.

The need for palliative care has never been greater and is increasing at a rapid pace due to ageing of the world's population, increases in cancer and other non- communicable diseases, along with the impact of COVID-19. By 2060 the need for palliative care just at the end of life is expected to rise from 26 million in 2016 to 48 million (1).

Outside North America, Western Europe, and Australia, access to quality palliative care continues to be minimal even though 76% of the need is in low-and-middle income countries. Children are also less likely to have access to palliative care than adults.

While the need for palliative care was initially recognized primarily for people living with cancer, there is now growing global awareness that it is essential for individuals affected by a wide range of chronic and life-limiting conditions, including advanced HIV disease, congestive heart failure, cerebrovascular disease, neurodegenerative disorders and dementias, chronic respiratory diseases, drug-resistant tuberculosis, injury, advanced kidney and liver disease, and diseases of older people. However, there remains a huge unmet need for palliative care for these health problems in most parts of the world.

The purpose of this Atlas is to systematically document the global need for palliative care and to provide evidence-informed data to support development, implementation, and scale-up of services. This document addresses the following questions:

- What is palliative care?
- How many people need palliative care worldwide?
- What are the main diseases requiring palliative care?
- What are the main barriers to palliative care?
- Where are the existing gaps?
- How well is palliative care developed in each country?
- Where is palliative care currently available?
- What are the models palliative care programmes worldwide?
- What guidance documents are available for palliative care?
- What is the way forward?

What is palliative care for adults, for children?

WHO definition of palliative care

In 2002, the World Health Organization (2) established a revised definition of palliative care for adults and children, the introduction for which was modified in the 2014 WHO Palliative Care Resolution:
Palliative care is an approach that improves the quality of life of patients (adults and children) and their families who are facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual. Palliative care:

- provides relief from pain and other distressing symptoms,
- affirms life and regards dying as a normal process,
- intends neither to hasten or postpone death,
- integrates the psychological and spiritual aspects of patient care,
- offers a support system to help patients live as actively as possible until death,
- offers a support system to help the family cope during the patients' illness and in their own bereavement,
- uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated,
- will enhance quality of life, and may also positively influence the course of illness,
- is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

WHO definition of palliative care for children

Palliative care for children represents a special, albeit closely related field to adult palliative care. WHO's definition of palliative care appropriate for children and their families is as follows; the principles apply to other paediatric chronic disorders (3).
Palliative care for children is the active total care of the child's body, mind and spirit, and involves giving support to the family.

- It begins when illness is diagnosed and continues regardless of whether a child receives treatment directed at the disease.
- Health providers must evaluate and alleviate a child's physical, psychological, and social distress.
- Effective palliative care requires a broad multidisciplinary approach that includes the family and makes use of available community resources; it can be successfully implemented even if resources are limited.
- It can be provided in tertiary care facilities, in community health centres and even in children's homes.

Definition of Hospice

Hospes and *hospitium* are Latin roots for the sacred duty of reciprocal hospitality. Later, hospice, derived from these words and was used to describe a place of refuge for weary or sick travellers seeking rest on life's journey.

Today, hospice care is one model of providing palliative care including the relief of pain, symptoms, and emotional or spiritual distress, and is often focused on care near the end-of-life. Care is delivered by an interdisciplinary team and prioritizes quality of life, comfort, and dignity. Care ensures support for the patient and their family. Whenever possible, care is provided in the patient and/or families preferred setting, respecting each person's culture, preferences, and values. The word hospice has also been used to describe a place where palliative care is delivered (4).



Courtesy of WHPCA

What is the relationship between curative and palliative care?

The aim of palliative care is to relieve suffering to improve quality of life for those with serious health related suffering. Palliative care can be delivered at the same time as treatments aimed at curing or slowing disease. Palliative care professionals closely monitor symptoms and can help identify when treatments may be increasing a person's suffering, supporting informed decision-making as illness progresses or improves.

A Global Mandate for Expanding Palliative Care

1. Palliative Care and Human Rights

Palliative care is a basic human right. However noble and self-evident this proposition is, it needs to be based on a solid foundation (5). Under international law, a universal right to health care exists (6). That right is articulated in multiple United Nations human rights conventions (7). As Palliative Care is a vital component of health care; it is a human right. The logic of this concept has been recognised within the United Nations human rights system (8).

What is the content of this right? The Committee that oversees the main articulation of the international right to health set out the important elements of the health right. It stated that the obligation on signatory nations is availability, accessibility, acceptability and quality of health care provision (9). They set out "core obligations" on all signatory nations, irrespective of their resources (10). Relevant to Palliative Care, those core obligations include access to WHO Essential Medications (including morphine), the provision of palliative care without discrimination and the presence of a national health policy that includes palliative care. The Committee stated it is critical to provide "attention and care for chronically and terminally persons, sparing them avoidable pain and enabling them to die with dignity." (8)

In addition to health care, other sources for the human right to Palliative Care are the right to non-discrimination, the principle of human dignity and the right against cruel and inhuman treatment.

As a point of advocacy, the concept of palliative care as a human right has been endorsed by multiple organizations and Palliative Care bodies (11).

That advocacy contributed to the seminal resolution of the World Health Assembly (WHA) on Palliative Care in 2014(12). It called upon member states and the WHO to improve access to palliative care as a core component of health systems.

In the modern era, another universal standard, relevant to palliative care, emerged: Universal Health Coverage (UHC). UHC "aims at ensuring people worldwide have access to essential health services without suffering financial hardship, from health promotion, treatment, rehabilitation and palliative care." (13) In essence, UHC is "an expression of an important dimension of [the right to health.]" (13)

In summary, there are three pillars of international obligations on nations to provide palliative care: international human rights law; the World Health Assembly Resolution and Universal Health Coverage. Together, they provide a clear framework and impetus for nations to engage in the creation, nurturing and progressing of palliative care services domestically and internationally.

2. World Health Assembly Resolution on Palliative Care

In 2014 the World Health Assembly (WHA) unanimously passed resolution WHA67.19 "Strengthening of Palliative Care as a Component of Comprehensive Care Throughout the Life Course."(14) This resolution calls on all member states to strengthen and integrate palliative care throughout their health care systems by ensuring that policies are implemented, comprehensive education on palliative care is available, essential palliative care medicines are available and accessible, and that palliative care is funded and implemented. The resolution called on WHO to strengthen palliative care in the following areas:

- Supporting integrating palliative care into all relevant global disease control and health system plans.
- Supporting member states to develop guidelines and tools to integrate palliative care across disease groups and levels of care, addressing ethical issues related to the provision of comprehensive palliative care.
- Supporting Member States to improve access to palliative care medicines through improved national regulations and delivery systems.
- Promoting increased access to palliative care for children, (in collaboration with UNICEF).
- Monitoring global situation of palliative care in collaboration with Member States and international partners indicators for evaluating palliative care services.
- Encouraging adequate funding for palliative care programmes and research, especially in resource-limited countries; and
- Encouraging research on models of palliative care that are effective in low- and middle-income settings.

See **Appendix 3** for details from the WISH (World Innovation Summit on Health) report on progress in implementing the aims of the resolution ten years after passage

3. Overview of Palliative Care Economics Case for Support

1. Summary of the economic benefits of investing in palliative care.

Research evidence shows that, in addition to the benefits to individuals of all ages who have access to palliative care, palliative care results in cost savings. This evidence provides added incentive to health managers and policy makers to mainstream palliative (5) care services into national health plans.

Palliative care reduces resource use and associated costs of hospital inpatient admissions as goals of care discussions and discharge planning result in shorter lengths of stay for people with serious illness. Better

understanding of patient preferences can eliminate use of some services that have limited efficacy near the end of life resulting in fewer non-beneficial treatments and the associated costs. Improved pain and symptom control, and access to outpatient and home care services, reduces the risk of repeat hospital admissions (15 16). Active patient involvement in health decision-making result in improved symptom control and improved physical and mental health, thus reducing needs for additional health care services and the associated costs (17).

Living with incurable disease is a significant life event that affects not only the health but also the well-being and labour market participation of patients and family members. Informal caregivers are those who care, unpaid, for a sick family member or friend. Often, they have left their primary job or reduced their working hours to do so, and such caregiving causes significant loss of income (18) and can have negative health and wellbeing consequences on caregivers particularly when caring for children (19). Palliative care benefits informal caregivers through reducing the burden of care which then improves caregiver and family quality of life. Better experiences of serious illness, end of life care and bereavement have long-term health benefits for caregivers and family members, supporting holistic household well-being, ongoing schooling for dependents and employment for adult caregivers (20 21).

2. Current healthcare costs

Living with and dying from serious, life-limiting illness is one of the most costly things that humans do, in every country, regardless of whether the country is of low-, middle- or high-income status (22). It is critically important to ensure that resources used at this time in a person's life focus on providing the best experience for the patient and their family, avoiding, wherever possible, impoverishment and the burden of inter-generational debt (23 24). Wherever documented, costs of healthcare near the end of life are high across the globe (25). Health care provided in the last year of life is known to account for a large proportion of these costs. Health system costs increase in advanced illness because of additional clinic visits, in-patient hospitalisation, admission to intensive care units, and the impact of medication costs. Depending on national funding mechanisms, these costs, plus additional costs of transport, medication and caregiving, may require exorbitant out-of-pocket expenditure by patients and family members, often drawing on the resources of extended family networks (23).

The fact that clinicians may not recognise the stage of the illness or may be reluctant to communicate the progressive nature of the illness means that patients and families continue to seek curative treatment (26). In addition, non-beneficial treatment may be continued because of uncertainty of prognosis, a sense of duty to cure, family demands, lack of opportunity for end-of-life discussions or advance care planning, communication failures between health professionals and patients (and family members), "a culture of doing everything possible even if against the patient's wishes", a perception of "death as treatment failure". Patient-centred discussions would result in recommendation to continue disease modifying treatment if there is uncertainty regarding disease progression and prognosis. However, these discussions would provide space to consider withdrawal of treatment, if appropriate, and to focus on supportive interventions including palliative care (27).

3. Suggestions of funding mechanisms for palliative care

There is good evidence that better use could be made of existing end-of-life care resources, where access is given to symptom management and palliative care services (25 28 29). Making access to palliative care affordable and easier for service users reduces the burden on other services such as hospital care and ICU care, which are less appropriate and less effective in advanced illness. While the level of pooled funds for health care does and will vary between countries, with similar differences in the scope of services funded by pooled funds, the mechanisms for funding essential palliative care should ensure that these avoid significant user fees and minimise the risk of catastrophic costs to families.

The Lancet Commission (2018) estimated that for low-income countries the annual cost of the PC essential package is about USD 2.16 per capita, or 2-3% of the cost of the model UHC package developed by the third edition of the Disease Control Priorities. This essential package of palliative care (30) should be considered as part of the process of priority setting for developing explicit health benefit service packages. Where palliative care has been developed by and funded by NGOs and other voluntary organisations, (17 31) there may be value in retaining these additional resources, recognising that the need for care will increase. However, the aim should be to develop funding flows in palliative care within existing pooled funding financing mechanisms to ensure equity of access to palliative care.

Palliative Care and Universal Health Coverage

The 2015 UN Sustainable Development Goals are the roadmap to improving life on earth. The continuum of universal health coverage under the United Nations Sustainable Development Goal number three (3.8) includes Promotion, Prevention, Treatment, Rehabilitation, & Palliative Care. There is no 'universal' health coverage without palliative care. All nations need to include palliative care in their plans for Universal Health Coverage. While there is no clear measurement of palliative care in UHC **Figures 1, 2, & 3** show the progress and lack of progress in achieving universal health coverage worldwide in general. **Figures 4, 5, & 6** show the degree of financial hardship in health by region and income group in 2023. Palliative care is one of the ethical ways of reducing poverty due to unnecessary heath costs.

Figure 1:
UHC Service Coverage Map -SDG 3.8.1- (y=2023)

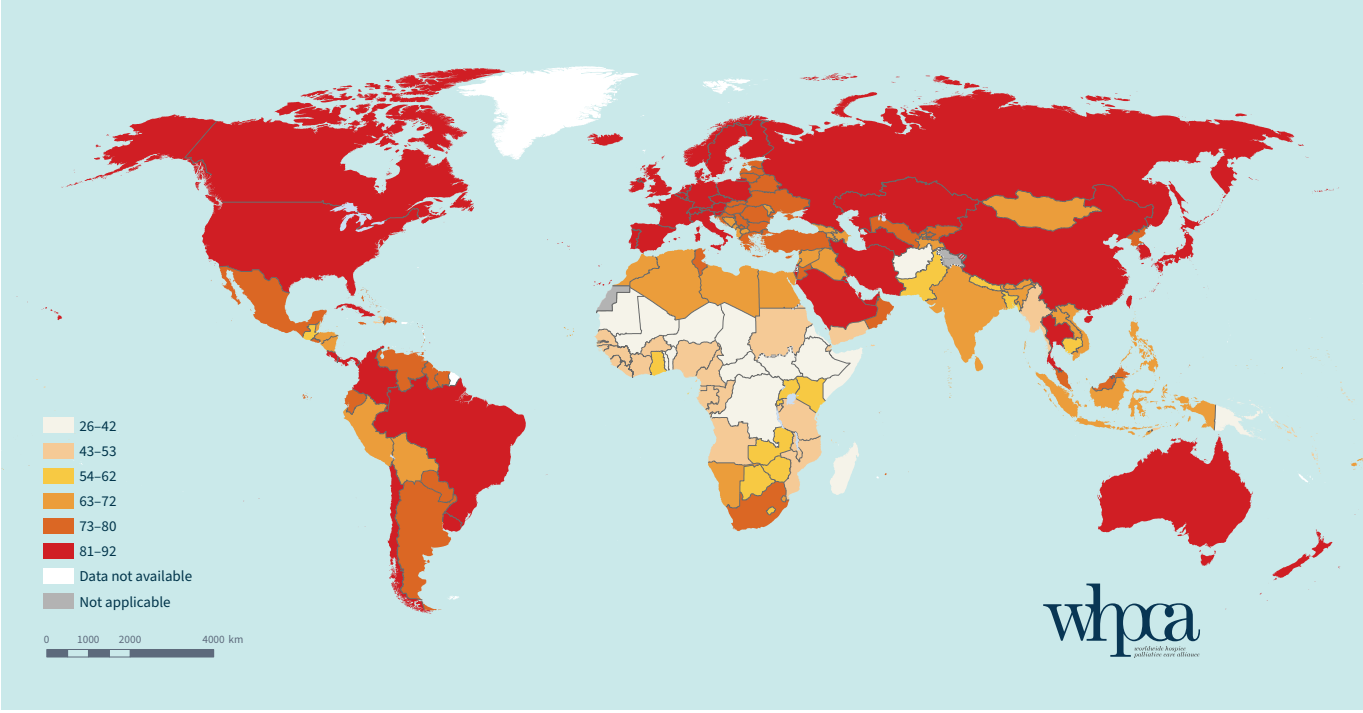


Figure 2:
UHC Service Coverage Index -SDG 3.8.1- by WHO Region (y=2023)

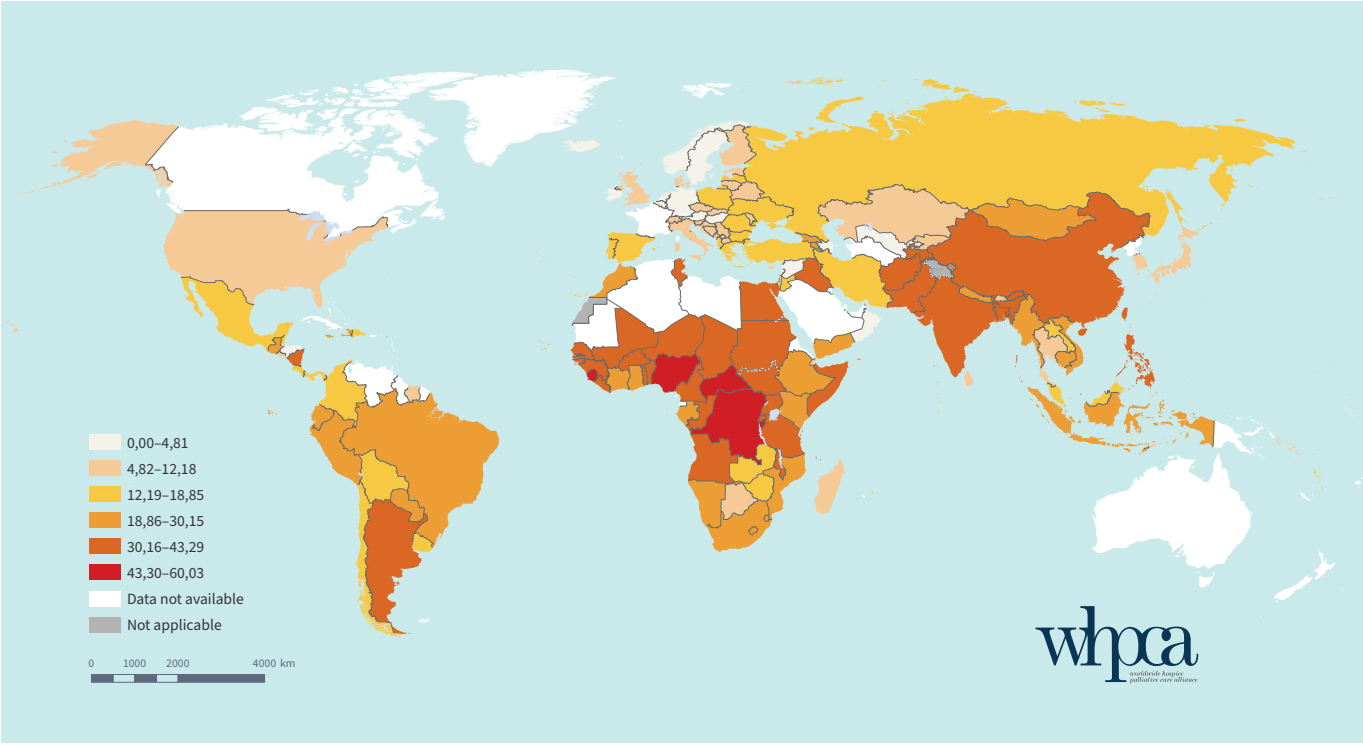


Figure 3:
UHC Service Coverage Index -SDG 3.8.1- by WHO Region (y=2023)

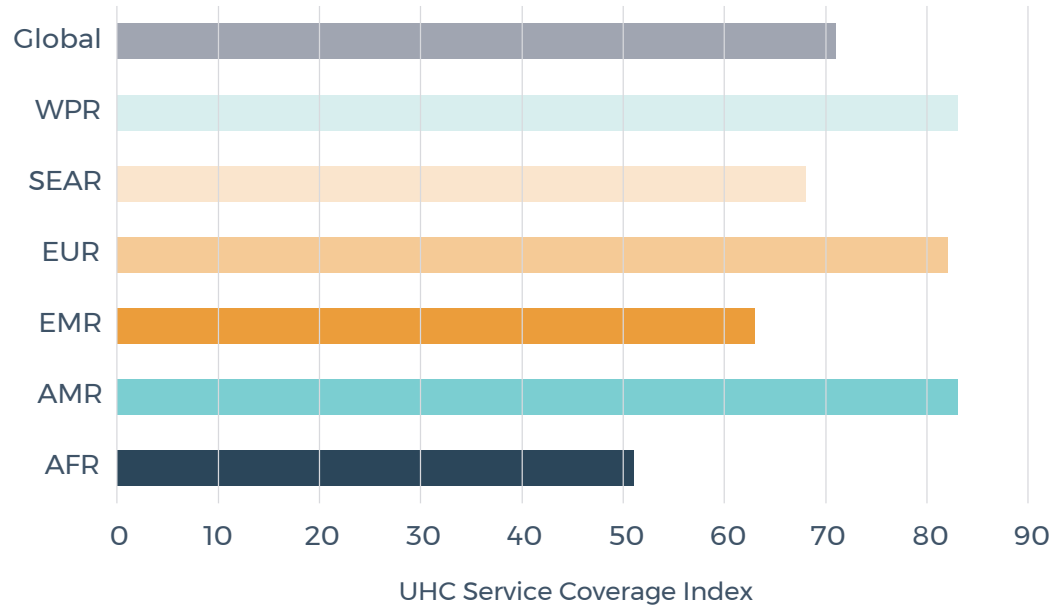
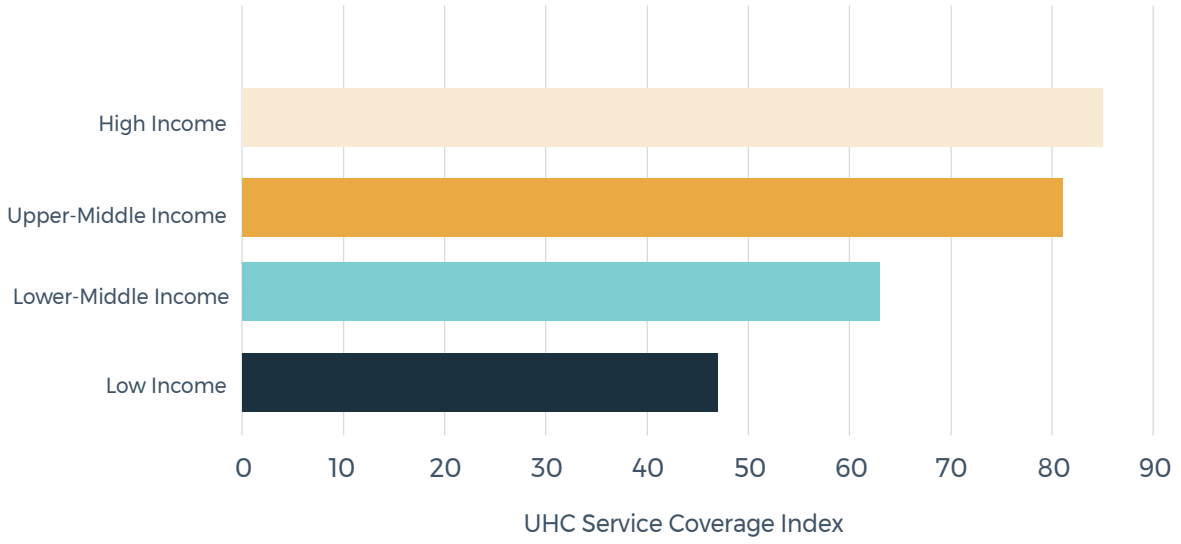


Figure 4:
Financial hardship in health and components Map -SDG 3.8.2



Source: *World Health Organization. UHC service coverage index (year=2023). Global Health Observatory; 2026 Available from: https://www.who.int/data/gho/data/indicators/indicator-details/GHO/uhc-index-of-service-coverage*

Figure 5:
Financial hardship in health and components -SDG 3.8.2- by WHO Region (% population; y=2022)

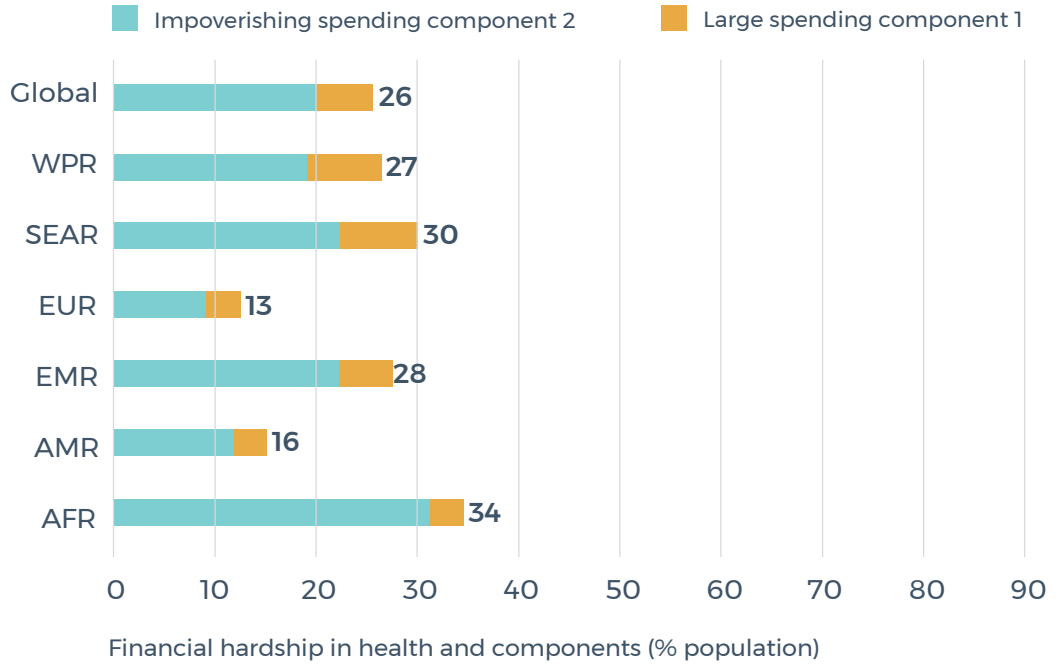
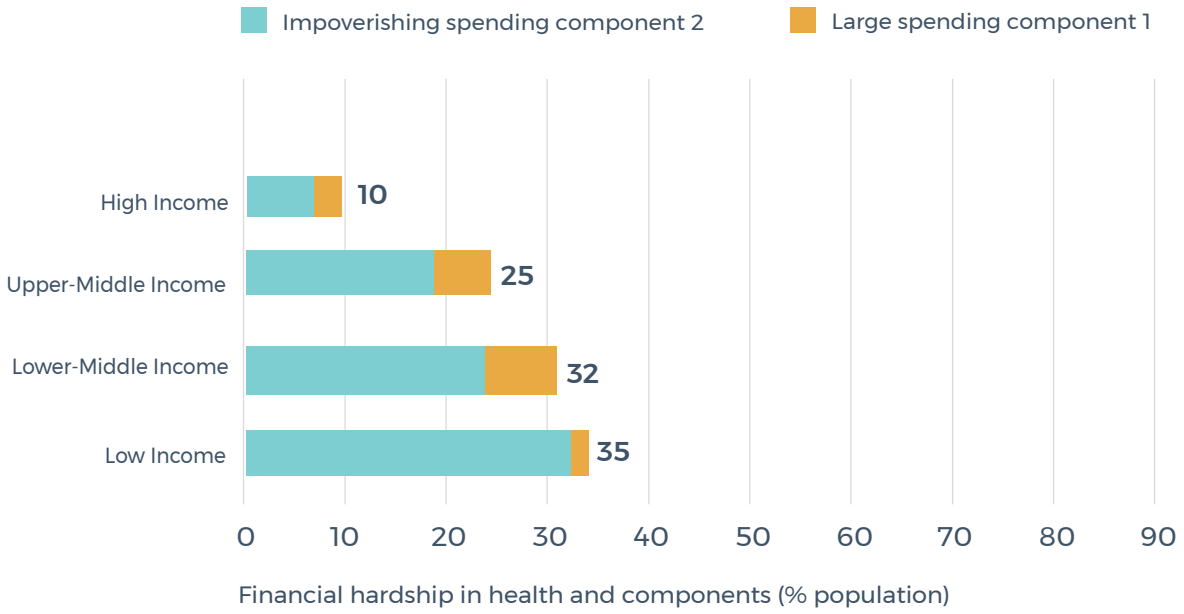


Figure 6:
Financial hardship in health and components -SDG 3.8.2- by WB income category (% population; y=2022)



Source: *World Health Organization. Financial hardship in health and components (y=2022). Global Health Observatory; 2026. Available from: https://www.who.int/data/gho/data/indicators/indicator-details/GHO/financial-hardship-in-health-and-components-of-population-by-country*



Courtesy of Epiphany Ewusu

Chapter 2

How many adults and children need palliative care worldwide?

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The authors acknowledge contributors to the Lancet Commission on Global Access to Palliative Care and Pain Relief report that introduced the serious health-related suffering (SHS) methodology and contributors to subsequent efforts that have updated the methodology and conducted relevant SHS empirical analyses. We would like to specifically express our gratitude to expert contributors to the SHS 2.0 methodology, as the extended estimates presented in this chapter apply these methods (Julia Ambler, Nickhill Bhakta, Jim Cleary, Megan Doherty, Richard Hain, Dean T. Jamison, Rut Kiman, Mary Ann Muckaden, Christian Ntizimira, Pedro E. Pérez-Cruz, Marianne Phillips, Dingle Spence, David Watkins).



Executive Summary

Worldwide, more than 73.5 million people (adults and children combined) experience serious health-related suffering (SHS) and require palliative care every year, including 45.9 million prior to and 27.6 million near the end of life. Thus, most people in need (62.4%) are non-decedents who need palliative care prior to their last year of life. The majority (64.3%) are adults over 50 years old and at least 14.4% are children. The burden of SHS, and the corresponding need for palliative care, are immense. Yet palliative care is still not accessible by most people in need, especially in low- and middle-income countries (LMICs).

Non-communicable diseases account for 73.6% of adult palliative care need. Among adults, the health conditions that most account for SHS and generate the greatest need for palliative care interventions are cancer (excluding leukaemia) (27.9%), HIV/AIDS (18.7%), cerebrovascular diseases (13.2%), and dementia (12.3%). Most adults in need of palliative care (72.9%) live in LMICs. The Western Pacific, Africa, and South-East Asia Regions account for 63.6% of adults in need of palliative care, while the European and Americas Regions account for 31.8% and the Eastern Mediterranean Region account for 4.6%. The greatest need per 100,000 population is in the Africa Region (2,161 per 100,000) (related to the high incidence of HIV) followed by Europe (1,490) and the Americas (1,239) Regions, where population ageing and higher prevalence of chronic non-communicable diseases contribute substantially to SHS. In the Africa Region, HIV/AIDS predominates over all other conditions (66.5%) with cancer (excluding leukaemia) accounting for just 7.7% of SHS.

Globally, the need for children's palliative care arises predominantly from non-malignant diseases, which account for the greatest burden across all regions. Children with endocrine, metabolic, blood and immunes disorders (EMBID) represent over half (51.4%) of the need for palliative care, followed by children with extreme prematurity and birth trauma (18.0%), injury, poisoning, and external causes (6.7%) and HIV/AIDS (6.2%). Cancer and leukaemia represent just 5.0% of the overall palliative care need among children.

The vast majority (96.2%) of children aged 0-19 years in need of palliative care live in LMICs. Taking population size into account, the need for children's palliative care is highest in the African Region (936 per 100,000), followed by Southeast Asia (308 per 100,000). More specifically, the Africa Region accounts for over half the need for palliative care among children (55.9%), followed by South-East Asia (18.1%), the Eastern Mediterranean (9.2%), the Western Pacific (8.9%), and finally, Europe and the Americas, which together account for only 7.9% of palliative care need among children.

Introduction

The World Health Assembly resolved in 2014 that the provision of palliative care is an ethical responsibility of health systems and a key component of universal health coverage (UHC) (32). The effective integration of palliative care into health systems requires accurate assessment of global palliative care need. Up-to-date estimates enable health care planners, implementers and managers to organise the resources and training necessary to respond appropriately to evolving need (33 34 35). Decedents are defined as people who will die within the year of estimation and thus will be captured by the mortality data, while non-decedents are defined as people who will not die within the year of estimation and thus will be captured in the prevalence data (38). This Atlas, now in its third edition, assesses palliative care need at regular intervals and provides updated estimates to 2023 (36). With time, epidemiological transitions, as well as changes in prevention, early detection and treatment of serious illness, and rehabilitation alter the types and distribution of palliative care needs for both decedents and non-decedents. The estimates are based on the concept of serious health-related suffering (SHS) pioneered by the Lancet Commission on Global Access to Palliative Care and Pain Relief and subsequent efforts to strengthen methods and estimation by the Research Hub on Global Access to Palliative Care and Pain Relief (36 38 39). Suffering is health-related when it is associated with illness or

injury of any kind, and it is moderate or severe when it cannot be relieved without the intervention of a health care professional, and when it compromises physical, social, spiritual, and/or emotional functioning. Palliative care should be focused on relieving SHS due to severe illness, particularly at the end of life. SHS is a proxy for palliative care need (37).

Summary of methodological updates:

This third edition presents data based on considerable expansion of the conceptualisation and methodology for estimating palliative care need compared to the second edition of the Atlas. The SHS methodology was first introduced and detailed in the 2018 report of the Lancet Commission on Global Access to Palliative Care and Pain Relief and its data appendix (37). The SHS 2.0 methodology, on which the estimates presented in this chapter are premised, refined the approach, as described in-depth in the corresponding paper with related strengths and limitations (38). Moreover, over time estimates of SHS from 1990 to 2021 and specifically of children 0-19 years using SHS 2.0 methods have been published (36,39). The SHS data are available through the website of the International Association for Hospice and Palliative Care - IAHPC (https://iahpc.org) and detailed in other publications (38 39).

The key methodological differences, as compared to the second Atlas, are as follows:

- The SHS estimates are anchored in the Global Burden of Diseases, Injuries, and Risk Factors Study (GBD) data, using country-specific disease mortality, incidence and prevalence data, introducing adjustments to reduce risk of double counting across a subset of diseases, and revisions to non-decedent estimates for several conditions.

- The methodology for estimating SHS in children has been revised to incorporate in-depth considerations necessary for generating children-specific multipliers (the proportions or ratios children dying or living with SHS in any given year). Views of an expert panel to generate the multipliers were gathered through an online survey, two semi-structured expert panel meetings followed by continued consultation throughout. Applying these changes to the methodology, along with the inclusion of EMBID (which includes three sub-conditions: type 1 diabetes, sickle cell disorders, and thalassaemia) has notably increased the estimated number of children with SHS from the second edition of the Atlas (39).

- The number of health conditions by which SHS is categorized increased from 20 to 21. The original groups included: Alzheimer and other dementias, arteriosclerosis, cerebrovascular disease, chronic ischemic heart disease, congenital malformation, degenerative CNS disease, haemorrhagic fevers, HIV/AIDS1 , inflammatory CNS disease, injury, leukaemia, liver disease, low birth weight-premature birth-birth trauma, lung disease, malignant neoplasm, malnutrition, musculoskeletal disorder, non-ischemic heart disease, renal failure, and tuberculosis. Endocrine, metabolic, blood and immunes disorders (EMBID) was added as a major cause of SHS among children.

- World Bank Income Groups are from World Bank (WB) 2024 Income Group Classification, and population data are from the GBD 2023 Population Estimates.

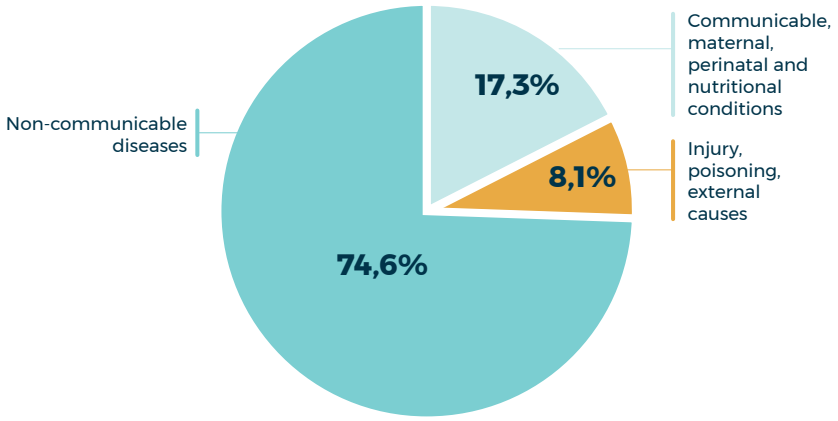
1 *As compared to the rest of the Atlas and corresponding to the GBD data on which SHS estimates are based, the terminology of HIV/AIDS is used in this chapter.*

Overall Mortality Worldwide

As a point of reference, in 2023 there were 60,043,000 deaths from 204 reporting countries and territories worldwide. The great majority of those deaths, (74.6%), were due to non-communicable diseases. **(Figure 7)**

Figure 7:
Major causes of death worldwide for all ages, males and females (2023)

60,043,000 deaths

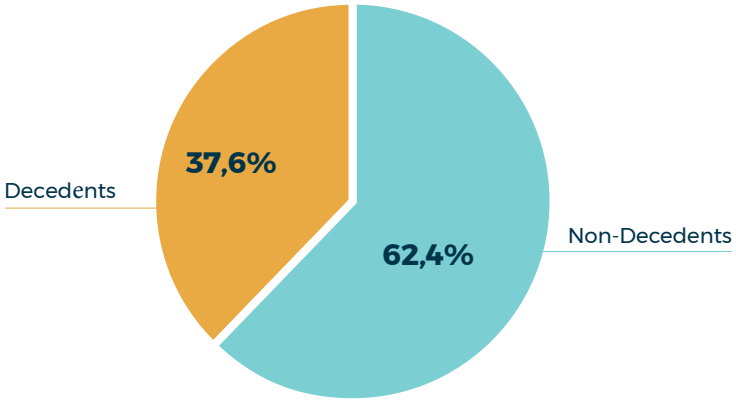


Estimates of people in need of palliative care worldwide

The total, all-age, global need for palliative care is estimated to be approximately 73,586,000 people including both decedents and non-decedents. The need for non-decedents [45,938,000] was higher than for decedents [27,648,000] **(Figure 8)**. Non-decedents accounted for 62.4% of all people with SHS in 2023.

Figure 8:
Need for palliative care for decedents and non-decedents (all ages all sexes; 2023)

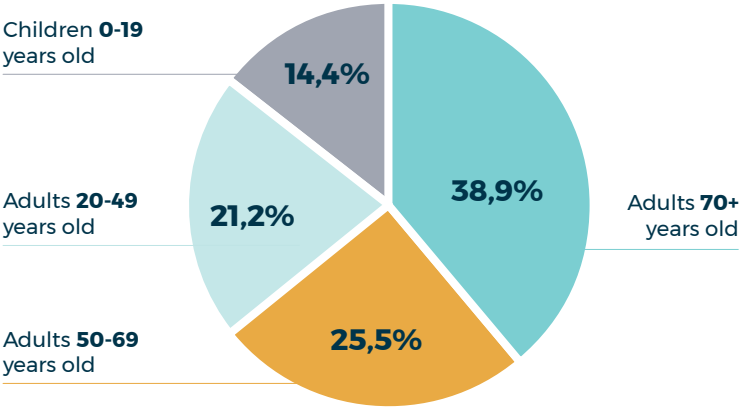
N = 73,586,000 people



Approximately 38.9% of patients in need of palliative care are aged 70 years or older, 25.5% aged 50-69 and, 21.2% aged 20-49 and 14.4% are children (0-19 years) **(Figure 9).**

Figure 9:
Worldwide need for palliative care by age group 2023

N = 73,586,000 people



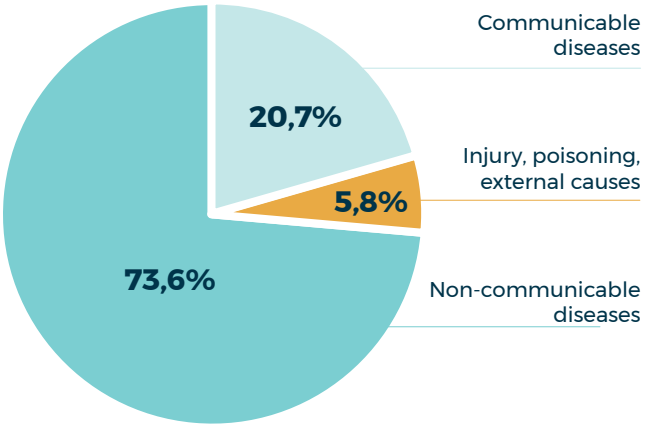
Adults in need of palliative care worldwide

Among adults (aged 20 years and over), 73.6% (46.3 million people) of decedent and non-decedent palliative care need is associated with a non-communicable disease. Communicable diseases such as HIV/AIDS, tuberculosis, and haemorrhagic fever, as well as some injuries also account for an important part of palliative care for adults **(Figure 10)**.

Total need for palliative care for adults was approximately 62,960,000 and there was nearly equal gender distribution (female, 49.8%).

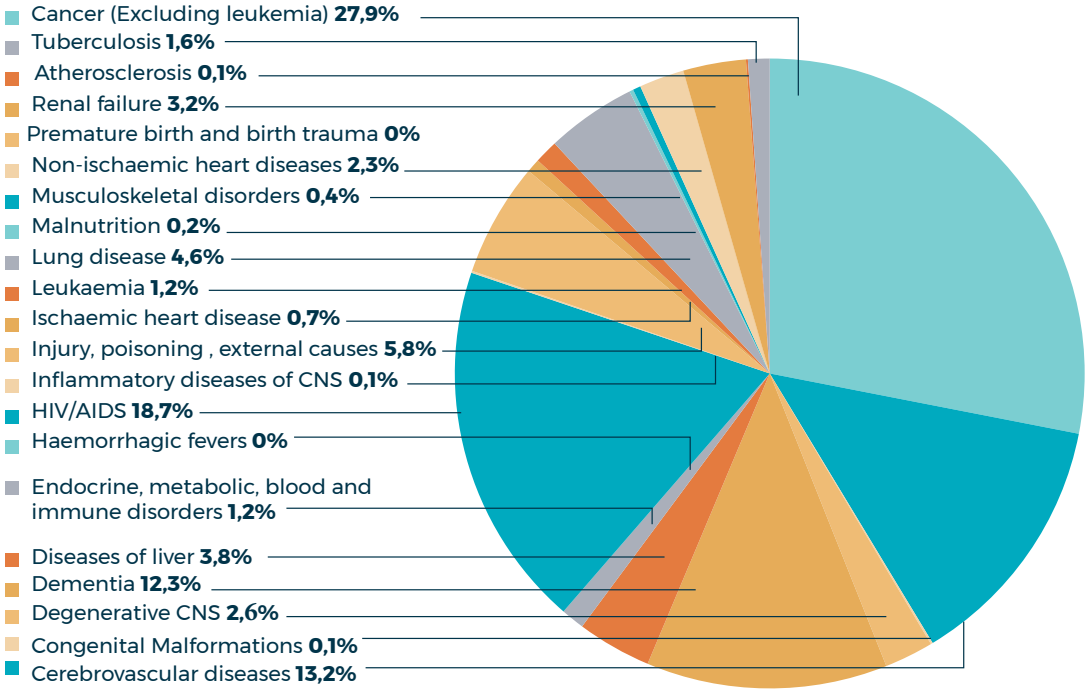
Figure 10:
Worldwide need for palliative care for adults, by major diagnostic group (20+ years, 2023)
Percentages may not sum to 100% due to rounding

N = 62,960,000 adults



Although the largest single disease group accounting for adult palliative care need is cancer (excluding leukaemia) (27.9%), over 70% is associated with other conditions as shown in **Figure 11**. HIV/AIDS, cerebrovascular diseases, and dementia follow in terms of share of SHS burden.

Figure 11:
Worldwide need for palliative care for adults, by disease groups (20+ years, 2023)
Percentages may not sum to 100% due to rounding



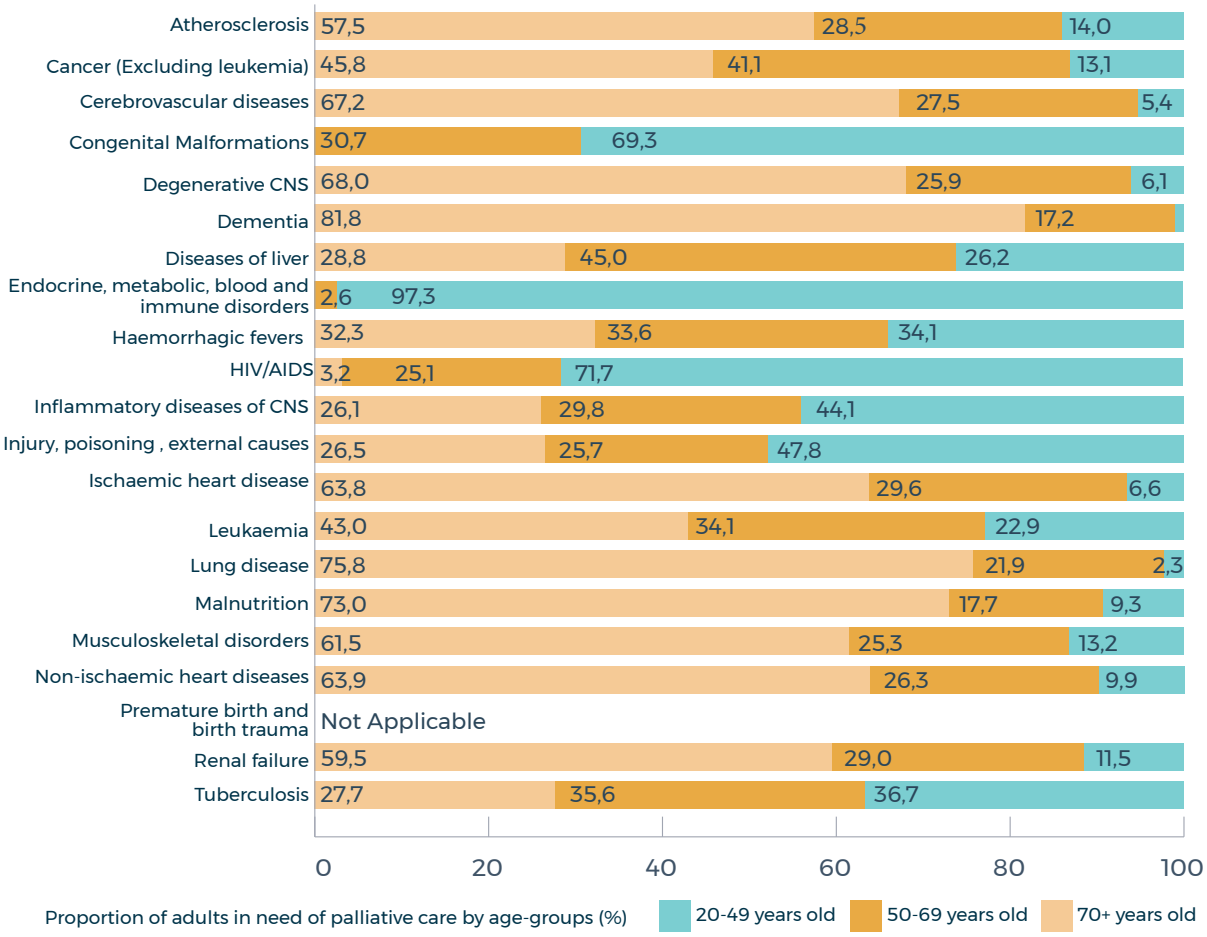
N = 62,960,000 adults

The need for palliative care varies by age group **(Figure 12)** for all 21 diagnostic groups with younger adults contributing more to EMBID, HIV/AIDS, congenital conditions, injury, and inflammatory diseases of CNS.

Figure 12:

Worldwide need for palliative care for adults, by age and disease groups (20+ years, 2023)

Percentages may not sum to 100% due to rounding



Using WHO Member States regional groupings, more than a quarter of adults needing palliative care (28.6%) reside in the Western Pacific Region, followed by the Africa Region (20.4%), Europe (17.3%) and South-East Asia (14.7%). The corresponding proportions in the Americas and Eastern Mediterranean Regions are 14.6% and 4.6%, respectively **(Figure 13).** However, when adjusted for population size, the Africa Region has the highest number of adults in need of palliative care per 100,000 adult population, followed by Europe and the Americas Regions **(Figure 14)**.

Figure 13:

Worldwide need for palliative care for adults, by WHO Region (20+ years, 2023)

N = 62,960,000 adults

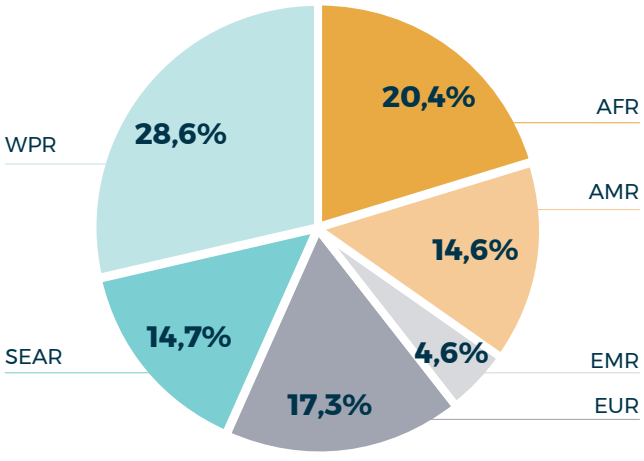
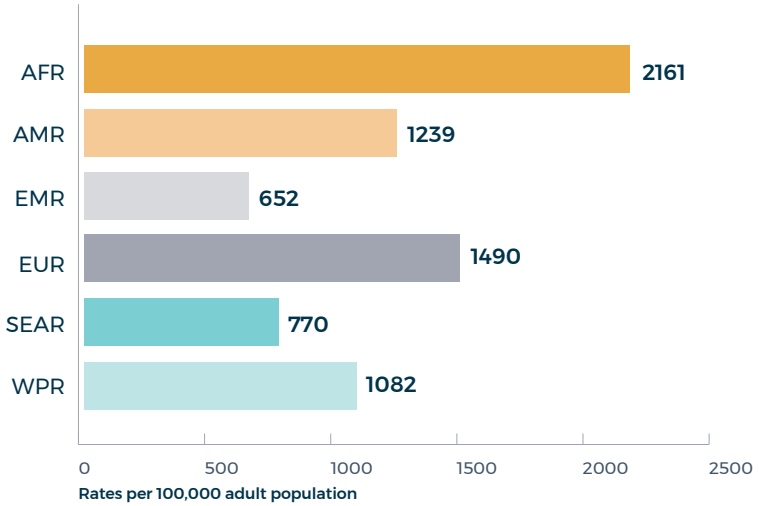


Figure 14:
Worldwide need for palliative care for adults, by WHO region and per 100,000 population (20+ years; 183 countries; 2023)

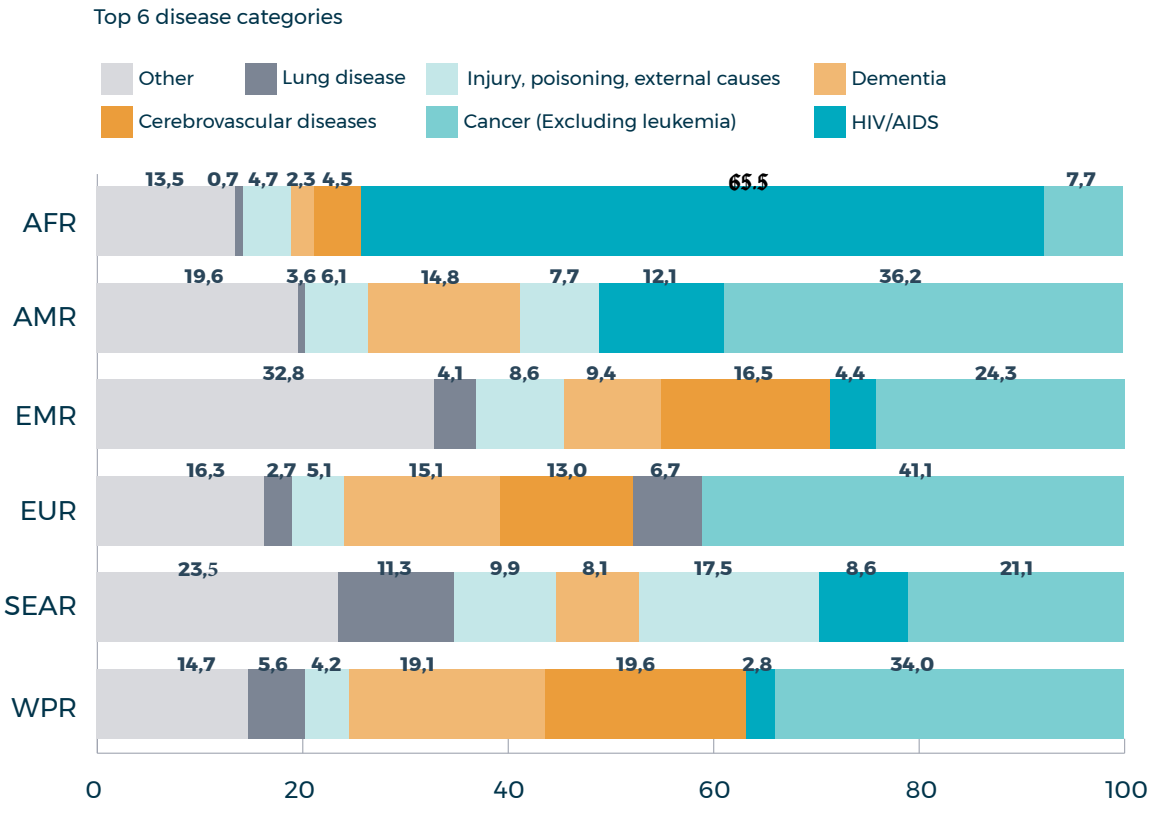
N = 183 countries



Analysing by region, the need for palliative care is grouped into seven categories: cancers (excluding leukaemia); HIV/AIDS; Cerebrovascular diseases; Dementia; Injuries, Poisoning, external causes; lung diseases; and other diseases. HIV/AIDS predominates in the African Region. The proportion of adults in need of palliative care for cancer (excluding leukaemia) is relatively high for all regions except the African Region. It ranges from 7.7% in the African Region to 36.2% in the American Region and 41.1% in the European Region **(Figure 15)**

Figure 15:
Worldwide need for palliative care for adults, by WHO region and disease categories (20+ years; 183 countries; 2023)

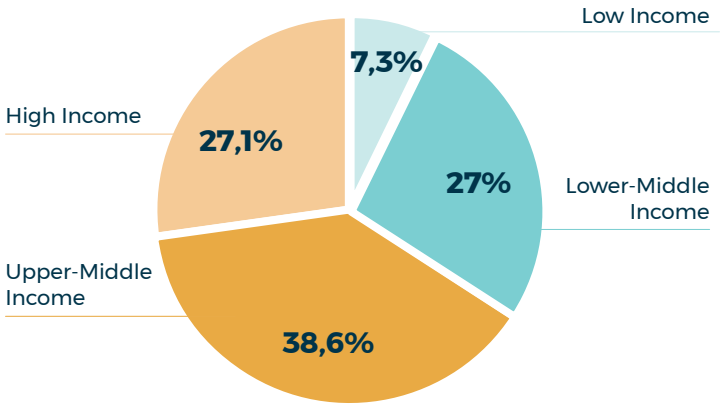
Percentages may not sum to 100% due to rounding



N = 183 countries

Figure 16: Worldwide need for palliative care for adults, by World Bank Income category (20+ years; 2023)

N = 62,960,000 adults



The vast majority, 72.9%, of the 63.0 million adults in need of palliative care live in LMICs **(Figure 16)**. Most (65.6%) live in the upper and lower middle-income groups. However, the highest ratios per 100,000 adult population in need of palliative care are found in high-income countries (HICs) **(Figure 17)**, which could be attributed to aging populations and individuals living longer due to improved access to health care. The conditions that most often generate a need for palliative care in decedents and non-decedents differ between HICs and LMICs. There are many more non-decedents with HIV/AIDS who need palliative care in LMICs than in HICs **(Figures 18 & 19)**.

Figure 17: Worldwide need for palliative care for adults, per 100,000 population by World Bank Income category (20+ years; 2023)

N = 183 countries

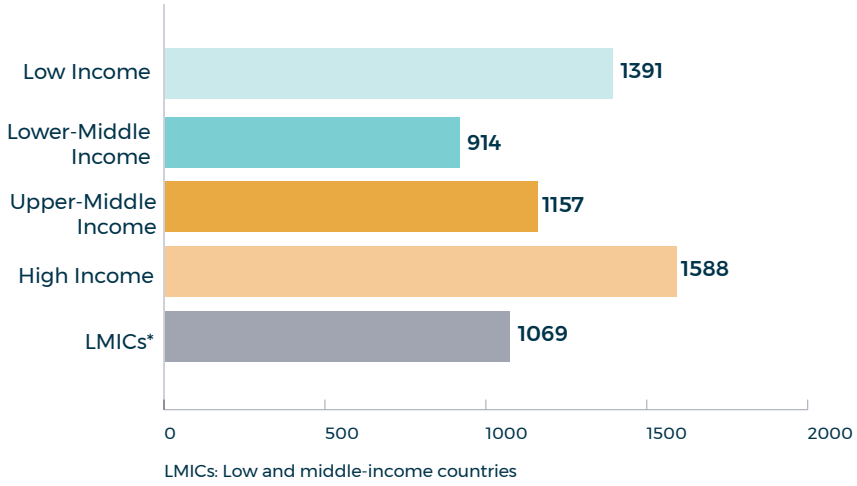


Figure 18: Worldwide need for palliative care for adult decedents and non-decedents by major disease categories* in LMICs (20+ years; 2023)

N = 45,868,000 adults

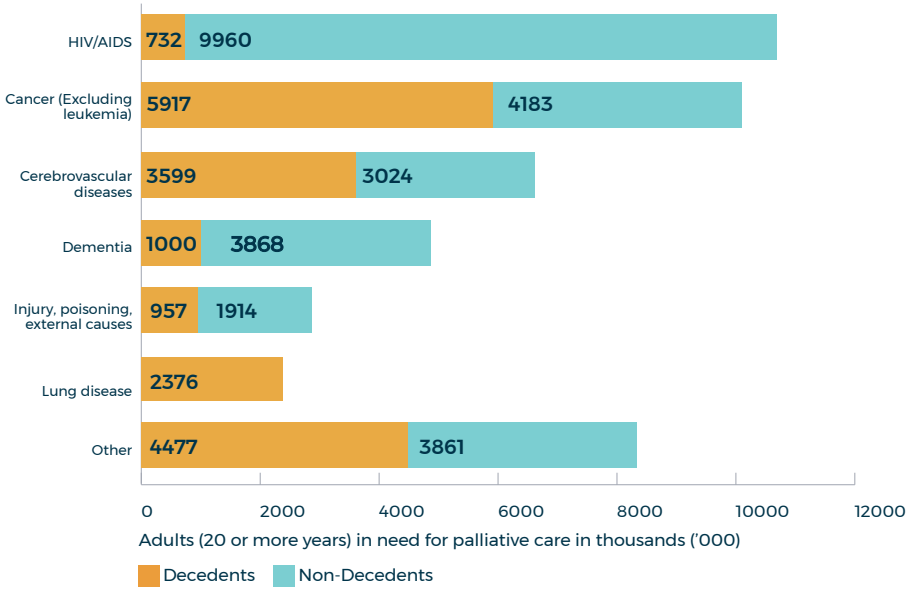
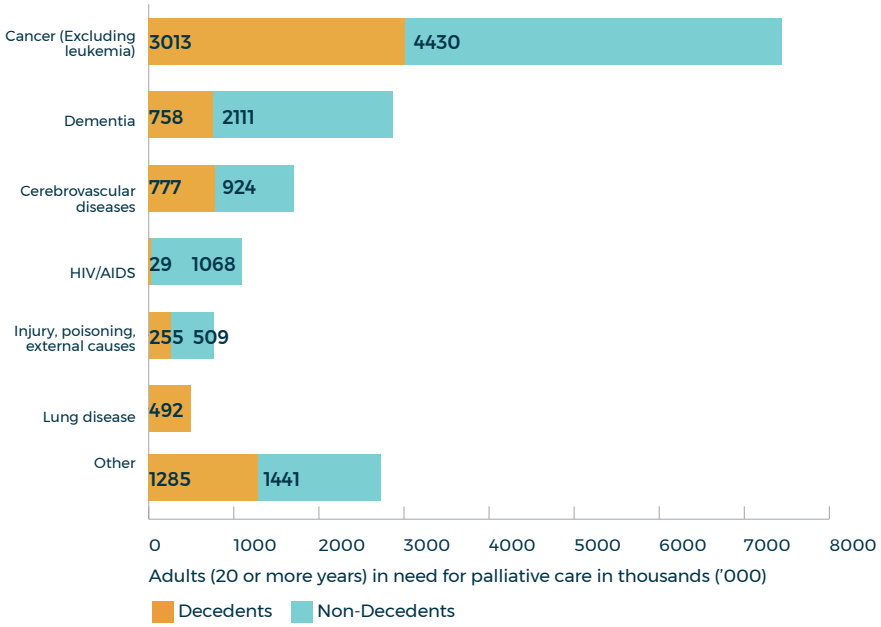


Figure 19:
Worldwide need for palliative care for adult decedents and non-decedents by major disease categories* in HICs (20+ years; 2023)

N = 17,092,000 adults



Children in need of palliative care worldwide

The estimated total number of children in need of palliative care worldwide in 2023 is 10.6 million (N = 10,626,000 children). Children and adolescents aged 0-19 comprise 14.4% of the total global palliative care needs **(Figure 9)**. There is a slightly higher proportion of males (53.4%) experiencing SHS than females. It is important to note that the number of children in need of palliative care is much higher than that reported in the previous edition of the Atlas. Changes in methodology including the addition of EMBID to SHS associated conditions, utilising children-specific multipliers, and changing the age range from 0-17 years to 0-19 years have all contributed to this increase. The methodological refinements improve the robustness of estimates on the burden of SHS experienced by children.

Most children in need of palliative care are in the African and the South-East Asian Regions (55.9% and 18.1% respectively), followed by the Eastern Mediterranean (9.2%), Western Pacific Regions (8.9%), and Region of the Americas (5.0%). In contrast, the European Region has only 2.9% of the total **(Figure 20)**. The African, South-East Asian, and Eastern Mediterranean Regions have the highest rates per 100,000 children (936, 308, and 297, respectively) **(Figure 21)**.

Figure 20:
Worldwide need for palliative care for children by WHO region (0-19 years; 2023)

N =10,626,000 children

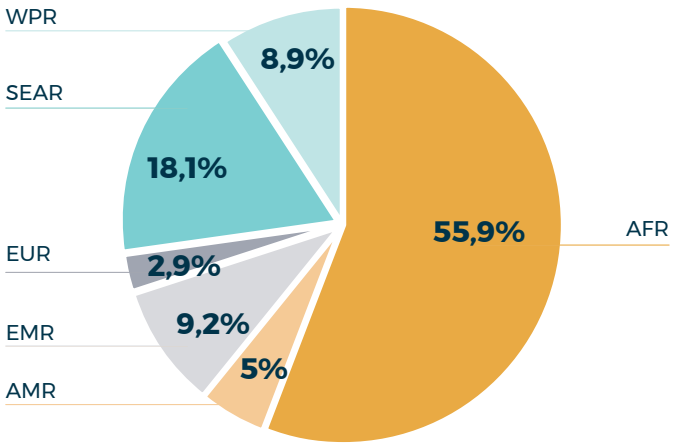
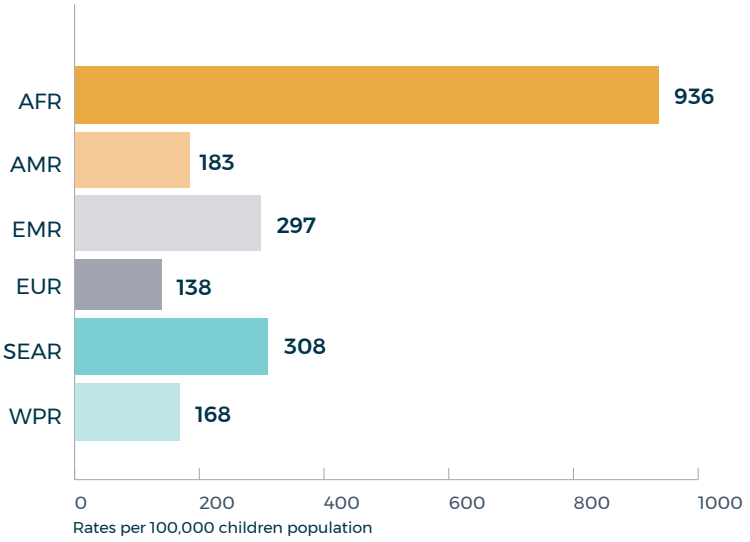


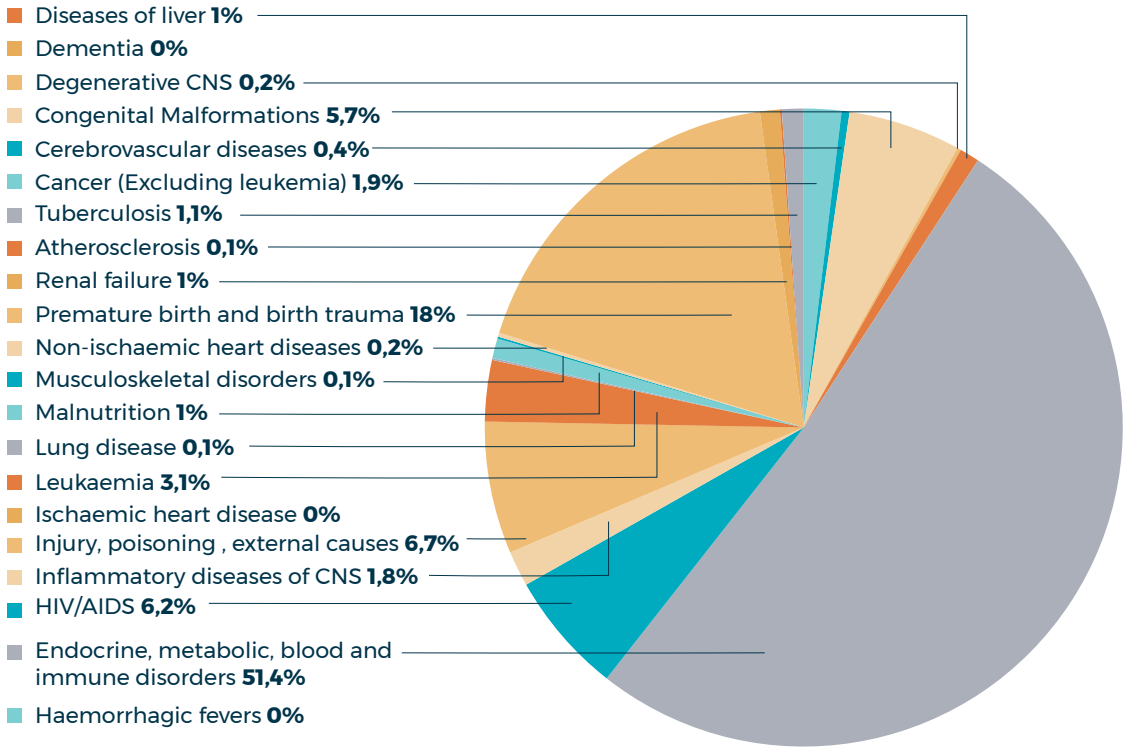
Figure 21:
Worldwide need for palliative care for children per 100,000 population by WHO region (0-19 years; 2023)



The condition that generates the greatest need for palliative care among children is EMBID (51.4%), followed by premature birth and birth trauma (18.0%) injury, poisoning, external causes (6.7%), and HIV/AIDS (6.2%). Cancers excluding leukaemia only account for 1.9% and including leukaemia account for 5.0% **(Figure 22)**.

Non-malignant diseases excluding HIV/AIDS generate the greatest need for palliative care among children in all WHO regions. Cancer (excluding leukaemia) generates a small proportion of the need in every region with the highest relative contribution of cancer (excluding leukaemia) in the Americas or European Regions **(Figure 23)**.

Figure 22:
Worldwide need for palliative care for children by disease groups (0-19 years; 2023)
Percentages may not sum to 100% due to rounding

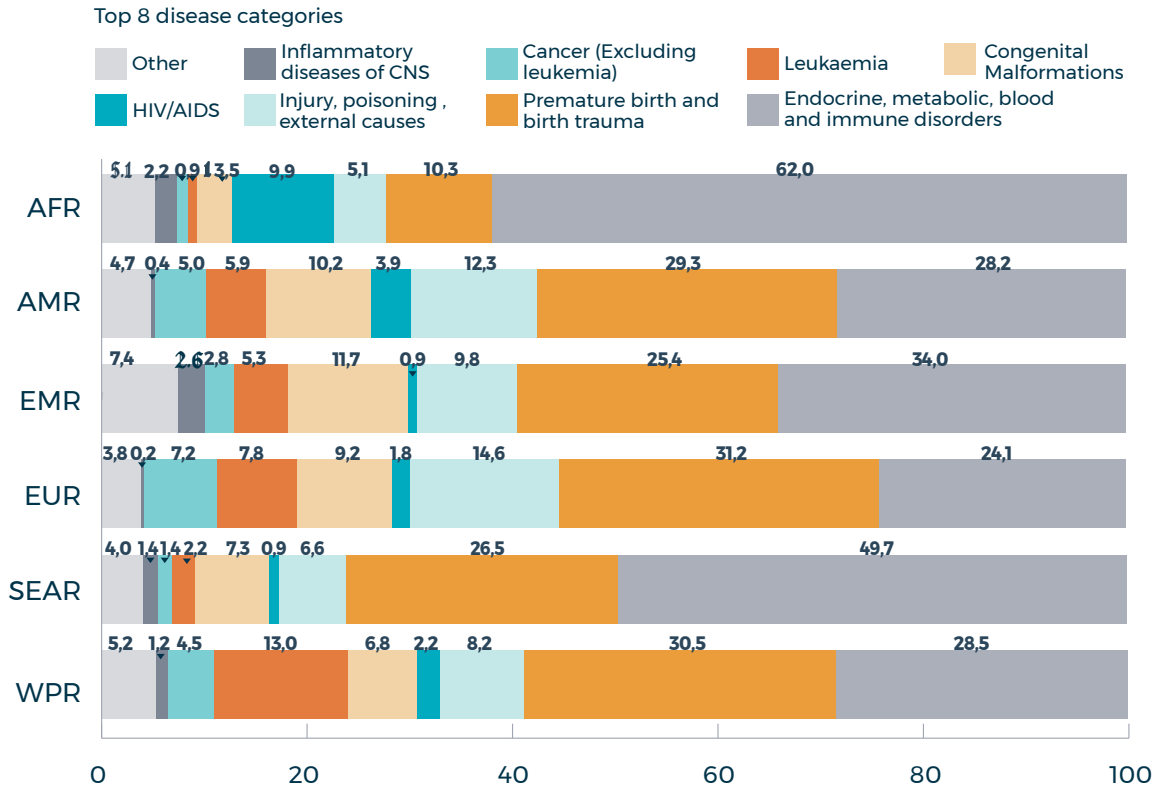


N = 10,626,000 children

Figure 23:

Worldwide need for palliative care for children (0-19) by WHO regions and disease categories (183 countries: 2023)

Percentages may not sum to 100% due to rounding



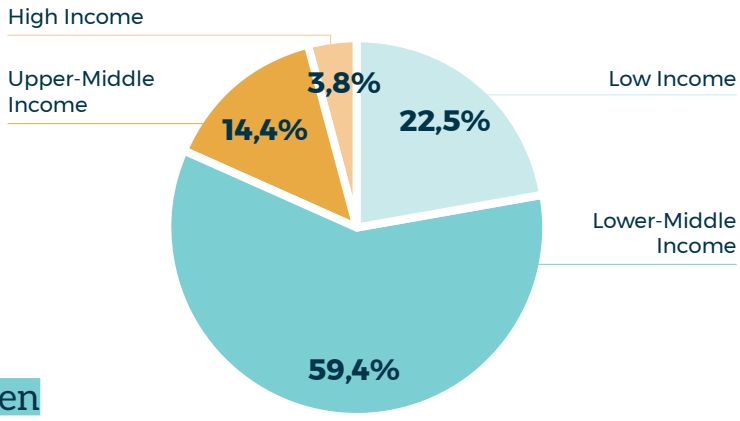
N = 183 countries

Most children (96.2%) in need of palliative care live in LMICs. More than half (59.4%) are in lower middle-income countries and almost one quarter in low-income countries **(Figure 24)**.

Figure 24:

Worldwide need for palliative care for children (0-19) by income group (183 countries: 2023)

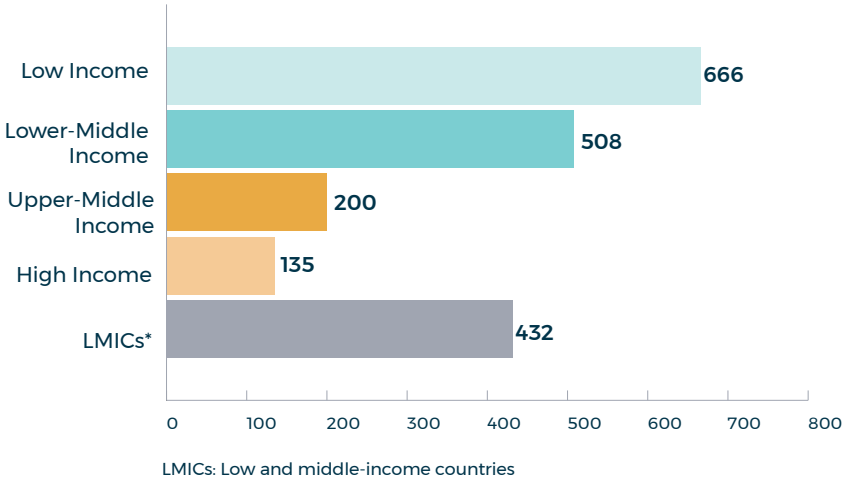
Percentages may not sum to 100% due to rounding



N = 10,626,000 children

There is an inverse relationship between the ratio of children in need of palliative care and country income level. The highest ratios per 100,000 child population (0-19 years) in need of palliative care are found in the low-income countries (666) with the lowest rate in HICs (135) **(Figure 25)**.

Figure 25:
Worldwide need for palliative care for children per 100,000 population by World Bank income category (0-19 years; 2023)



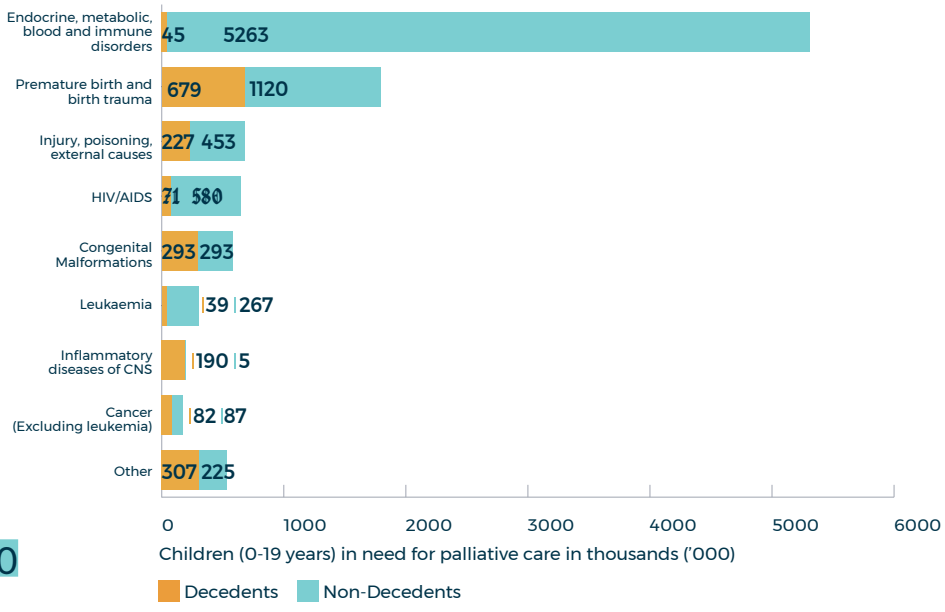
N = 183 countries

LMICs: Low and middle-income countries

The conditions that most often generate a need for palliative care in decedents and non-decedents for children globally are EMBID and premature birth and birth trauma **(Figures 26 & 27)**.

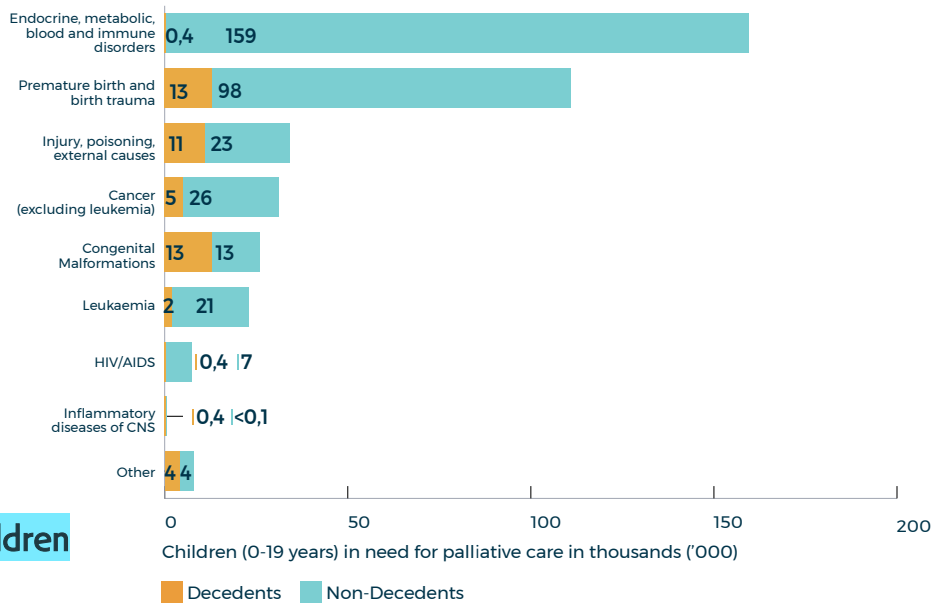
The conditions that generate the palliative care need in decedent and non-decedent children slightly differs between HICs and LMICs. There are much higher numbers of non-decedent as compared to decedent children with EMBID and HIV/AIDS, among others, in LMICs **(Figures 26 & 27).**

Figure 26:
Worldwide need for palliative care for children (0-19, decedents and non-decedents, by major disease categories* in LMICs (2023)



N = 10,226,000 children

Figure 27: Worldwide need for palliative care for children (0-19, decedents and non-decedents, by major disease categories* in HICs (2023)



N = 400,000 children

The 2023 findings highlight the higher proportion of non-decedents, as compared to decedents, in need of palliative care and the vast majority of the burden of SHS associated with non-communicable diseases. Moreover, differences in the distribution of the SHS burden between adults and children in terms of conditions and geographic location underscore the importance of incorporating age-specific considerations in estimating SHS.

Chapter 3

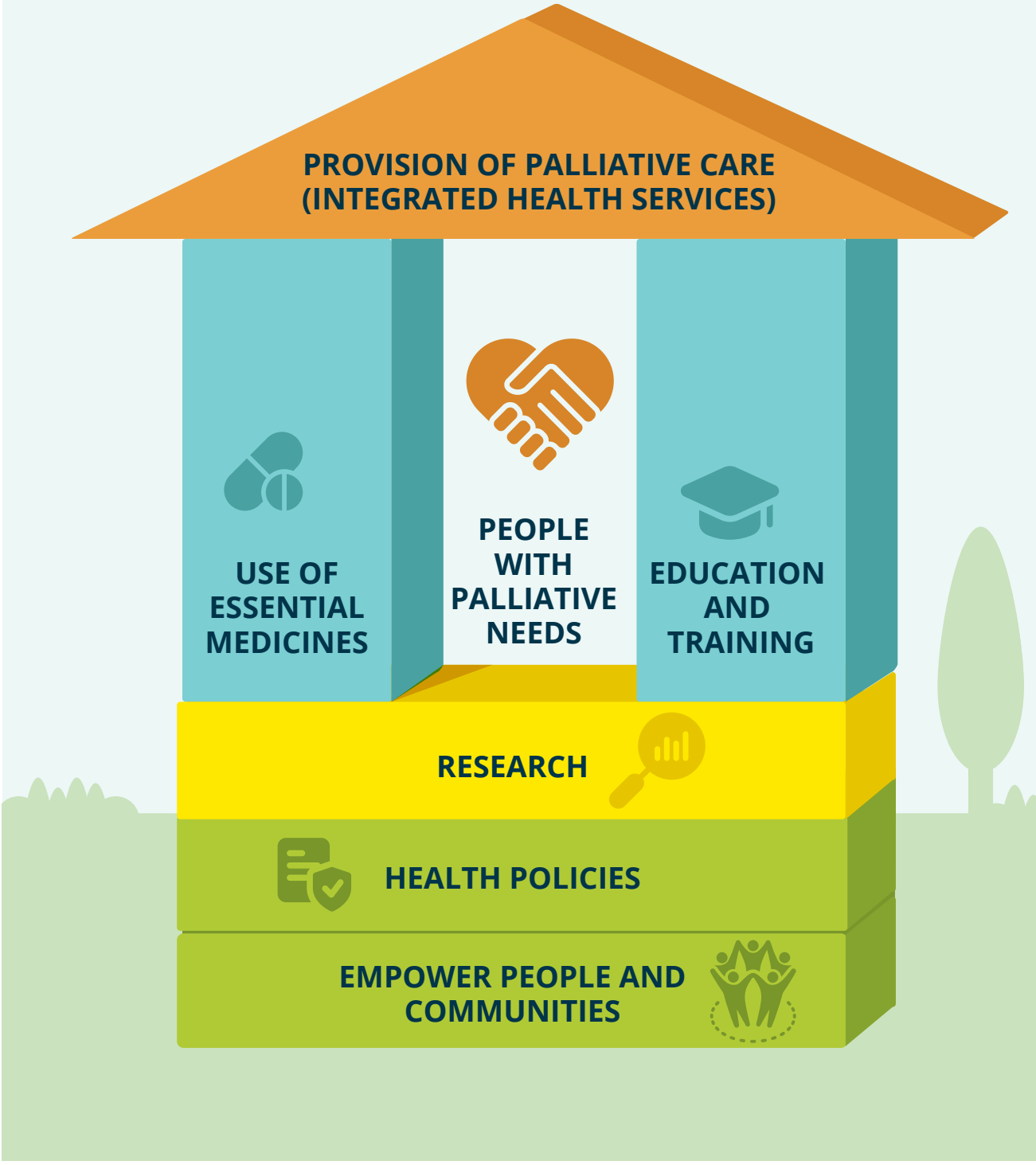
What are the main barriers to palliative care development?

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Palliative care development now follows a new public health model **(See Figure 28)** developed by the WHO that emphasizes *policy, education, medication availability, research, individual and community empowerment, and integrated implementation.*[40] There are many barriers to achieving each of these components. This chapter will examine these six barriers along with some key issues including

- Palliative Health Workforce Need
- Psychological, Social, Cultural, & Financial Barriers
- Barriers to Children's Palliative Care
- New Essential and Extended Packages of Palliative Care for Adults and Children
- Palliative Care for Special Populations
  - Humanitarian Emergencies
  - Stroke
  - Advanced Respiratory Illnesses (COPD, ILD, PH, CF)
- Summary and Conclusions

Figure 28
Public health model for palliative care development(40)



Policy

Without international and national policies that support the provision of palliative care it is quite difficult for any palliative care to develop (41). In some countries there is no government support whatsoever for palliative care. In others, such as Romania and Zimbabwe, charitable palliative care services have supported development. But even in these cases legal permission to operate must be granted. Policy is therefore the fundamental component needed to drive development, because without it other changes cannot be introduced nor demonstrable changes made and sustained and integration into existing health care services is limited. Types of policies needed include:

- Adherence and adaptation in alignment with international regulations and policy guidelines established and validated by multilateral organizations.
- laws that acknowledge and define that palliative care is part of the healthcare system.
- national standards defining how palliative care programmes must operate
- clinical guidelines for the delivery of palliative care services
- establishment of palliative care as a recognized medical specialty/sub-specialty
- regulations that establish palliative care as a recognized type of health-care provider with accompanying licensing provisions
- inclusion of palliative care in key national policies including cancer control, NCDs, HIV and TB
- a funded national strategy and action plan on palliative care implementation.

A review of the global status of all palliative care policy development was done by Clelland et al, 2020 (42) and found only 55 countries with any national plan for palliative care. A more up to date 2025 review done by Tripodoro et al (43) has identified 91 countries with such plans and the 2023 mapping by ICPCN identified 14 countries with specific policies for Children's palliative care and 66 countries where children's palliative care was included in a policy that covers adults and children.

Education

The vast majority of health professionals worldwide have little or no knowledge of the principles and practices of palliative care. A growing body of knowledge has been accumulated over the past 50+ years on the science of palliative care and palliative medicine. There are now at least 20 professional journals devoted to palliative care, a growing body of peer-reviewed literature, and numerous books, internet sites, blogs and forums devoted to all aspects of palliative care.

See **Appendix 2** for listings

Palliative care education is needed at three levels:

1. **Basic palliative care** training for all health professionals and paraprofessionals including physicians, nurses, mental health professionals, clergy, volunteers and therapist.
2. **Intermediate training** for those routinely working with patients with life- threatening illnesses.
3. **Specialist palliative care training** for patients with more complex symptom management needs and for those who will teach palliative care and do research.

Curricula for these three levels exist, however, there is no consensus on the amount of training needed and most of the existing educational programmes are in English. There is also a need to carry out community education and awareness campaigns about palliative care at the same time as services are established. When services are delivered patients and families also need extensive training on how to provide care including personal care, body mechanics, symptoms to expect and how to manage, along with signs/symptoms of impending death and so forth.

Medication Availability

Most medications for adults and separately for children are in the *WHO Model Lists of Essential Medicines for Pain and Palliative Care, included in the 24th Edition 2025 for adults*, (44) and the *10th Edition of the Model List of Essential Medicines for Children*, (45) especially controlled substances namely, opioids, that are required for the delivery of quality palliative care. Access to opioid medications for pain control is an enormous problem worldwide. Over eighty percent of the world's population lacks adequate access to opioid medications for pain control according to the International Narcotics Control Board (46). Australia, Canada, New Zealand, the United States, and several European countries accounted for more than 90% of the global consumption of opioid analgesics while Low-and-Middle-Income Countries (LMICs) consumed only 10% of global opioids.

The UN Single Convention on Narcotic Drugs, (47) approved by most countries in 1961, called for balance between mitigating diversion of illicit opioids and other psychoactive substances while also allowing for adequate provision of these drugs for medical and scientific use. Since that time, the major focus has remained on control of illicit use of these drugs, and even restricting licit medicines, with little emphasis on enhancing access for medical and scientific use. The worldwide palliative care community and related human rights organizations have advocated for balance to be restored by paying equal attention to both medical use and prevention of illicit use. In 2016, the Commission on Narcotic Drugs (CND) included "access to controlled medicines" as an area of focus in the UN General Assembly Special Session and High-Level Meeting on the World Drug Problem (48). A subsequent 2019 Ministerial Declaration(49) reinforced the need and commitment to address the pathos of disparity in access and availability of controlled substances for medical and scientific purposes, especially for pain and palliative care.

During the March 2022 plenary session of the CND, a Global Appeal was launched by the CND Chair, the Directors-General of UNODC and WHO and the President of INCB to increase global awareness of the urgency to improve access and availability and increase efforts among governments and stakeholders towards effective policy measures and in-country projects.

While the true need for opioids per capita remains under debate, and will vary by country depending on age, disease rates, medical conditions and many other factors. An estimate of opioid need for 188 countries used average usage in the 20 top countries in the Human Development Index (HDI) as a reference point for development of an adequacy of consumption measure (ACM). According to this analysis 83% of the world's countries have low to non- existent access to opioids, 4% have moderate access, and 7% have adequate access, while for the remaining 6% of countries insufficient data is available.

A more recent article from the Lancet Commission on Palliative Care and Pain Relief described a methodology for calculating a measure of opioid accessibility—Distributed Opioids in Morphine Equivalents (DOME)—and discusses its use in estimating the unmet need for opioids in palliative care and monitoring progress in providing opioid access for palliative care (50).

Key indicators of opioid availability are found in the reports of opioid usage that are published by the International Narcotics Control Board (INCB) (51). There is enormous variability in consumption per capita around the world and many barriers to increasing the availability and consumption of opioids for medical and scientific use. These barriers include overly strict regulation, limitations on available forms of medication particularly oral opioids, lack of supply and distribution systems, limitations on who can prescribe, fear of law enforcement intervention into medical use, and so forth.

As highlighted in the INCB 2024 Annual Report, of particular concern is the fact that "While morphine has historically been the most readily available and affordable opioid analgesic for pain relief and palliative care, its distribution has been uneven, and it has largely been utilized to produce other drugs. […] most of the morphine manufactured is utilized for the manufacture of other substances. About 33 tons of morphine are consumed directly for palliative care, and mostly in high-income countries, with only 4.75 tons being consumed in middle- and low-income countries (52).

Average opioid analgesic consumption of the top 20 countries of the Human Development Index (HDI) increased from 84 morphine milligram equivalents per capita (2000) to 256 morphine milligram equivalents per capita (2015). However, the overall consumption for all countries, due to limited access in most countries was only about 33.25 mg per capita in 2017 and the consumption of morphine, mainly used in palliative care was less than 5 mg per capita **(Table 1)**.

In this regard, in using the INCB data for practical application revealed the relevance of a morphine equivalence (ME) metric in demonstrating the extent that morphine consumption relates to total consumption of other widely used licit opioids. It is that metric that is reflected in the table and maps below. **Table 1** shows that morphine consumption has declined for all major opioids (minus methadone which is principally used for opioid use disorder treatment). **(Figures 29 and 30)** and are shown for global and country comparisons.

Table 1

2021 Global Opioid Consumption Data (International Narcotics Control Board)

Year	2017	2021
Global Morphine Consumption (mg/person)	4.9282	4.4768
ME in mg/person ALL Opioids Minus Methadone		
Morphine	4.9282	4.4768
Codeine	0.1782	0.1661
Fentanyl	15.030	11.4720
Hydromorphone	2.2142	2.1189
Pethidine	0.0618	0.0418
Oxycodone	10.8375	10.2835
Total ME in mg/person minus Methadone	**33.2496**	**28.5591**

only 4.75 tons
of morphine are being consumed in middle- and low-income countries

Figure 29:
Global Map of Morphine Consumption Per Capita

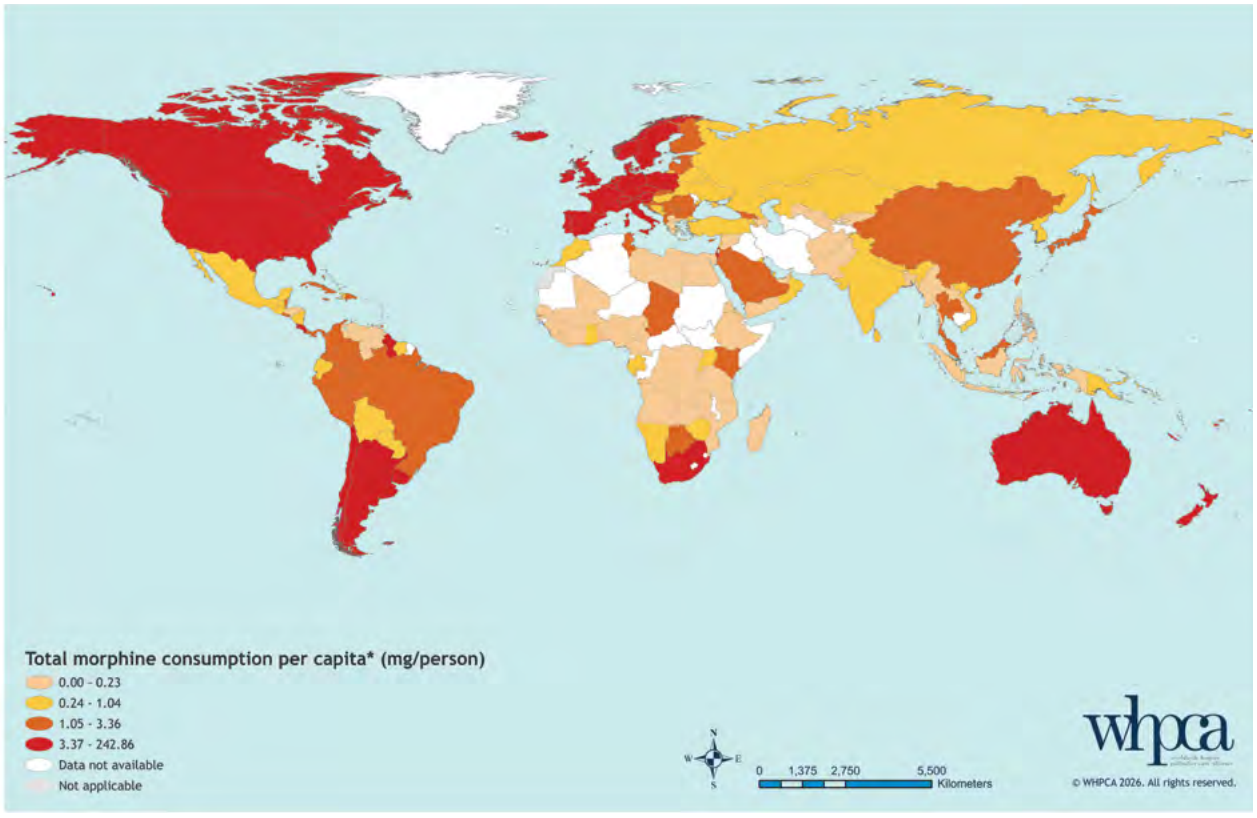
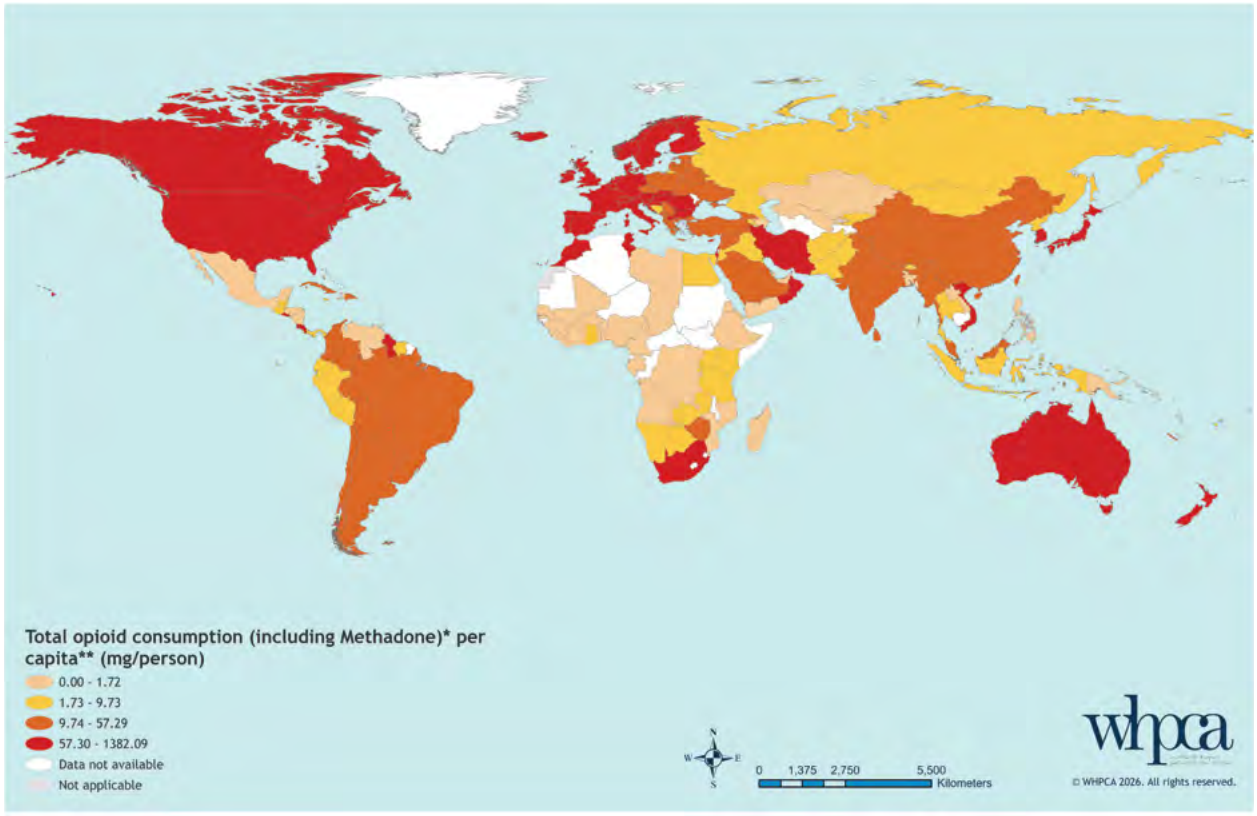


Figure 30:
Global Map of Total Opioid Consumption in Morphine Equivalents (minus methadone) Per Capita



Research

All modern healthcare should ideally be driven by scientific evidence. Palliative care as a relatively new discipline in healthcare that has been growing an evidence base built on research. Building this base has been more challenging than many other disciplines. This is due to a variety of factors including:

- **Lack of funding** for research into palliative care
- **Inability to do randomized researc**h due to ethical concerns about limiting access to palliative care in control groups
- **Difficulty accruing seriously ill subjects** due to their increasing disability while under care and difficulties with patient communication ability
- **Lack of well-trained researchers** with sufficient ability to utilize complex research methodologies.
- Palliative care not seen as a high enough priority among multiple areas of research.

Ethically the only way for palliative care researchers to conduct randomized controlled trials (RCTs) is if there is equipoise as to whether a new treatment is more effective than current standard of practice. This limits efforts to demonstrate palliative care's overall effectiveness. RCT's are one way to demonstrate high strength of evidence. Otherwise, a very large body of large quasi-experimental research is needed.

While the evidence base and body of knowledge for the field of palliative care is growing, it is critical that the rigor of research continues to be strengthened. Most assessments of the of strength of evidence of the field have found at best moderate and mostly low or very low levels of evidence. Without moderate to strong evidence the field will lack the ability to ensure that governments and health care institutions feel compelled to adopt palliative care guidelines broadly.

Community Empowerment

The hospice and palliative care movement began as a response to the depersonalization of modern medicine. Dissatisfied health professionals and community members believed there was a better way and in the 1960's began to look for ways to help bring both birth and death back into the community. Dying and death is not so much a medical event as it is a human experience. Throughout the ages people have spent their final days at home cared for by families and communities. Even today it is estimated that 80-90% of long-term caregiving is done by families, friends, and communities not paid health professionals or institutions. However, without proper training and support there is risk that family members may experience trauma and harm when helplessly witnessing a family member's unrelieved and unremitting suffering. Prolonged continuous caregiving may also lead to negative health outcomes for caregivers.

One of the secrets of palliative care is attention to training and empowering families to provide care to their seriously ill loved ones. Being available around the clock is also critical to preventing bad outcomes and unnecessary emergency and hospital use. However, 24-hour support is not universally included in palliative care services.

Parallel to the development of palliative care, particularly home-based care, has been the development of various types of compassionate community models and programmes. These include the charter for compassion, age and dementia friendly cities, and the compassionate cities program which aim to mobilise volunteers in communities to provide an extra layer of support for the serious ill and bereaved. Together with palliative care professionals and volunteers this is an effective way to ensure that both patients and families get the help and support they need (See work of Public Health and Palliative Care in **Appendix 2**). https://www.phpci.org/

Implementation

Palliative care programme development has been highly uneven worldwide (see **Chapter 4** for service mapping) and is closely associated with Human Development Index levels, universal health coverage, and World Bank income classifications (53). In the absence of supportive policies and sustainable financing mechanisms, progress has largely depended on the efforts of individual pioneers who have established hospice and palliative care services through personal commitment and sacrifice. Addressing the substantial unmet need for palliative care will require greater integration into existing health systems, particularly within primary and long-term care. Home-based care should be prioritized, as most palliative care services can be effectively delivered in patients' homes, with inpatient care reserved for selected indications.

Effective implementation, particularly at the policy level, requires adherence to international treaties and guidelines. After seven years of collaborative work by an international expert group co-chaired by Professor Julia Downing of the International Children's Palliative Care Network, the WHO Essential Medicines Division released the WHO Guidelines on Balanced National Controlled Medicines Policies to Ensure Medical Access and Safety in late 2025 (54). These guidelines provide a critical framework for improving access to essential controlled medicines.

Access to essential controlled medicines remains a cornerstone of high-quality palliative care. Despite progress in some regions, 80% of the world's population continues to have little or no access to these medicines. The release of the WHO Guidelines underscores the urgent need for renewed, coordinated efforts to overcome persistent regulatory and implementation barriers. Accordingly, the WHO has called on international agencies, UN entities, Member States, and civil society to develop and implement initiatives aligned with these guidelines.

In response to this global need and building on the longstanding work of the Pain & Policy Studies Group and Walther Global, Team Humanity International (THI) has been entrusted with advancing and expanding policy and implementation efforts in close collaboration with the WHO Essential Medicines Division and key global stakeholders. This renewed momentum reflects both the scale of global inequities and the WHO's call for collaborative, action-oriented implementation.

As emphasized by Dr. Deus Mubangizi, Director of the WHO Essential Medicines Division, these guidelines are intended to be practical tools to improve safe and equitable access to essential controlled medicines, particularly for the nearly 80% of the global population with limited or no access. Their effective implementation will require sustained collaboration among the WHO, Member States, national ministries, regulators, clinicians, educators, researchers, and civil society.

Collectively, these interdependent pillars—policy, education, access to essential medicines, and social and political support—are fundamental to making palliative care a global health priority and a practical reality worldwide **(see Figure 28)**.

Health Workforce Need

Reaching over **73 million people** needing palliative care globally, including over **27 million near the end-of-life** will require a major increase in the professional and paraprofessional workforce trained in at least basic or primary palliative care. WHPCA has estimated that approximately 2 million health care workers would be needed to care for a daily census of over 27 million patients just at the end of life, including approximately 400,000 palliative care community health workers mainly in low and middle-income countries. This assumes 27 million patients receiving an average of 80 days of palliative care near the end-of life, plus those before the end of life (non-decedents) who will need intermittent care. A daily census of approximately 7.2 million patients. At present we estimate that there are approximately 600,000 health care workers engaged in delivering palliative care globally out of a total of 65 million worldwide including 29 million nurses and 2.2 million midwives (55). At the very least another **2.1 million health care professionals are needed** to meet the current need, which is expected to grow at least 83% by 2060.

Volunteers also play an important role in palliative care and bring the community dimension into compassionate care. It is estimated that there are over 2.4 million people volunteering in palliative care around the world. Bridging the gap in access to palliative care will mainly require all the elements in the above public health model but especially ensuring that all health professionals receive training in palliative care before graduating from professional schools.

Barriers to Children's Palliative Care

The development of children's palliative care has often lagged behind that for adults, and whilst many of the barriers impacting the development of palliative care for adults also apply to children, there are also barriers specific to children's palliative care, and those that are similar are often but amplified when applied to children e.g. fear of using opioids in children. As can be seen in the mapping of children's palliative care in **chapter 4**, there is vast inequity in the provision around the world, and achieving equity will require a deliberate reallocation of resources to address the barriers and structural inequities that systematically disadvantage children and their families (56 57).

Figure 31 highlights some of the key barriers to children's palliative care provision, thinking not only from the policy and service delivery perspective, but also those impacting the child and their families. Many studies have been undertaken to understand these barriers (58) across regions, (59 60 61) within countries (62 63 64 65) and in individual services (66 67) and whilst there are unique barriers, many similarities exist, thus highlighting the importance of learning from each other, sharing solutions and coming together as a children's palliative care community to address the issues.

2.1 million
Amount of health care professionals are needed to meet current demand

Figure 31:
Barriers to Children's Palliative Care



Psychological, social, cultural, and financial barriers

The development of palliative care for both adults and children has been limited by additional human factors. Both hospice and palliative care have come to be associated with the end of life and dying. Psychologically most people fear and avoid anything relating to death. There is often a belief that even acknowledging the possibility that one may die soon is harmful. There is no evidence to support this belief, and evidence points to the possibility that palliative care may improve survival (68 69 70 71 72 73). However, efforts to engage the public and policy makers on the need for palliative care have met with limited success.

Many cultures have expressly prohibited informing patients of their diagnosis and prognosis when it is life-threatening. Previously this had been the case in most cultures, but views have been changing in the past several decades to the point where there is now some acceptance of the idea that patients themselves should be given the choice as to whether to receive this information (74 75).

These cultural and human factors play a prominent role in the implementation of improved access and availability policies and practices for administering controlled substances in medically supervised environments. Any further policy development and practitioner training will need to take these factors into account and integrate them into comprehensive, patient-centered solutions.

Cultural and human traditions and factors cannot be considered as separate or immune from international and national legal frameworks, specifically those concerning the respect for human dignity. In this context, it is noteworthy to quote an excerpt from the opening remarks by Dr Jallal Toufiq, then President of the International Narcotics Control Board, at its 141st session : “While the legal framework comprising the three international drug control conventions gives State Parties a large degree of discretion in the manner in which they implement their legal obligations under the conventions, it also establishes a series of parameters within which this discretion is to be exercised. Broadly, these include the limitation of the use of narcotic drugs and psychotropic substances exclusively to medical and scientific purposes subject to the provisions of the conventions, the respect for human dignity and rights, the adequate provision of controlled substances to meet legitimate medical needs, and the principle of proportionality in the formulation of criminal justice policy for drug-related behaviours.” (76)

Serious illness can have a major impact financially. In many countries effective medical treatment may only be available to those with the financial resources to pay for care. In the United States of America approximately half of personal bankruptcies are due to medical bills. While hospice and palliative care have been found to be cost effective in many studies these are mainly in developed countries (See chapter one pg 13).

Essential and Expanded Palliative Care Packages for Adults and Children

Background and Method

In 2018 the Lancet Commission on Palliative Care and Pain Relief and developed the Essential Package for Palliative Care and Pain Relief (LEP), a minimum set of evidence-based interventions and services intended for implementation across all levels of healthcare. Although, the LEP was initially designed to be applied across the lifespan for adults and children, a version specifically designed for children - the Essential Package of Paediatric Palliative Care and Symptom Relief was published in that same year by the WHO.

The methods, results and recommendations are available in an open access article (77). This section summarizes important aspects of the resulting packages and offers a link where readers can download the four packages (Essential – adults and children / Expanded – adults and children).

The Essential Packages are designed to be low-cost, list the medicines, equipment, and personnel necessary to reduce serious health-related suffering. They are "what must be available" in primary care anywhere in the world. This sets the procurement and availability foundation for bedside care. The updated Essential Packages (**Figures 32 & 33**) maintain most of the original components in the LEP (adults) and in the WHO package (paediatric), with meaningful enhancements to better serve both adults and children.

Figure 32

What is the Essential Package of Palliative Care Services for Adults?

Essential Palliative Care Package for Adults

Medications

- Amitriptyline (oral) poverty)
- Bisacodyl (oral)
- Dexamethasone (oral & injectable)
- Diazepam (oral & injectable)
- Fluconazole (oral)
- Fluoxetine (oral)
- Furosemide (oral & injectable)
- Haloperidol (oral & injectable)
- Hyoscine butylbromide (injectable)
- Ibuprofen (oral)
- Lactulose (oral)
- Loperamide (oral)
- Metoclopramide (oral & injectable)
- Metronidazole (oral tablets to be crushed for topical application)
- Morphine (oral IR & injectable) Naloxone (injectable)
- Omeprazole (oral) Paracetamol (oral & suppositories)
- Petroleum jelly

Equipment

- Adult diapers (or cotton and plastic if extreme
- Bandages/dressing (wound care)
- Flashlight with rechargeable battery
- Nasogastric drainage or feeding tube
- Pressure reducing mattress
- Urinary catheters
- Opioid lock box
- Oral care supplies (mucosal protecting)
- Oxygen
- Thermometer

Human Resource

- Medical doctors
- Nurses
- Social workers
- Physical therapist
- Psychologist or counsellor
- Pharmacist
- Spiritual care provider
- Community health workers
- Clinical support staff
- Non-clinical support staff

Tania Pastrana, Liliana De Lima, Veronica Dussel, Xiaoxiao Jiang Kwete, Julia Downing, Marie Fallon, Liz Grant, Afsan Bhadelia, Lukas Radbruch. Global Consensus-Based Essential and Expanded Packages for Palliative Care and Pain Relief for Adults and Children: A Delphi Study, Journal of Pain and Symptom Management, 2025, ISSN 0885-3924, https://doi.org/10.1016/j.jpainsymman.2025.08.027

Figure 33
What is the Essential Package of Palliative Care Services for Children?

Essential Paediatric Palliative Care Package

Medications

- Amitriptyline (oral) Bisacodyl (oral)
- Dexamethasone (oral & injectable)
- Diazepam (oral & injectable)
- Diphenhydramine (oral & injectable)
- Fluconazole (oral)
- Fluoxetine (oral)
- Furosemide (oral & injectable)
- Haloperidol (oral & injectable)
- Hyoscine butylbromide (injectable, oral liquid) Ibuprofen (oral)
- Lactulose (oral)
- Loperamide (oral)
- Metoclopramide (oral & injectable)
- Metronidazole (oral tablets to be crushed for topical application)
- Morphine (oral IR & injectable)
- Naloxone (injectable)
- Omeprazole (oral)
- Paracetamol (oral)
- Petroleum Jelly
- Ondansetron
- Oxygen

Equipment

- Bandages/dressing (wound care)
- Bed pan and urinal
- Diapers (baby and adult) or cotton and plastic
- Flashlight with rechargeable battery
- Gloves (disposable)
- Masks
- Nasogastric drainage or feeding tube
- Opioid lock box
- Oral care supplies (mucosal protecting)
- Pressure reducing mattress
- Syringes
- Thermometer
- Urinary catheters

Human Resource

- Community health workers
- Local spiritual counsellor
- Medical doctors
- Nurses
- Pharmacist
- Physical therapist
- Social worker, psychologist, or grief counsellor

What the Packages can be used for?

These globally validated Essential and Expanded Packages for adults and children offer a practical adaptable framework to guide national health strategies, strengthen palliative care services, and reduce SHS. Their adoption can meaningfully contribute to achieving Universal Health Coverage.

The Essential and Expanded Packages are framed as policy blueprints "to guide national health strategies." They are designed to be publicly financed entitlements aligned with universal health coverage, as an implementation target for decision-makers (health ministries, purchasers, and supply chains).

By their focus on preparedness, the packages explicitly support public financing and health system resilience—including in emergencies—and add basic equipment that is often missing in low-resource sites (e.g., wound care materials, thermometers).

These packages are more than lists—they are powerful tools for advocacy and implementation. Integrated into national health systems and supported by local palliative care associations, they can help countries advance toward the relief of serious health-related suffering.

Download all versions of the essential and expanded packages at:
https://iahpc.org/what-we-do/research/essential-and-expanded-palliative-care-packages-for-adults-and-children/?utm_source=communications&utm_medium=email&utm_campaign=world_day_achieving_the_promise_universal_access_to_palliative_care_essential_and_expanded_pc_packages&utm_term=2025-10-22

Palliative Care for Special Populations

The need for palliative care in humanitarian emergencies

Complex Humanitarian Emergencies (CHE) are increasing across the world. These multifaceted humanitarian crises occur in a country, region or society where there has been considerable breakdown of authority resulting from internal or external conflict. CHEs require a multi-sectoral, international response and represent a critical threat to the health, safety, security and wellbeing of a community, a country or a region (UNHCR definition). CHE's may be of slow or sudden onset and can be a protracted situation that includes refugee settings. Major causes related to CHEs are persecution, conflict, violence, climate emergencies, economic factors and human rights violations.

Emergencies cause immense suffering and usually increase mortality. Palliative care is essential to the health response in humanitarian emergencies. The main goals of a humanitarian health response save lives, alleviate suffering, and protect human dignity during crises, this aligns with the goals of palliative care, the relief of suffering and promotion of quality of life.

Per the Global Overview for 2026 from the Office for the Coordination of Humanitarian Affairs (OCHA), 230 million people are estimated to need humanitarian aid in 2026. Humanitarian crises often occur within already fragile, vulnerable and/or conflict affected settings with limited access to palliative care and fragile health systems. The impact of the social determinants of health increase when a humanitarian emergency occurs. In addition, CHEs disproportionally affect women and children; the elderly and those with disabilities. Complex and premature births increase, which increases the need for perinatal and neonatal palliative care.

Figure 34 from WHO Integrating palliative care and symptom relief into the response to humanitarian emergencies and crises https://www.who.int/publications/i/item/9789241514460

Figure 34:
Integrating Palliative Care and Symptom Relief into Humanitarian Emergencies

Category	Colour code	Description
1. IMMEDIATE	Red	Survival possible with immediate treatment.
2. DELAYED	Yellow	Not in immediate danger of death, but treatment needed soon. Would be treated immediately under normal circumstances.
3. MINIMAL	Green	Will need medical care at some point after patients with more critical conditions have been treated.
4. EXPECTANT	Blue	Survival not possible given the care that is available.

Recommended triage categories in humanitarian emergencies and crise

Category	Colour code	Description
1a. IMMEDIATE	Red	Survival possible with immediate treatment Palliative care should be integrated with life-sustaining treatment as much as possible.
2a. EXPECTANT	Blue	Survival not possible given the care that is available Palliative care is require
	Yellow	Not in immediate danger of death, but treatment needed soon. Palliative care and/or symptom relief may nevertheless be needed immediately.
3. MINIMAL	Green	Will need medical care at some point, after patients with more critical conditions have been treated. Symptom relief may be needed.

Source: Adapted from Hayward-Karlsson et al. 2005 (33), and WHO/ICRC 2017.

Humanitarian response workers prioritize saving lives, and palliative care can be provided alongside potentially life-saving interventions. The three stages of a humanitarian emergency into which palliative care can be integrated are:



During a CHE, who needs palliative care support?

- People with pre-existing palliative care needs due to communicable or non-communicable diseases, or those developing a condition during the emergency.
- People with controlled communicable diseases or NCDs that may have progressed due to treatment disruptions and /or lack of access to treatment.
- Premature neonates and those with birth injuries, congenital and genetic conditions.
- Children, older persons, those with disabilities and/or mental health conditions, including dementia.
- People with traumatic injuries requiring pain management.
- People who are actively dying.
- People experiencing loss, grief, and bereavement.
- Staff requiring psychological and spiritual support.

Challenges providing palliative care in humanitarian emergencies

This Atlas outlines barriers to providing palliative care across country-income levels. These barriers persist and may worsen during CHEs. The humanitarian setting carries additional challenges. It may be dangerous and may lack adequate protection for health workers. Humanitarian response teams prioritize housing, protection, access to food and water, and saving lives. Ethical decision-making in CHEs is complex, often rapid, and is affected by triage priorities, and lack of physical and human resources.

The local / country health care system provides the structure for the provision of health care. OCHA and other UN agencies (e.g., UNICEF, UNHCR), work collaboratively with existing health care resources. The provision of palliative care during the emergency, will mostly depend on whether palliative care was established previously in the country. For example, during the ongoing Russo-Ukrainian War, some palliative care development and education has continued. During CHEs healthcare, including palliative care is often possible with external support from providers in other countries.

What is needed to provide palliative care in humanitarian settings?

- Expertise in palliative care.
- Knowledge and understanding of international humanitarian laws and conventions governing health activities in humanitarian settings.
- Acceptance of potential dangers to life while working in humanitarian emergency settings.
- Willingness to work collaboratively and with respect for other humanitarian response organizations and respect for local culture, and beliefs including around death and burial rituals.
- Integration of palliative care at all stages while respecting the humanitarian triage system.
- Advocacy for access to essential palliative care medicines as listed by WHO, including opioids and other pain medicines.

While there has been focus on educating humanitarian health responders in palliative care, we recommend that palliative care practitioners receive education in humanitarian response principles. Education of all health care providers in both palliative care and humanitarian health responses is necessary as humanitarian crises and displacement increase globally.

Displaced Persons Internally and across borders

During CHEs, population displacement increases both internally, within and across countries. In 2025 122 million people were forcibly displaced worldwide. This includes: 42.7 million refugees and 73.5 million internally displaced people, 71% of whom were in LMICs. For those displaced, loss and trauma cause mental and spiritual distress, enhanced by interruption of death rituals and burials; displacement from family and known environments, lack of income and loss of own culture while adapting to new cultures. For those with new or existing conditions requiring palliative care, disruption of treatment leads to increased mortality. Loss, grief and bereavement also require long-term interventions, social, mental health and spiritual support that fall under the purview of palliative care. Fortunately, there are good examples of palliative care provision for refugees (e.g., Uganda, Cox's Bazaar) (78). While the median time spent as a refugee is at present 5 years, many may remain refugees for decades, and develop conditions requiring palliative care during that time.

While the numbers of babies, children and adults with palliative care needs in humanitarian emergencies is uncertain, their suffering and those providing palliative care within these settings requires a strong and coordinated response from the global palliative care community. **PallCHASE** – Palliative Care in Humanitarian Aid Situations and Emergencies – is a global organization working to increase access to palliative care in humanitarian emergencies.





PallCHASE is a global organization working to increase access to palliative care in humanitarian emergencies.

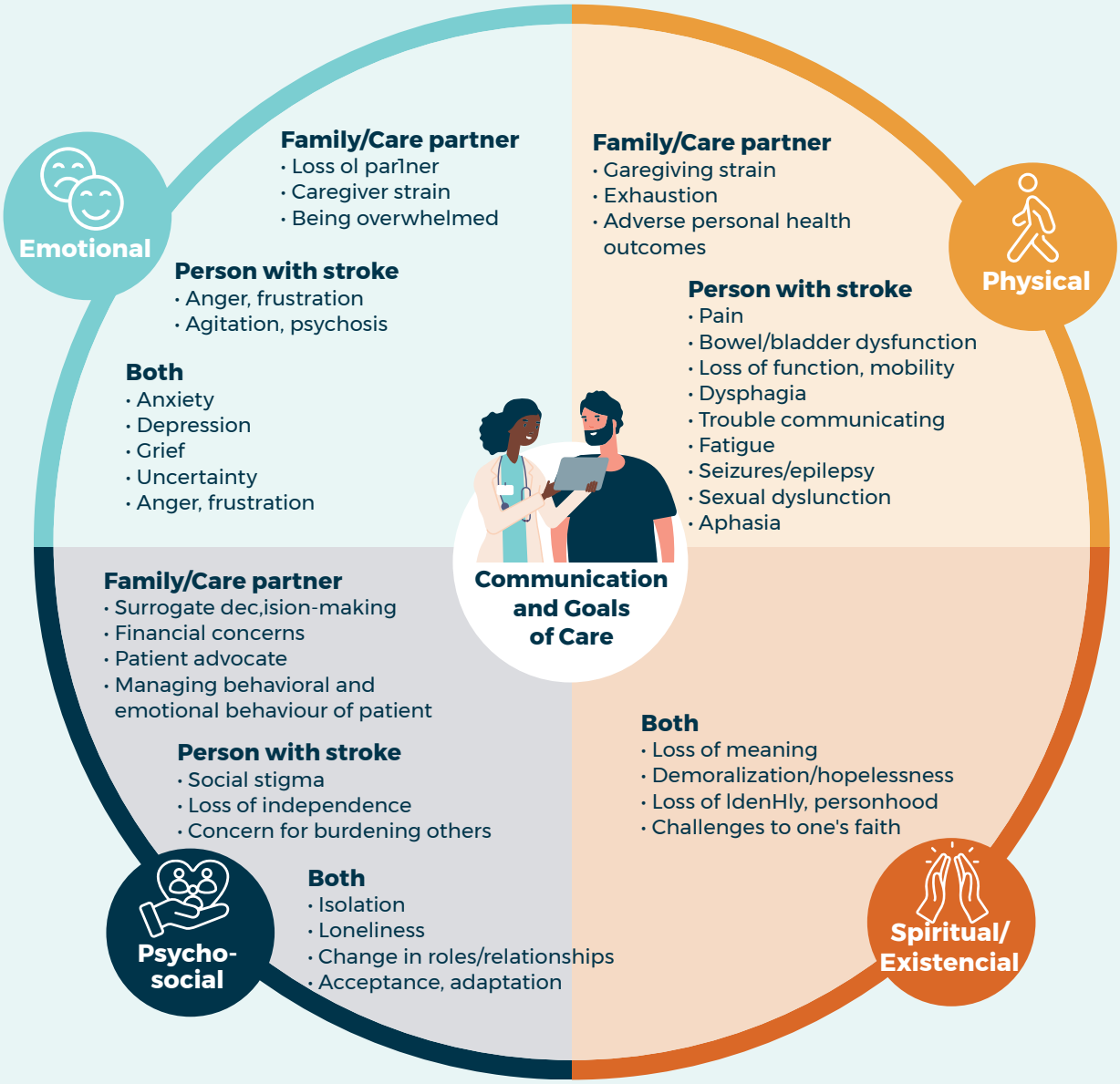
Palliative care and Stroke

Stroke is common, disabling and deadly. As the 5th leading cause of death in the US, stroke results in 1 death every 4 minutes and is a leading cause of cognitive and physical disability (79). Globally, 42% of disability adjusted life years lost through neurological disease are lost through stroke, and 64% of neurological deaths are due to stroke (80). Recent advances in acute treatment have led to reduced morbidity and mortality, but also to an increased number of survivors, who, along with their family members, are faced with unique, unmet palliative care needs including steep declines in quality of life, receipt of care that does not reflect patients' values and preferences, and high rates of caregiver burden.

One in 3 stroke survivors develops cognitive impairment due to vascular contributions to cognitive impairment and dementia (VCID), which may worsen over time due to concomitant Alzheimer disease and related dementia (ADRD) or immunological processes triggered by the stroke itself, (81) and the incidence of post-stroke dementia, an overt form of VCID, is highest in patients with severe stroke (82). Cognitive, affective and behavioural consequences of stroke are more strongly associated with poor quality of life than measures of physical disability, (83) and the challenges of navigating the fragmented healthcare system and providing day-to-day care usually fall on family caregivers.

The field of neuropalliative care emerged from a recognition that high quality, highly competent palliative care for people living with neurologic disease requires research specific to these distinct populations. **Figure 35** is a conceptual model of care for people with serious neurological illness, for whom 'total pain' encompasses unique and multiple dimensions of suffering, including cognitive and physical disabilities, emotional, psychosocial and existential pain (84). Addressing these needs to improve quality of life holistically, requires specific skills in communication about prognosis and goals of care.

Figure 35:
Palliative care model of "Total pain" adapted for Stroke



The field of neuropalliative care emerged from a recognition that high quality, highly competent palliative

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Symptom management after stroke

Stroke survivors often experience a range of physical symptoms such as central post-stroke pain, spasticity, and depression, which are frequently underdiagnosed and require careful assessment and treatment with medications like antidepressants and anticonvulsants as well as physical therapy (85 86). Emotional and psychosocial support is essential for both patients and their family care partners who grieve significant losses and face anxiety, depression, and continued uncertainty. Clinicians should offer compassionate communication, recognize the patient-caregiver relationship as a unit of care, and consider dyadic interventions to improve outcomes (87). Spiritual distress is also common and often overlooked, despite evidence that spiritual support can enhance psychological well-being; clinicians should proactively address these concerns and offer referrals to chaplains or spiritual care providers (88).

Communication about prognosis and goals of care

Patients with severe stroke are typically robbed of their ability to participate in treatment decisions around life-sustaining treatment, especially in the hyperacute setting when these decisions must be made. Clinicians engage with family members and surrogate decision-makers in a shared decision-making process aiming to provide goal-concordant care—care aligned with the patient's values and preferences. While family members are tasked with considering their loved ones minimally acceptable level of recovery, clinicians are tasked with providing compassionate and honest information. Substantial prognostic uncertainty typically complicates early decision-making and can cause emotional and spiritual distress. Effective communication practices include offering best-case/worst-case scenarios, and using time-limited trials to support families in navigating complex choices (89). A time-limited trials is an agreement to provide a certain treatment (typically a form of artificial life support) for a specific time period that may allow for a clearer prognosis to emerge and help guide future decisions (90). Advance care planning, though recommended, is infrequently practiced among stroke survivors, despite its importance in clarifying goals and designating surrogates for future decision-making.

End of life care after stroke

Most stroke patients die in hospitals or nursing facilities after a decision is made to withdraw life-sustaining treatments, with an increasing number of patients dying at home. End-of-life care should prioritize comfort and emotional support, especially since stroke often impairs communication and awareness. Pain and breathing difficulties are common and best managed with opioids and benzodiazepines. Families should be prepared for physical changes as death approaches, including reduced intake, breathing changes, and secretions. Hospice care is dedicated care at the end-of-life and differs vastly across countries as to how much and what type of care it includes, and to what extent it is covered by health insurance.

Future directions

While major neurologic and palliative care societies have recognized the need to advance primary and specialty palliative care services for neurologic populations, (85 91 92) substantial gaps remain and more research to support this work is urgently needed.

Palliative Care and Serious Respiratory Illness

Significant global disease burden.

A serious respiratory illness (SRI) is any respiratory condition (e.g., chronic obstructive pulmonary disease (COPD), pulmonary hypertension, interstitial lung disease, lung cancer) that carries a high risk of mortality and symptom burden (e.g., dyspnea, depression) and either negatively impacts a person's daily function or quality of life or negatively impacts their caregivers (93 94). According to updated data from the Lancet Commission on Global Access to Palliative Care and Pain Relief, lung disease is one of the most common causes of serious health-related suffering (SHS) in both the proportion of people affected globally and the prevalence of daily physical and psychological symptoms (95).

While the prevalence and incidence of SRIs vary by country and region, lung cancer and COPD are the most common and - like many SRIs - are driven largely by tobacco use and environmental exposures, including biomass fuels, radon, arsenic, and air pollution, which exhibit notable country-specific variations contributing to risks. Lung cancer is the second most frequently diagnosed cancer and is responsible for the most annual deaths of any cancer type worldwide (96). There were approximately 2.48 million new cases and 1.82 million deaths attributed to lung cancer in 2022 which is expected to grow to almost 5 million by 2050 (97). In 2020, 480 million people were affected by COPD which is projected to increase to approximately 600 million globally by 2050 (97) Besides the physical illness burden in SRI (e.g., breathlessness, fatigue), these patients suffer from significant psychological symptom burden including depression, anxiety, and cognitive consequences of chronic hypoxia (95 98). Social symptom burden is also emerging as an underrecognized component of SRIs. For instance, social isolation and loneliness is deeply intertwined with breathlessness and fatigue limits social interactions and community engagement (99).

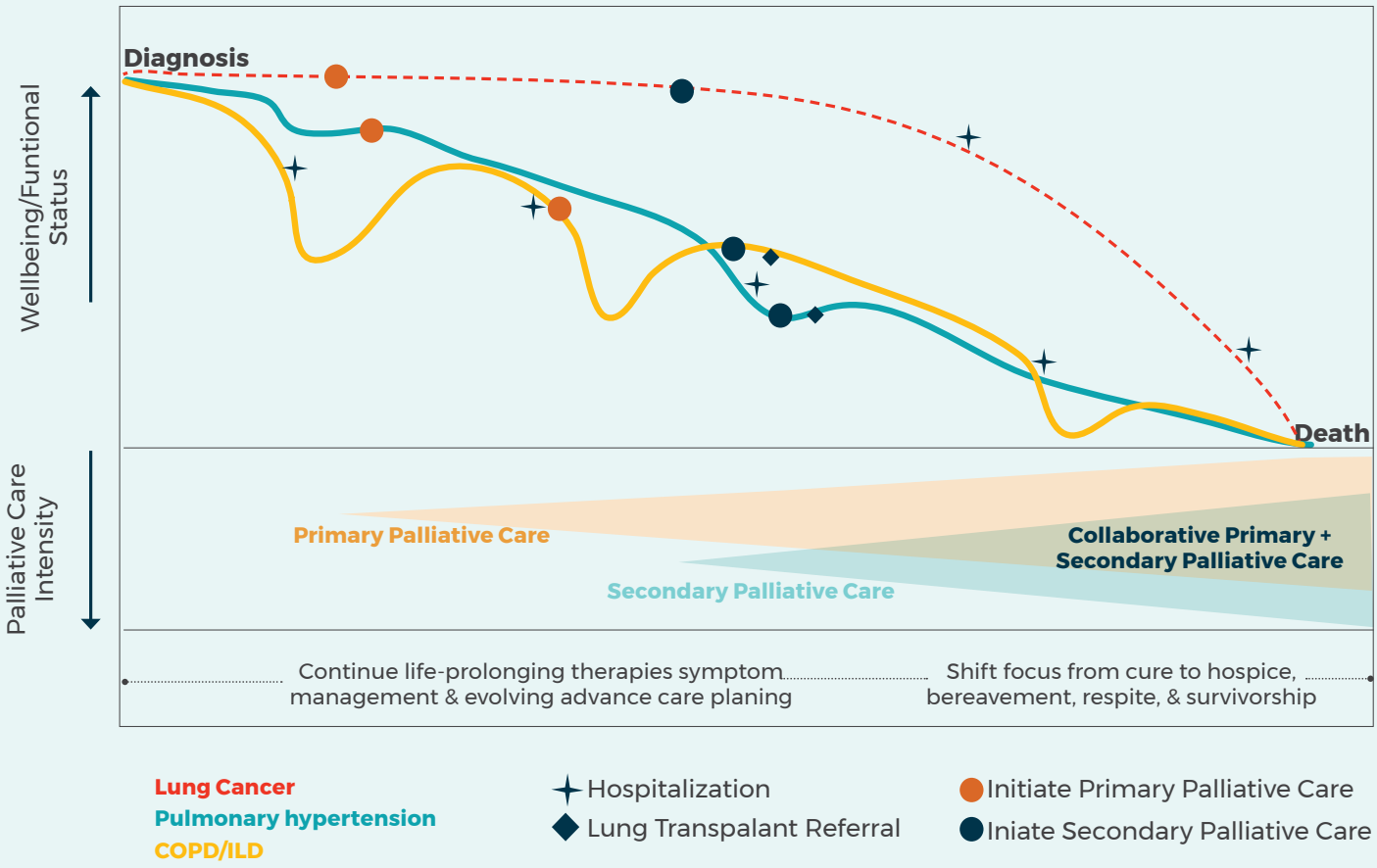
Underutilization of palliative care.

While there is improved palliative care integration in lung cancer, influenced by a strong evidence base, (100 101) few patients with non-malignant SRIs receive timely palliative care (102 103). While this underutilization is multifactorial, the model of palliative care integration and workforce shortages are likely key contributors. Palliative care services in the U.S. are heavily influenced by the public–private fee-for-service reimbursement system and therefore, are well established in inpatient settings (104). While this model may be conducive to people with cancer where inpatient care and settings are centric, those with SRIs receive most of their usual medical care in outpatient settings. Furthermore, the specialist palliative care workforce shortage and lack of availability of services globally limits integration in both malignant and non-malignant SRI (105 106). As a result, we need to envision new models of palliative care integration to better serve people with SRI that are not entirely dependent on the availability of specialty palliative care services (94 107). Primary palliative care (i.e. palliative care delivered by non-specialists such as respiratory specialists) will need to be a core component of this care model to meet the growing needs of people with SRI. **(Fig. 36)**

Figure 36:

Primary and Specialty Palliative Care Integration in SRI. (published with permission from ATS) Reprinted with permission of the American Thoracic Society.

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Cite: Sullivan DR, Iyer AS, Enguidanos S, et al. Palliative Care Early in the Care Continuum among Patients with Serious Respiratory Illness: An Official ATS/AAHPM/HPNA/SWHPN Policy Statement. Am J Respir Crit Care Med. 2022;206(6):e44-e69. doi:10.1164/rccm.202207-1262ST
The American Journal of Respiratory and Critical Care Medicine is an official journal of the American Thoracic Society.



Comprehensive Symptom Assessment and Management.

Multidisciplinary approaches to symptom assessment and management are needed in SRIs. Detailed patient-reported symptom assessments increase rates of symptom discussions between patients and their clinicians. (108 109) Comprehensive, individualized assessments can help determine the true impact of an illness on a person's life, including limitations on activity, psychological manifestations and lack of social connectedness, economic hardships, and effects on families and caregivers, among others. Respiratory clinicians should routinely utilize evidence-based symptom assessments to assess longitudinal changes and new symptoms at each clinical encounter (94). This approach may promote earlier recognition of severe symptomatology and promote interprofessional collaboration uniting primary care, clinicians, respiratory specialists, and palliative care specialists to better meet the palliative needs of people with SRI. An early, concurrent, and collaborative primary palliative care approach beginning at diagnosis and comanaged among clinicians, with a focus on the well-being of the patient and their family, may be the most sustainable path forward (110).

Breathlessness Clinics.

Breathlessness intervention services or clinics target chronic, refractory symptoms across SRIs. They are often multidisciplinary and allow a single point of access for services integrating palliative care, respiratory medicine, physiotherapy, and occupational therapy, among others. In studies these clinics improved breathlessness, quality of life, and survival while reducing unscheduled healthcare use (111 112 113 114) These clinics and their integrated respiratory and palliative care may be a feasible model in SRIs as they are associated with improved respiratory and end-of-life care.

Future Directions.

People with SRIs suffer from substantial physical, psychological, and social symptom burden contributing to a tremendous load of global SHS. Although, people with lung cancer are benefitting from earlier and improved palliative care integration, most people with SRIs and their families do not derive meaningful benefit from palliative care as it is underused or delivered too late in the disease trajectory. To address this gap, we must more effectively integrate palliative care into SRI management through comprehensive symptom assessment, development of innovative models of care delivery, and expansion of the primary palliative care workforce, objectives currently being addressed by international initiatives such as the Lancet Respiratory Medicine Commission on Palliative Care Integration in Serious Respiratory Illness (115).

Summary and conclusions

Palliative care is still relatively new to national health systems, particularly in LMICs. A public health approach is needed to foster the development of palliative care services and to overcome existing barriers to palliative care development. Despite progress on policy and awareness raising propelled by international bodies such as CND and INCB, significant barriers exist in the lack of clear policies establishing palliative care, lack of educational programmes to teach palliative care, lack of research on palliative care especially in LMICs, lack of essential medications needed to deliver palliative care, and lack of organized programmes to deliver palliative care. All these barriers can be overcome. Existing resources are available that can be adapted to individual countries to fill these gaps. What we urgently need is the will to recognize that lack of palliative care is a problem that leads to unnecessary suffering for the people who are among the most vulnerable in any society and the funding and collaborative support to get us there.

Chapter 4

How are palliative care services developing worldwide to address the unmet need for care?

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London, UK 2026
www.thewhpca.org

Responding to the enormous unmet need for palliative care continues to be very challenging. In the over 50 years since the opening of St. Christopher's Hospice in the United Kingdom there has been a slow but steady growth in programmes that serve the needs of those with life-threatening illness. There are now approximately 33,700 hospice or palliative care service units worldwide caring for over 10.4 million patients (**see Pg 65**).

Parallel to the development of services, we have seen in **Chapter 3** the huge need for access to palliative care education, and at the same time access to essential palliative care medications in most countries. This chapter includes the following sections on the development of palliative care globally:

- WHO Country Capacity 2023 Survey Results
- Mapping Levels of Palliative Care Development 2025 Survey Results
- Estimates of Specialised Service Providers and Patients Receiving Palliative Care Globally
- Primary Palliative Care Development
- Mapping Levels of Paediatric Palliative Care Development
- Impact of Family Caregivers in Palliative Care
- Provision of Bereavement Support to Families Public Health Model

Mapping palliative care development by country helps track global progress. Wright, Lynch, & Clark published the first such study in 2006, classifying nations into four groups: no activity, capacity building, localised care, and integration with mainstream healthcare.

This research showed that the methodology and categorisation needed improvement. The original 2006 mapping was updated in 2011 with new criteria, refining groups 3 and 4 into subcategories (3a, 3b, 4a, 4b). Results from Lynch, Connor, & Clark (2013) (116) informed the Atlas's first edition. Further refinements led to a third study using 2017 data (Bauer et al., 2019; Clark et al., 2020), (117 118) highlighting global progress in palliative care capacity (119).

In this new edition of the Global Atlas a fourth study mapping levels of palliative care development was conducted by the ATLANTES group at the University of Navarra building on previous efforts utilizing an agreed set of fourteen WHO indicators of national palliative care development.

Parallel to the ATLANTES mapping study is an effort to also measure the number of people receiving palliative care worldwide. This research uses the number of palliative care services worldwide, from the mapping study, to estimate the number of patients being served against the growing need worldwide.

The WHO conducts a bi-annual survey of all member states on their development of care for those with NCDs. Included in this survey are several questions on palliative care also reported here. These include funding for palliative care, integration into primary care settings, and availability of opioids for treatment.

A new section on primary palliative care explores efforts to integrate palliative care into primary care worldwide including new proposed indicators. Efforts to reach the millions currently unable to access palliative care rest on how effective we will be in preparing primary care workers to deliver basic palliative care.

This chapter also covers global paediatric palliative care development, which has progressed more slowly than adult care. Using new 2023 data from the ICPCN and a five-level schema, we outline current levels, remaining gaps, and specific challenges in providing palliative care for children worldwide.

Our ability to deliver palliative care is dependent on family carers. A new section has been added on intensive caregiving to highlight the importance of this topic and to provide guidance on how we can more effectively support families.

Finally, in this chapter we also explore the related importance of providing bereavement support to families before, during, and after the death of a family member. Using a public health approach, we highlight the needs of the bereaved and the impact of grief on the health of the population.

Results of palliative care findings from the WHO Country Capacity Survey

for the Prevention and Control of Non-communicable Diseases (2023)

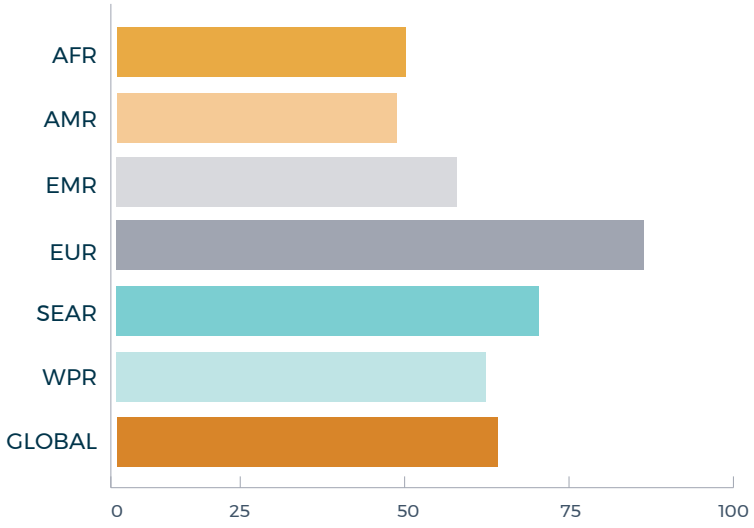
The WHO conducts a bi-annual survey (120) to assess all member states' capacity for the prevention and control of noncommunicable diseases (NCDs). The 2023 survey included questions about the level of palliative care policy and development in 193 WHO member states. Based on survey responses it produced the following results:

- NCD funding for palliative care by region **(Figure 37)**

In 2023, 63% of reporting countries globally reported some funding for palliative care within their national NCD policy, an increase from 50% in 2019. EURO had the greatest funding though all regions claimed funding of at least 50%. The types and amounts of funding were not available.

Figure 37
Percentage of Countries with Funding for Palliative Care by WHO Region*

*Responding countries to the Global NCD capacity survey n=193 member states



- Percentage of countries with palliative care reported as generally available in a primary health care, community-, or home-based care setting, by WHO region and World Bank income group **(Figures 38-39)**

These trends highlight both the growing recognition of palliative care as an essential NCD service and the unfinished agenda for integrating palliative care into primary health care as part of universal health coverage. While more countries report services reaching at least half of those in need, funding for palliative care remains fragile and falling, from 68% in 2019 to 65% in 2023, making palliative care one of the least-funded NCD functions.

Strengthening primary palliative care—through policy, sustainable financing, workforce development and collaboration between primary care teams, community services and specialist palliative care—is critical to close these gaps and ensure that people living with NCDs can access timely, continuous, and person-centered palliative care close to home.

Figure 38

Percentage of countries with palliative care in primary care

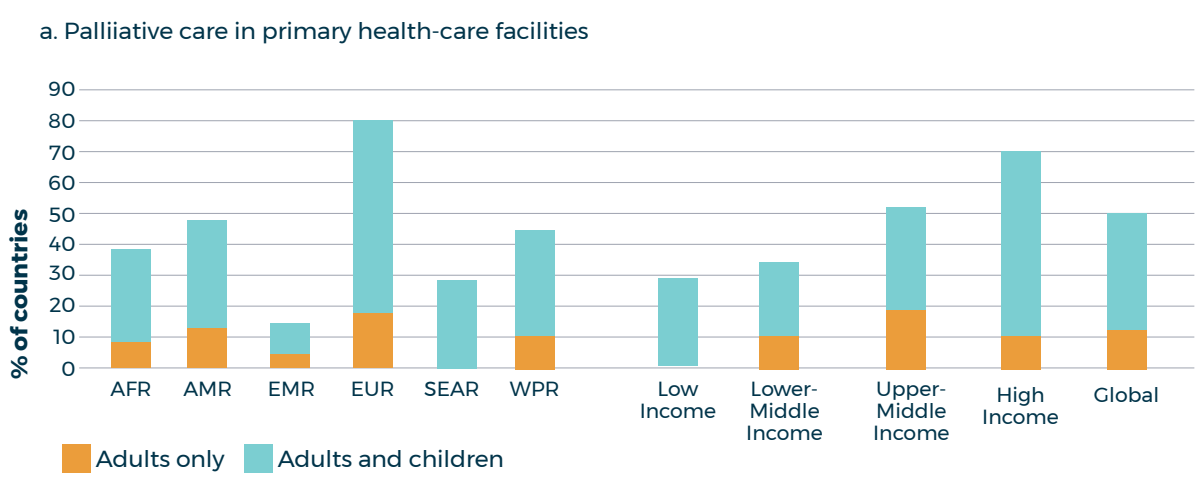
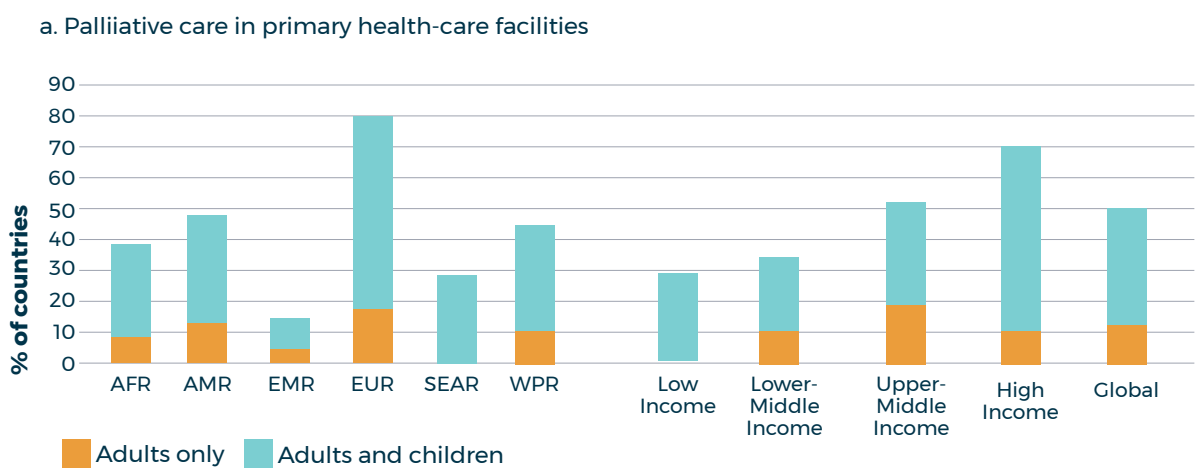


Figure 39

Percentage of countries with palliative care in home care

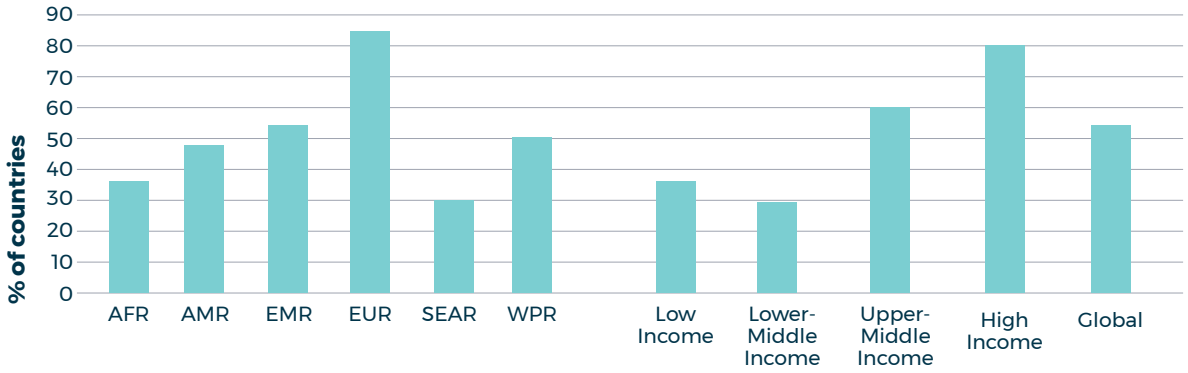


- Availability of oral morphine by region and income group **(Figure 40)**

In 2023, 52% of reporting countries globally reported that oral morphine was generally available, up from 44% in 2019 with wide variability by region and income group. Opioid pain relief for palliative care remains sparsely available in LMICs though higher in low income than lower-middle. These reports conflict with those from the international narcotics control board **(see chapter 3)**.

Figure 40

Percentage of countries with Oral morphine reported as generally available in public health sector primary care facilities, by WHO region and World Bank income group*****



***Responding countries to the Global survey n=193 Member States. WHO regions as of 2023 where Indonesia is in South-East Asia Region.*
****World Bank income groups based on FY24 classification.*

Conclusion

There is a substantial gap in funding and availability of palliative care for NCDs amongst country groups by income. Funding for palliative care was an issue, with the percentage of countries reporting spending on palliative care falling from 69% to 65% compared to 2021 – a decline seen in all regions except the South-East Asa Region. Palliative care remains unavailable to most patients in over 40% of countries. Of particular concern is funding for palliative care – already one of the least-funded areas of the NCD response – which remains inadequate. There is an urgent need to scale up palliative care services for NCDs in LMICs through policies, resources, services in primary care and access to opioids such as morphine.

The next section will describe the development of palliative care for all countries using measures developed by the WHO.

Mapping levels of palliative care development: a global update 2025

We present the latest results from a global initiative that has monitored country-level progress in palliative care for nearly two decades, starting in 2006 (121), with subsequent updates in 2011 (122) and 2017 (published in 2020) (123), and now for 2025 (124). Over this period, these studies have played a pivotal role in shaping advocacy, informing planning, and supporting monitoring efforts worldwide. (125 126) In 2014, the second study formed a key part of the evidence base for the 67th World Health Assembly (WHA) Resolution on Palliative Care, supported by all member states (122). The 2021 World Health Organization (WHO) report, *Assessing the Development of Palliative Care Worldwide: A Set of Actionable Indicators*, outlines 14 universally applicable indicators for monitoring and evaluating PC services (127) **(Table 2)**. Based on the WHO's Conceptual framework of PC development, empowering communities, health policies, research, education, essential medicines, and integrated healthcare services, this model was visualised as "the house of PC". By improving service quality, raising awareness, and promoting transparency, these indicators support Universal Health Coverage (UHC) and reduce global health inequities.

Table 2

Relationship between the sets of indicators and the Conceptual palliative care development (WHO, 2021)

Dimension	#	Indicators for Monitoring Palliative Care Development
Empowerment of people 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 the 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 a 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 a 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 in the country estimated by peer-reviewed articles
Essential medicines	8	Reported annual opioid consumption, excluding methadone, in Defined Daily Dose 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 level
Education and training	11	Proportion of medical and nursing schools with palliative care formal education in undergraduate curricula
	12	Specialisation in palliative medicine for physicians
Integrated palliative care services	13	Number of specialised palliative care programmes in the country per population
	14	Number of specialised palliative care programmes for the paediatric population in the country

This update highlights a nearly two-decade-long global effort to monitor country-level PC development across income categories. Building on the new WHO conceptual framework for global PC development, it classifies countries into four development levels: Emerging, Progressing, Established, and Advanced while also tracking progress since 2020. These findings provide valuable insights to guide policy and advocacy, with the overarching goal of alleviating SHS worldwide and advancing equitable access to PC services.
This methodology marks a departure from the previous edition of the Global Map (2020), which divided Levels 3 and 4 according to the extent of PC integration into national health systems (e.g., 3a: isolated provision, 3b: generalised provision, 4a: preliminary integration, 4b: advanced integration). The 2025 classification aligns with the broader WHO framework, which incorporates policies, essential medicines, education, research, service delivery, and community empowerment. **Table 3** provides an approximate mapping between the six-category model used in earlier World Maps and the new four-level system, ensuring both historical comparability and continuity in interpretation.

Table 3

Proposed Correspondence Between the 2020 Global Map Categories and the 2025 Classification

2025 Levels of Palliative Care Development	Country or territory profile	Approximate Correspondence with 2020 Global Map Categories
Emerging	Countries with minimal or absent PC development often lack basic policy, services, education, and access to medicine.	1 – No known activity
		2 – Capacity building
Progressing	Countries demonstrating initial and uneven development across several components, with isolated initiatives without system-wide integration.	3a – Isolated provision
Established	Countries with more consistent development across dimensions, including recognised services and policy frameworks, though gaps remain.	3b – Generalised provision
		4a – Preliminary integration into the health system
Advanced	Countries with high levels of integration, access, coverage, and governance mechanisms, reflecting sustained policy implementation and monitoring.	4b – Advanced integration into the health system

One of the ongoing objectives of this research has been to enhance the quality of study design with each iteration, incorporating published feedback, (128) while also introducing an evolving analysis of global palliative care development over time. The fourth study, based on data collected in 2024–2025, pursued two main aims. First, to assign each jurisdiction to one of four categories of palliative care development, drawing on assessments from a network of consultants trained through an asynchronous, tutored online course accredited by the University of Navarra. A total of 441 participants from different countries and territories completed the course and provided survey responses. These data were analysed and validated to generate a Global Development Score (GDS) (124), reflecting each country's overall performance across all dimensions. Second, to examine changes in category allocation over time by comparing the current results with those from the 2020 study.

Categorisation of palliative care development 2025, N = 201

Table 4

Group 1 countries: **EMERGING** Countries with minimal or absent palliative care development often lack basic policy, services, education, and access to medicine.

Level 1 Emerging 81 countries (40%) 942 million people (12 % of the world population)	**Africa** 26 countries 335 million inh.	Seychelles, Congo, Rep., Mozambique, Togo, Guinea, Gambia, The, Liberia, Burundi, Lesotho, Madagascar, Sierra Leone, Burkina Faso, Comoros, South Sudan, Eritrea, Guinea-Bissau, Chad, Equatorial Guinea, Central African Republic, Sao Tome and Principe, Algeria, Angola, Gabon, Mali, Mauritania and Niger.
	Americas 15 countries 85 million inh.	Dominican Republic, Grenada, Jamaica, Venezuela, Bolivia, Nicaragua, Guyana, Honduras, Saint Lucia, Haiti, Bahamas, Antigua and Barbuda, St. Kitts and Nevis, St. Vincent and the Grenadines and Suriname
	Eastern Mediterranean 14 countries 374 million inh.	Sudan, Tunisia, Qatar, Egypt, Arab Rep., Oman, United Arab Emirates, Bahrain, Djibouti, Iraq, Syrian Arab Republic, Somalia, Libya, Afghanistan and Yemen.
	Europe 9 countries 78 million inh.	Kyrgyzstan, Vatican, Tajikistan, Uzbekistan, Albania Bosnia-Herzegovina, Kosovo, Azerbaijan and Turkmenistan.
	South-East Asia and Western Pacific 17 countries 70 million inh.	Timor Leste, Macao SAR, Nepal, Vanuatu, Lao PDR, Cambodia, Samoa, Solomon Islands, Marshall Islands, Papua New Guinea, Micronesia Federated States, Fiji, Kiribati, Tokelau, Niue, Nauru and Tuvalu.

Table 5

Group 2 countries: **PROGRESSING** Countries demonstrating initial and uneven development across several components, with isolated initiatives without system-wide integration.

Level 2 Progressing 57 countries (28%) 3162 million people (39 % of the world population)	**Africa** 16 countries 701 million inh.	Ghana, Nigeria, Zimbabwe, Namibia, Tanzania, Eswatini, Cameroon. Cabo Verde, Benin, Congo, Democratic Republic of the, Zambia, Botswana, Mauritius, Cote d'Ivoire, Ethiopia and Senegal.
	Americas 9 countries 90 million inh.	Belize, Peru, Cuba, Ecuador, Paraguay, Barbados, Trinidad and Tobago, Dominica and Guatemala.
	Eastern Mediterranean 5 countries 383 million inh.	Lebanon, Saudi Arabia, Iran, Palestinian, Occ. Territory, and Pakistan
	Europe 16 countries 184 million inh.	San Marino, Monaco, Republic of Moldova, Greece, Türkiye, Andorra, Belarus, Estonia, Kazakhstan, Montenegro, Ukraine, Cyprus, Georgia, Bulgaria, Armenia, and North Macedonia
	Southeast and Western Asia 11 countries 1804 million inh.	Philippines, Sri-Lanka, India, Bhutan, Maldives, Tonga, Bangladesh, Cook Islands, Palau Brunei Darussalam and Myanmar.

Table 6

Group 3 countries: ESTABLISHED Countries with more consistent development across dimensions, including recognised services and policy frameworks, though gaps remain

Level 3 Established 34 countries (17%) 2878 million people (35 % of the world population)	**Africa** 4 countries 154 million inh.	South Africa, Malawi Kenya, Rwanda
	Americas 7 countries 490 million inh.	Argentina, Panama, Brazil, Canada, Colombia, Mexico, El Salvador
	Eastern Mediterranean 3 countries 54 million inh.	Jordan, Kuwait, and Morocco
	Europe 15 countries 259 million inh.	Russian Federation, Israel, Hungary, Poland, Czech Republic, Finland, Lithuania, Liechtenstein, Malta, Slovenia, Romania, Slovakia, Croatia, Serbia and Latvia.
	South East and Western Asia 5 countries 1830 million inh.	Malaysia, Mongolia, China, Vietnam and Indonesia

Table 7

Group 4 countries: ADVANCED Countries with high levels of integration, access, coverage, and governance mechanisms, reflecting sustained policy implementation and monitoring

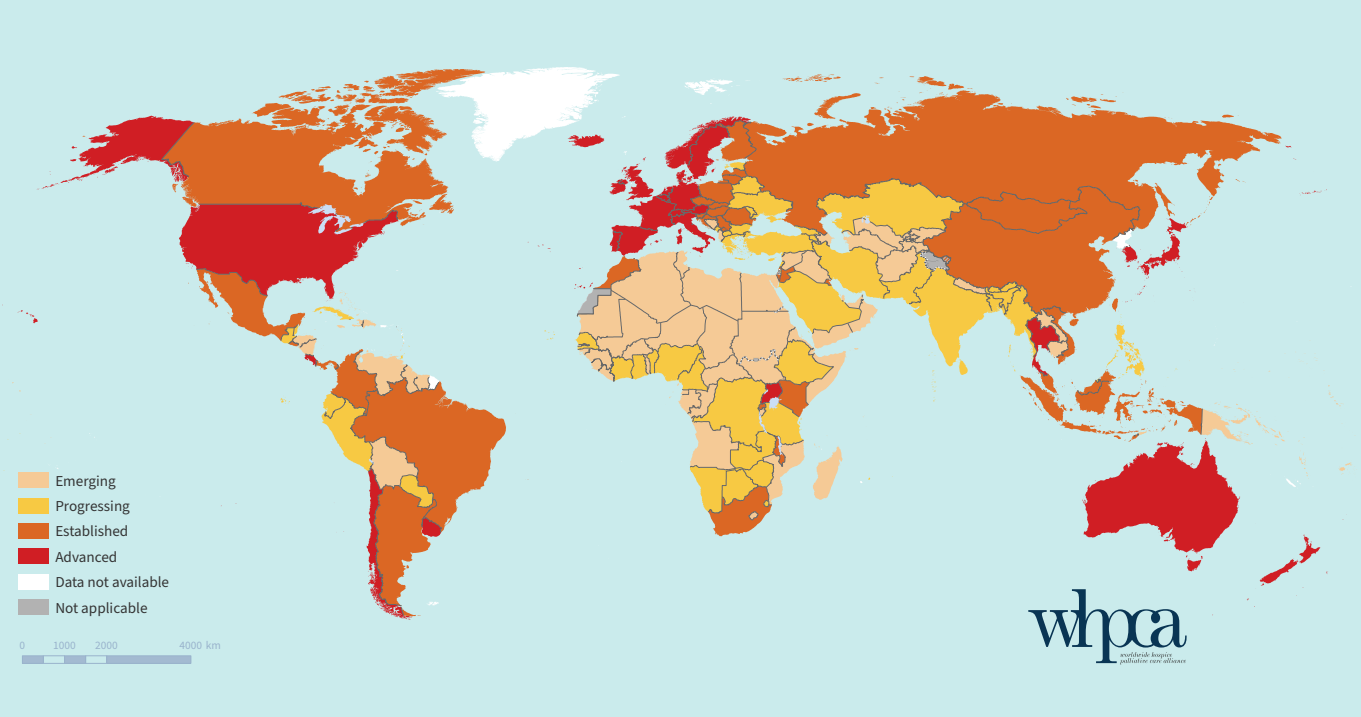
Level 4 Advanced 29 countries (14%) 1143 million people (14 % of the world population)	**Africa** 1 country 49 million inh.	Uganda
	Americas 4 countries 363 million inh.	Uruguay, Costa Rica, Chile, United States
	Eastern Mediterranean	none
	Europe 16 countries 414 million inh.	Germany, Netherlands, Austria, Norway., Sweden, Switzerland, France, Ireland, Italy, Belgium, Denmark, Luxembourg, United Kingdom, Iceland, Portugal and Spain
	South East and Western Asia 8 countries 317 million inh.	Chinese Taipei (Taiwan), Australia, Hong Kong SAR, Japan, Thailand, New Zealand, Singapore, and Republic of Korea.

Correspondence between the 2020 and 2025 Global Classifications of Palliative Care Development

The comparison between the 2020 global mapping categories and the 2025 palliative care development levels reveals a moderate degree of concordance, especially among countries at the top tiers. In 2025, 70% of those classified as "Advanced" had been in category 4b in 2020, supporting the proposed equivalence. Only 22% of the countries considered "Established" correspond to the former 3b or 4a levels. Among those classified as the previous 3a category 10% matched with "Progressing." Of the countries now classified as "Emerging," 20% were previously in Levels 1 or 2; the rest came from higher categories, possibly due to reclassification, downgrades, or improved data.

Figure 41

Levels of palliative care development in all countries



(reproduced with permission of the authors) (124)

Summary and Conclusions

This fourth global mapping of palliative care development, and the first to apply the WHO Conceptual Framework, provides a multidimensional assessment of progress across policies, education, medicines, service delivery, research, and community empowerment. Findings reveal persistent global inequities: over half of the world's population lives in countries with Emerging or Progressing PC, and fewer than one in five in Advanced systems. The updated WHO model has proven to be a robust methodological tool, supporting a holistic evaluation. However, the lack of change in the number of Advanced-level countries since 2020, alongside downgrades in several high-income contexts, signals stagnation and highlights the need for sustained investment, improved data quality, and targeted action. Structural barriers, particularly in low- and middle-income countries, continue to hinder progress, with recurring challenges including underfunding, workforce shortages, inadequate infrastructure, and restricted access to essential medicines.

Notably, encouraging advances in parts of Africa, Asia, and Latin America demonstrate that meaningful palliative care development is achievable beyond high-resource settings, provided there is a political commitment, strategic resource allocation, and the adoption of locally adapted models. By combining population-based indicators with local expertise, this edition delivers an actionable diagnostic for national strategies and international cooperation, reaffirming palliative care as a fundamental component of UHC and human rights.

Estimating the Number of Services & Patients Receiving Specialized Palliative Care Globally in 2025 (129)

Between 2017 and 2025, the number of palliative care services worldwide and the number of patients receiving specialized palliative care increased substantially. Services grew from approximately 25,000 to 33,720, and patients served increased from almost 7 million to over 10.4 million. However, only an estimated 14% of the total global need for palliative care, not including most primary palliative care, is being met. Since this study focuses exclusively on specialist services, a substantial part of the unmet need could potentially be addressed through the expansion and integration of primary palliative care within health systems.

As of 2025 of the 33,720 palliative care services reported in our research almost 73% were in high income countries and 66.5% were in either the European or Americas region. The need for palliative care for both decedents and non-decedents has increased to almost 73.5 million per year. In high income countries over half the need for palliative care is being met while in low and middle-income countries only 4.4% of the need is being met **(see Table 8)**. **Figure 42** shows the rates of specialised services globally per 1 million population.

Table 8:

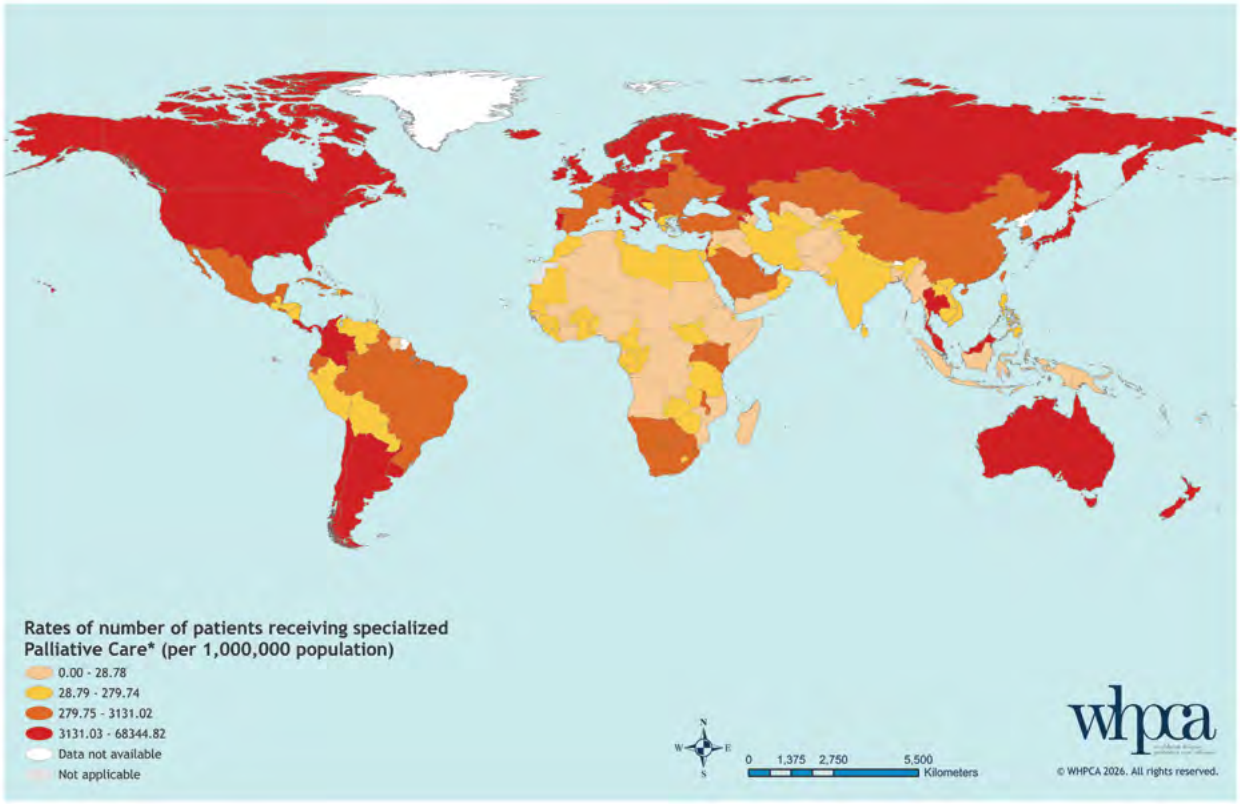
Number of Services and the Patients Served by Income Group and Region

Group	#Services	% of Total	#Patients receiving PC	Total Need for PC	% Need Met
WB Income					
LI	405	1,20%	54,865	7,488,000	0.72%
LM	1504	4,46%	281,248	25,240,000	1,11%
UM	7539	22,36%	2,239,083	26,002,000	8,61%
HI	24,272	72.98%	7,864,128	14,722,000	53.42%
Total	33,720	100.00%	10,438,324	73,453,000	14.21%
Regions					
AFR	827	2.45%	151,769	18,956,000	0.80%
AMR	11,085	32.87%	3,528,972	9,196,000	38.38%
EMR	234	0.69%	58,626	2,272,000	2.58%
EUR	11,350	33.66%	3,666,127	10,731,000	34.07%
SEAR	2,742	8.13%	716,364	10,663,000	6.72%
WPR	7,482	22.19%	2,326,746	21,636,000	10.75%
Total	33,720	100.00%	10,438,324	73,453,000	14.21%

Abbreviations:
***WB** = World Bank, **LI** = Low Income, **LM** = Lower Middle, **UM** = Upper Middle, **HI** = High Income, **AFR** = African, **AMR** = Americas, **EMR** = Eastern Mediterranean, **EUR** = European, **SEAR** = Southeast Asian, **WPR** = Western Pacific.*

Figure 42

Rates of Specialised Palliative Care Services per 1 million Population



The overall growth in palliative care services from 2017 to 2025 was over 35.5% with the highest growth in low-middle income countries. By region the highest growth was in the Southeast Asian and Eastern Mediterranean regions **(see Table 9)**.

Table 9

Comparison of Services from 2017 to 2025 by Income Group & Region

Group	Services 2017	Services 2025	Growth Rate
WB Income			
LI	233	405	73.82%
LM	586	1504	156.66%
UM	5922	7539	16.88%
HI	17602	24,272	37.89%
Total	24,871	33,720	35.58%
Regions			
AFR	557	827	48.77%
AMR	8,605	11,085	28.82%
EMR	78	234	200.00%
EUR	9,844	11,350	15.30%
SEAR	800	2,742	242.75%
WPR	4,987	7,482	50.03%
Total	24,871	33,720	35.58%

There was considerable growth in the numbers of patients served between 2017 and 2025 with an overall growth rate of over 50% due to the increase in number of specialised services. Like services the growth was most notable in low-middle income countries and the Southeast Asian and Eastern Mediterranean regions **(see Table 10).**

Table 10

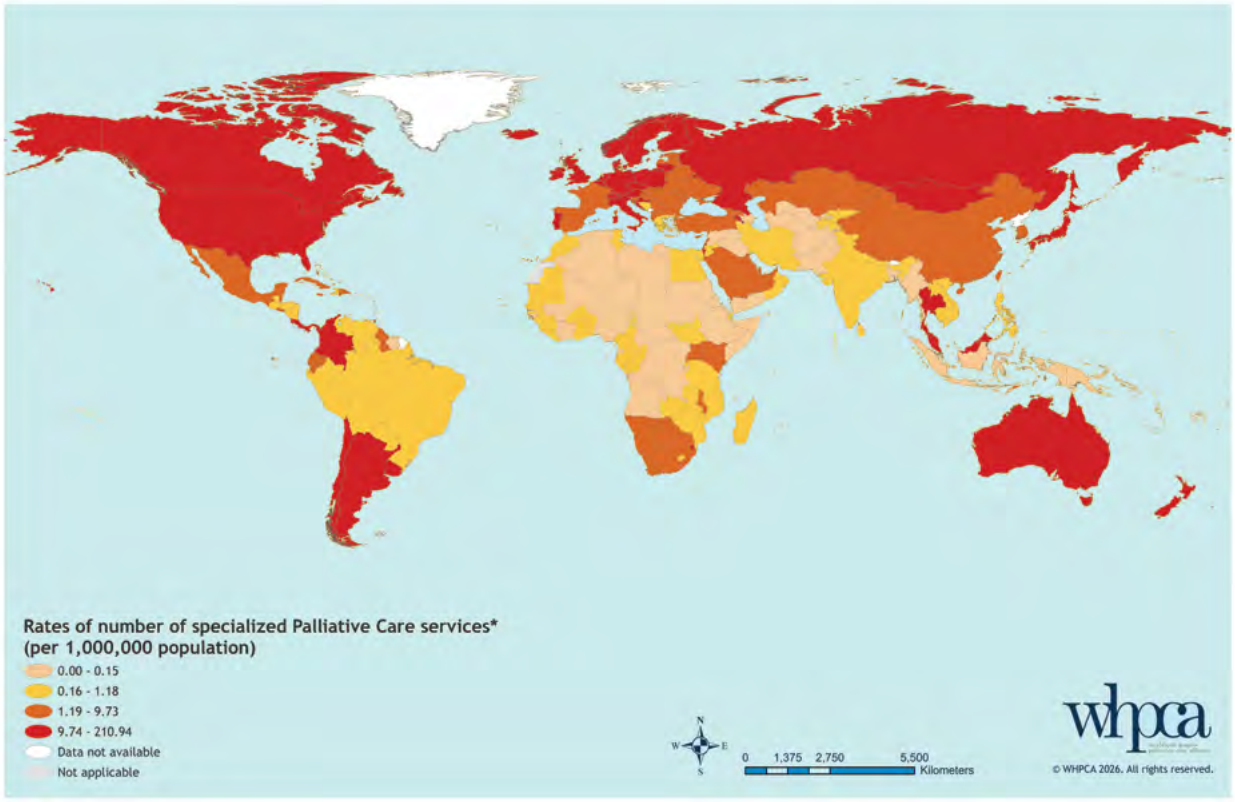
Comparison of Patients Served from 2017 to 2025 by Income Group & Region

Group	Patients 2017	Patients 2025	Growth Rate
WB Income			
LI	29,410	53,865	83.15%
LM	109,582	281,248	156.66%
UM	1,935,548	2,239,083	15.68%
HI	4,812,380	7,864,128	63.41 %
Total	6,886,920	10,438,324	51.57%
Regions			
AFR	114,263	151,769	32.82%
AMR	2,943,900	3,528,972	60.25%
EMR	23,569	58,626	148.74%
EUR	2,202,152	3,656,117	24.19%
SEAR	187,214	716,364	282.64%
WPR	1,415,822	2,326,746	64.34%
Total	6,886,920	10,438,324	51.57%

Figure 43 shows the rates of palliative care patients receiving services globally per million population. There continue to be notable gaps in access in the African, Eastern Mediterranean, and Latin American regions despite this growth.

Figure 43

Rates of patients receiving specialised palliative care per million population



Palliative Care in Primary Health Care

Palliative Care is an Essential Component of Primary Health Care

Most people with palliative needs live in the home environment, where their care (and their families' care) is largely provided by primary care and community services. Primary care has great potential to deliver palliative care in many ways – across diseases, the continuum of illness, dimensions of need, settings, and countries. Primary care exists in varying degrees of development worldwide and prioritizes people with chronic illnesses, throughout their life-course with a patient-centred approach that embraces care continuity and compassion, which are also tenets of palliative care (130). Thus, integrating palliative care into primary care is one of the most efficient ways to expand access and reduce avoidable suffering, especially in resource-constrained settings.

Advocacy and Education

International policy positions palliative care as a core function of primary care, central to equity, universal health coverage, and access to essential medicines (131 132 133 134 135 136). However, implementation at country level remains uneven, with wide variation in service organisation, integration and funding, clinical pathways for chronic conditions, access to essential medicines (including opioids), and the use of information systems for early identification and care planning.

Effective advocacy should align palliative care with existing primary health care priorities, secure its inclusion in standards and budgets, and link every policy commitment to practical delivery mechanisms such as care templates, referral pathways, and shared records with emergency services (135).

While education in palliative care has expanded in undergraduate and postgraduate medicine and nursing, coverage remains variable. The priority is scalable, practice-based training for interprofessional primary care and community teams, focused on early identification, brief holistic assessment, shared care planning, and local coordination. Short, modular workplace learning, supported by mentoring from primary and palliative care champions, is more likely to change practice than standalone courses (136).

Palliative Care as Part of Non-communicable Disease Management in Primary Care

In the WHO Country Capacity Survey (see previous section), 81% of primary care users aged 45 years and older live with at least one chronic condition, and 52% live with two or more (137). This highlights the scale of need for integrated, long-term care within primary health systems.

These findings point to both progress and gaps. While palliative care is increasingly recognised as an essential service for noncommunicable diseases (NCDs), integration into primary health care as part of universal health coverage remains incomplete. More countries now report reaching at least half of those in need; however, funding for palliative care is fragile and declining, falling from 68% in 2019 to 65% in 2023. Palliative care remains one of the least funded NCD functions (120).

To address this gap, governments and health system leaders should prioritise strengthening primary palliative care through supportive policy, sustainable financing, workforce development, and stronger collaboration between primary care teams, community services, and specialist palliative care. These actions are essential to ensure that people living with NCDs can access timely, continuous, and person-centred palliative care close to home.

Availability of essential pain and palliative care medicines at the primary care level

Across countries with data for both policy and medicines indicators, higher scores for inclusion of palliative care in the basic primary care package are moderately correlated with higher scores for the availability of essential pain and palliative care medicines in both urban and rural primary care. Integrating palliative care into primary care benefit packages is closely associated with better access to essential opioid analgesics at the primary care level, but large inequities within and between countries remain.

Models of primary palliative care

Various models for delivery of primary palliative care have been tested and can significantly improve palliative care delivery in the community.

In low- and middle-income countries, where health care systems may be unable to address patients' palliative care needs, non-governmental organisations and community volunteers help bridge the gap through patient advocacy, fund-raising, and enhancing free, continuous care at home (139 140). Community empowerment through capacity-building of multidisciplinary primary care teams, community health volunteers, and families has led to enhanced continuity of care (139 141 142 143).

Innovative techniques such as video-consultation and smartphone-based tele-consultation can ensure continuity of care, especially in remote and difficult-to-reach areas (144 145 146 147 148). Capacity building of primary care teams can help address barriers to accessing palliative care (141 149).

Case Example

One such successful model is the 'Hi-Five' approach to building palliative care workforce in Africa. The Kenya Hospice and Palliative Care Association (KEHPCA) in collaboration with Worldwide Hospice Palliative Care Alliance (WHPCA) developed an innovative and cost-effective model to expand palliative care delivery. This involved online training of five key health care providers who then each then mentored five of their colleagues. A ripple effect was created as each of them also committed to look after the palliative care needs of five patients and their families.

Towards Outcome Measures/ Indicators for Primary Palliative Care

Timely palliative care integration has been shown to improve access to pain and symptom control, reduce unnecessary hospital visits and resource-intensive interventions, facilitate early transition to home care, and reduce financial burdens on families and health systems (150 151 152 153).

Measuring the impact of primary palliative care is more complex than for specialist palliative care, due to the complexity and integration of primary care systems and data availability. Nevertheless, the core processes of Primary Palliative Care services are now established with a strong evidence base: identification, assessment, planning, and coordination (154). **(See Figure 44)**

The recent WHO Service Planning and Delivery and Implementation Programme (SDPI) (155) on the Palliative care platform also identifies these actions, as well as symptom control, as core to Palliative Care delivery in PHC. It would thus seem sensible to assess how well we are succeeding in achieving proactive, high-quality, personalised patient care acceptable to all in PHC by using indicators where available that track progress through these steps along the patient experience. Resources and tools to aid professionals assess progress with these steps are listed in the image below (154). These will complement wider indicators relating to advocacy, education, and availability of essential medicines.

Figure 44

Proposed Primary Palliative Care Indicators

Indicator	Rationale
1. Percentage of patients identified for palliative care before death	To assess progress towards universal palliative care coverage among people who die.
2. % with cancer and % with non-malignant disease	People with non-malignant disease are less commonly identified for a palliative care approach.
3. Median time before death identified (all patients)	Early or timely palliative care can prevent and lessen suffering across all dimensions from diagnosis to death and bereavement.
4. Median time before death (cancer vs non-malignant)	People with non-malignant diseases often have longer care needs, requiring more prolonged care and resources.
5. % with holistic assessment documented	To monitor that physical, psychological, social and spiritual needs are considered and treated.
6. % with advance care plan documented	Care planning is linked to more patient-centred care and better quality of life.
7. % with coordinated shared care plans	Shared plans improve patient experience and may prevent avoidable admissions.
8. % of children identified before death	To ensure children with life-limiting conditions are not overlooked and benefit from palliative care.
9. Routine carer and family support (Yes/No)	Carers have their own needs and supporting them improves care.
10. Community and voluntary involvement (Yes/No)	To capture the important contribution of voluntary and community resources.
11. After-death analyses by PHCT (Yes/No)	Structured reflection helps identify gaps and improve quality of care.

Case study #2 Outcome indicators:

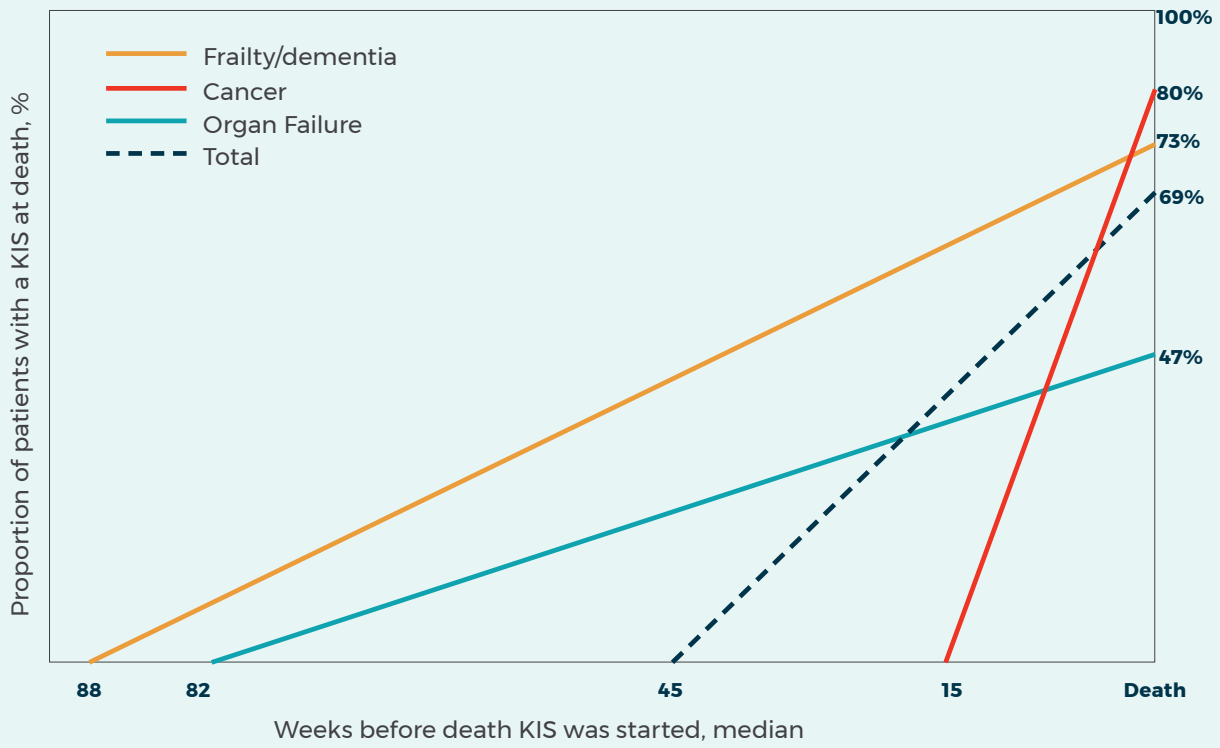
Electronic care co-ordination systems in Scotland: the Key Information Summary (KIS)

In Scotland, for 13 years, family doctors as part of their GP contract have routinely shared, electronically, summary advance care plans known as Key Information Summaries with hospitals and emergency settings, which are updated daily for patients receiving palliative care in the community, known as “anticipatory care”.

Seven years later, an after death analysis of routine primary care records revealed that patients with frailty and organ failure started advance care planning and received palliative care much earlier than cancer patients **(Figure 45)** (156). This study also showed that the first seven indicators listed above may be monitored using routinely collected data in primary care. Where available, such indicators could form an important part of benchmarking and feedback for primary care services, especially if data were collected in national datasets.

Figure 45

Proportion of patients with a Key Information Summary (KIS) in place before death, and if so, the median number of weeks before death KIS was started by trajectory (156).



Mapping Levels of Children's Palliative Care

Since the development of the first palliative care services for children there has been a slow growth of children's palliative care development. In many countries children's palliative care development has lagged behind that for adults (157 158 159) and accessibility to children's palliative care varies widely across the world and within countries. Estimates suggest that <10% of children who need palliative care globally can access it, (160 161) thus there are many gaps and much unmet need worldwide. Often the need for children's palliative care has not been recognised, nor the unique palliative care needs of children with life-limiting and life-threatening illnesses. Yet, as can be seen in Chapter 2 and in previous estimates, the need for children's palliative care is great, with 96% of need in low-and-middle-income countries (LMICs) **(Figure 20)** and >50% of need in the African region, and 18% in the Southeast Asia Region **(Figure 16)** (162).

Studies on children's palliative care development that parallel the mapping of adult palliative care have been published (161 163 164). A systematic review of children's palliative care published in 2011 found that 65.6% of countries had no known activities and 5.7% had provision reaching mainstream providers (163). This clearly highlighted the disparities between Africa, Asia and Latin America and North America and Europe. Disparities which have been echoed in subsequent work and were noted in the first two editions of the Global Atlas, (165 166) and are again echoed in this publication, although that gap is gradually narrowing.

The importance of mapping children's palliative care development has been recognised, and different methods have been used to do this over the years, including the systematic review, (163) the 1st edition of the Global Atlas, (165) the original regional atlases and the 2025 revised regional atlases. (167-171) The International Children's Palliative Care Network (ICPCN) has been mapping children's palliative care development for the past 20 years and has released various version of their global maps over the years (1998, (158) 2016, (157 172) 2018 (157 160 173) 2023, (161) whilst refining the methodology used. We report on the levels of children's palliative care development based on ICPCN's 2023 mapping, (151 174) to provide a measure of the progress that still need to be made, and to understand some of the global inequities in children's palliative care development.

The aim of the 2023 mapping was to: (161 174)

1. assess the global status of children's palliative care development to understand the status of development in each country/ region through an online survey; and
2. track changes in development over time,
3. utilise the results to inform and supporting ongoing efforts to development children's palliative care around the world.

Five categories were used in the mapping **(Table 11)**, which were aligned to the categories used in the Global Atlas (166) and ICPCN's previous mapping so that a comparison could be made over time.

Table 11

Levels of children's palliative care development

Level	Number of Countries (n=197)
Level 1	No know provision of children's palliative care or evidence of any capacity-building activities
Level 2	Evidence of capacity building activities for the provision of children's palliative care
Level 3	Evidence of localised provision of children's palliative care and capacity-building activities for the development of services
Level 4	Evidence of multiple children's palliative care services (broad provision), recognised training and work towards integration into health care services.
Level 5	Evidence of broad provision of children's palliative care recognised training and partial or full integration into health care services

The levels of development in 2023 can be found in **Table 12**, showing 42% of countries still at the lowest level of development and only 6% at the highest level.

42% of countries still at the lowest level of development and only 6% at the highest level

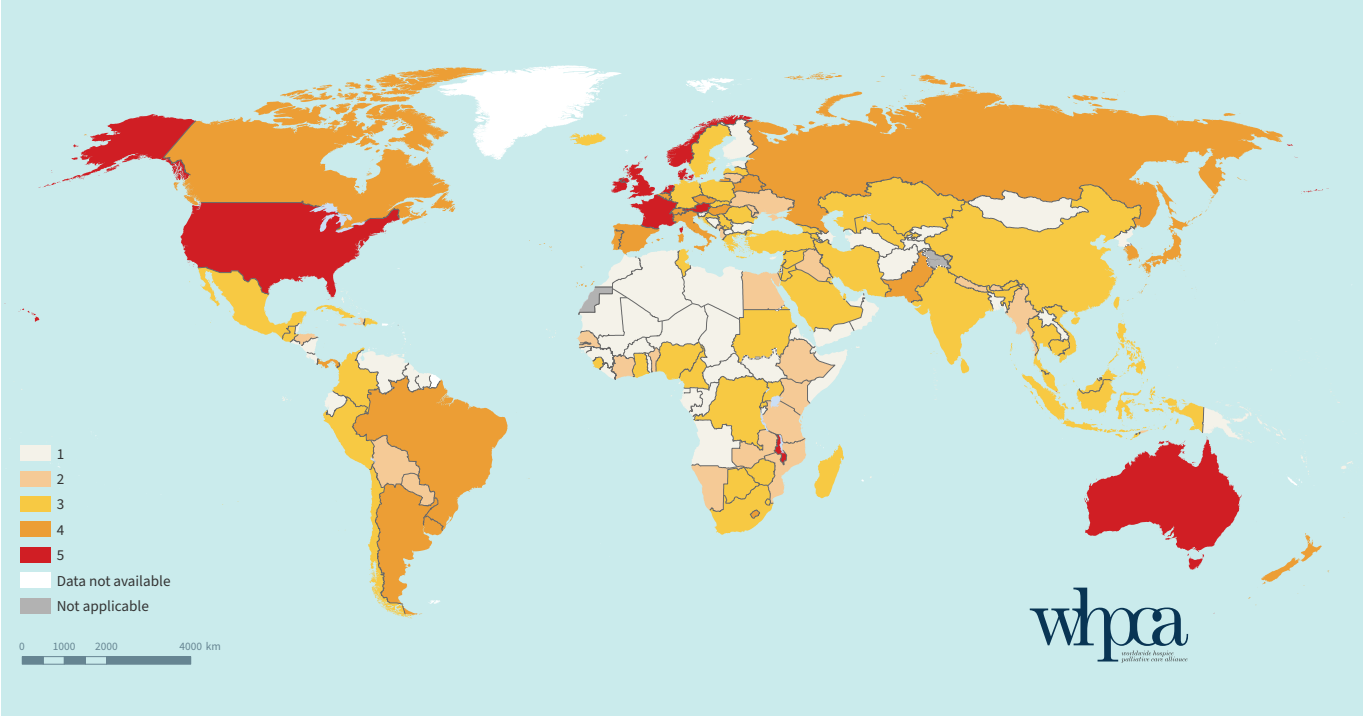
Table 12

Levels of children's palliative care development in 2023 (161)

Level	Number of Countries (n=197)	% of Countries
Level 1	83	42%
Level 2	28	14%
Level 3	55	28%
Level 4	20	10%
Level 5	11	6%

Figure 46

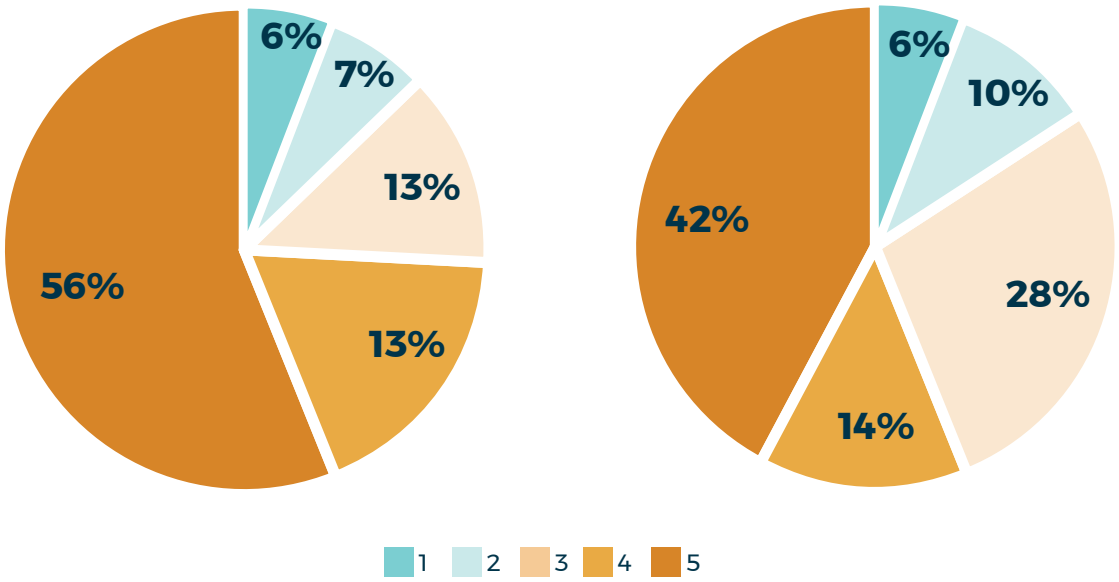
Global map of the levels of children's palliative care development per country in 2023.



Whilst there has not been an overall net percentage increase in countries at the highest level (Level 5), there has been an overall net increase in countries at levels 2,3, and 4, and a decrease in level 1. However, whilst many countries showed increased development in children's palliative care, there were also several countries that showed a reduction in development, with 17 countries moving down at least one level, and 31 countries staying at the same level. There are a variety of reasons why countries may have moved down a level, many related to economic, political and structural challenges, the impact of climate change, armed conflict and other humanitarian crises, or there was no response to the survey. There are also examples of where services are developing despite the impact of climate change and armed conflict.

Figure 47

Percentage of countries at the different levels of children's palliative care development in 2018 and 2023 (161)



Significant inequities continue to be seen in the development of children's palliative care around the world, and whilst global progress has been made, there are still significant gap in ensuring all children and their families needing palliative care can access it. (175) Regional. Disparities are evident, with the European region (EURO) having 7 countries at level 5, Eastern Mediterranean (EMRO) and the rest all having just one. The Western Pacific (WPRO) and African regions (AFRO) having the highest at level 2 with EURO and South-East Asia (SEARO) having the least, although this still accounts for a quarter of the countries within those regions. Whilst this mapping clearly illustrates those gaps at a country level, it is also important to remember that gaps exist within countries, including those at the highest level of development.

Table 13

Levels of children's palliative care development across WHO regions in 2023 (161).

	AFRO	AMRO	EMRO	EURO	SEARO	WPRO
Level 1	23 (48%)	15 (45%)	10 (45%)	14 (26%)	4 (25%)	17 (65%)
Level 2	10 (22%)	5 (15%)	2 (9%)	7 (13%)	4 (25%)	0
Level 3	12 (26%)	7 (31%)	9 (41%)	16 (30%)	7 (44%)	4 (15%)
Level 4	1 (2%)	5 (15%)	1 (5%)	9 (17%)	0	4 (15%)
Level 5	1 (2%)	1 (3%)	0	7 (13%)	1 (6%)	1 (4%)
	46	33	22	53	16	26

A range of indicators were assessed in the 2023 mapping exercise, (159) including looking at different models of children's palliative care, where services were provided (e.g. at home, in the community, in schools, in hospital and in a hospice) along with whom services were aimed at. A range of models were seen, with the countries showing more development of children's palliative care demonstrating integrated services across different settings, to enable seamless access to children's palliative care. The presence of specialist children's palliative care services globally is increasing, with this being mapped by the recent editions of the Regional Atlases, (175-180) although it is not possible to make comparisons due to differences in what is being measured. The importance of engaging communities to support provision, but also influence its development has also been recognised, with more emphasise being put on the public health approach to children's palliative care, in terms of service provision, education and advocacy (181 182 183).

Table 14

Levels of children's palliative care development in 2023.

Region	Number of Specialist Children's Palliative Care Services	Number of countries
Africa	102	21 out of 54 (39%)
Americas	375	22 out of 35 (63%)
Eastern Mediterranean	38	15 out of 22 (68%)
Europe	524	41 out of 56 (73%)
Asia Pacific	160	20 out of 41 (49%)

2025/26 mapping is underway, and much has happened in the past few years, with many countries/ regions having recognised its importance e.g. the Eastern Mediterranean (114). Whilst there are always limitations in any mapping, (161) it is clear that progress has been made in the development of children's palliative care. However, concerted efforts are needed to continue to remove the barriers, to reduce inequities within and between countries, and to ensure all children in need, and their families have access to palliative care.

"Intensive caregiving": family carers and palliative care

Life threatening illness is a 'family affair' that profoundly impacts the wellbeing of the person diagnosed with serious illness and their family (184). Family carers (also known as caregivers) are at the core of patient care; they are typically lay people, comprising close family members or friends who provide a significant level of support (practical, social or emotional) without remuneration (185). Their efforts also enable much-needed support to healthcare systems worldwide saving billions of dollars (186). At any given time, one out of four people acts as a family carer (187) and as highlighted by Rosalynn Carter: "There are only four kinds of people in the world–those who have been caregivers, those who are currently caregivers, those who will be caregivers, and those who will need caregivers."(188)

The UN estimate that 75–90% of care needs are met by unpaid caregivers. (189) Women spend up to 10 times more time than men on unpaid care work and their contributions to the health sector have been estimated to account for 3.1% of the global gross domestic product (190). Within the context of serious illness, the overwhelming majority of carers provide "intensive caregiving" which typically comprises in excess of 20 hours per week direct support (191). Women are also 60% more likely to provide this "intensive caregiving" (189).

It is vitally important not to pathologize the caregiver role and the majority of carers develop positive associations; however the transition to intensive caregiving is linked to negative psychosocial and physical sequalae for about one in three family carers (186 192). Across the spectrum of high-, low- and middle-income countries, intensive caregiving is associated with a greater likelihood of depression, sleep problems, and perceived stress regardless of country income levels (187).

Accordingly, many nations have established standards, policies and guidelines for responding to the needs of family carers as well as patients (193 194). The World Health Organization for example advocates that palliative care should be 'family centered', enhancing the quality of life of the patient and their family carers including during bereavement. (195) Yet, despite policy, clinical and research evidence advocating a family approach to palliative care, systemic inadequacies have impeded family centered care. These include lack of preparation for death, inability of many family carers to access health professional support and fragmented, inconsistent, variable health services (196). Comprehensive carer support is also a key factor determining whether the preference of home care and death can be realised; yet carer support is commonly inadequate leading to potentially unnecessary and high-cost hospital-based care.

While family carer bereavement support is integral to palliative care, it is typically insufficiently resourced, under-researched, and not systematically applied. It has been considered "the forgotten child" of the palliative care family (197). Morbidity and mortality associated with bereavement is an important public health issue, yet economic and resource investments to effectively implement and sustain integrated bereavement services are profoundly lacking at national and global levels (198).

Unfortunately, too, family carers value with rare exceptions are not sufficiently acknowledged. Their unmet needs are often greater than their care recipient and thus they have been referred to as "hidden patients." (199) In short, family caregiving remains invisible, undervalued and unaccounted for in national statistics, and neglected in economic and social policy making (200).

So, what are some examples of potential enablers to address these issues?

Research is critical to develop systematic change to address family carer burden. Yet in the US and UK, palliative care receives just 0.2% and 0.3% of all research funding respectively (201). Whilst there has been an increase in family carer research activity unless gaps in diversity and rigorous intervention and implementation research are addressed, there is a significant risk that needs of numerous carers will continue to be adequately met" (202 203).

Patients and family carers experience illness together, with one person's ability to cope affecting the other's. (204) Carer wellbeing can have a profound impact on the patient (205). Dyadic interventions, targeting the patient and family carer together, are potentially more likely to result in better outcomes for both parties than single target interventions, and may be more cost-effective (206 207 208). Young carers are particularly prone to isolation from peers and services. Ultimately, a whole-family approach to the provision of carer support is necessary (209 210). This will need to take into account the dramatic changes to what constitutes 'family' in contemporary society including the various cultural dimensions, and non-normative constructs of family (211).

Evidence to support family carers appears strongest and most consistent for flexible working conditions; psychological therapies, training and education interventions; and support groups. (212) Historically, much of the psychological and psychoeducational palliative care intervention research has been delivered in-person, with demonstrated improvements in patient quality of life, (213) family carer wellbeing, sense of preparedness, reduction of unmet needs and more favourable bereavement outcomes (207 214 215 216). Digital-health interventions also offer an innovative modality for the delivery of family carer interventions (217).

In many cases a combination of interventions, or a multi-dimensional intervention, is most effective and the type of intervention(s) needed will depend on the level and type of care need of the patient and the carer's circumstances. (212) The benefits of early palliative care have also been clearly demonstrated. It follows therefore that support for family carers must occur earlier on in the disease trajectory and given the accumulated evidence this should target preparing family carers for their role so they feel more confident and competent (215) bolstering their internal coping mechanisms and identifying those most at risk of poor outcomes (211). Whilst individual carer needs may vary there is a large body of research showing that there are similar needs for carers regardless of the patients underlying medical condition and this. (218)

From the perspective of the government, carers contribute to a reduction of global health care costs related to serious illness; however, inadequate support results in heavy hidden costs of informal caregiving. (219) Another enabler for enhanced family carer support must therefore involve identifying and addressing the direct and indirect costs of caregiving (220).

"Health outcomes of unpaid caregivers in low- and middle-income countries: A systematic review and meta-analysis" https://onlinelibrary.wiley.com/doi/10.1111/jocn.15450. This review found unpaid caregivers in low- and middle-income countries (LMICs) often face higher anxiety and depression, with worse outcomes in Asia and South America, contrasting with better health in some African studies, especially for lighter care loads (1-14 hrs/week). Caregivers for dementia/stroke fare worst, and women, predominantly caregivers, are particularly vulnerable, highlighting urgent needs for mental health support, policy changes recognizing care work, and culturally relevant interventions.

In addition to the aforementioned family carer strategies we should not lose sight of the fact that there are many existing examples of high quality carer interventions, policies and practices including in low-middle income countries. (189 221) The burning issue is how to effectively raise awareness of these and moreover implement and sustain these (222). Ultimately, we need a global approach and call to action that incorporates public health, clinical interventions, health economics and policy initiatives that are implemented at individual, institutional and societal levels (223). Initiatives such as the Lancet commission on the value of death (224) provide valuable insights for how we can inform worldwide improvements in carer support. The importance of engaging with people with lived experience of family caregiving is also paramount if we really want to bring about tangible impacts; the adage of "nothing about us, without us" must be front of mind (225).

In conclusion, intensive family caregiving has become one of the most important social and economic policy issues worldwide (226). It has been almost six decades since the birth of the modern hospice and palliative care movement and alarmingly as it stands the scorecard for systematic support and prevention of unnecessary carer suffering is far from positive. An increased investment in support for family carers is likely to result in improved patient well-being, longer period of care at home, enhanced bereavement outcomes and less burden on the healthcare system (214). One potential way of contributing to the resources required to improve carer support is through the reallocation of health care funds currently used for futile and sometimes inappropriately prescribed treatments towards readily accessible, early palliative care (214). Ultimately, a key measure of quality palliative care should be the well-being of family carers in the years after relinquishing the role (226). It's time for intensive global action!

Figure 48:
Global State of Caregiving



Increasing Attention to Bereavement Support as a Global Health Priority

Bereavement support has long been embedded in the WHO definition of palliative care, which includes assisting families "during the illness and in their own bereavement" (227). In addition, bereavement support is incorporated into several national and continental palliative care strategies, including India's National Programme for Palliative Care, (228) Australia's National Palliative Care Strategy, (229) New Zealand's Palliative Care Action Plan, (230) the United Kingdom's NICE guidelines, 231 Ireland's National Adult Palliative Care Policy, (232) and the African Palliative Care Association's Standards for Providing Quality Palliative Care (233). However, global implementation has been inconsistent. Around the world, families commonly experience a sharp withdrawal of support immediately following the patient's death, which can leave them feeling abandoned and vulnerable to adverse health outcomes. Consequently, with limited attention to development of care systems and limited investment in resources, bereavement care has been referred to as the "poor cousin" of palliative care (234).

Why does this matter? Research consistently demonstrates that bereaved individuals face elevated risks of mental and physical health challenges, including prolonged grief disorder, depression, suicidal ideation, cardiovascular disease, cancer, immune (235-238) dysfunction, reduced work capacity, and premature mortality. These risks are amplified in environments affected by poverty, conflict, humanitarian crises, and limited access to psychosocial care. Recognition of the public health toll have been highlighted in recent years, calling for coordinated, multilevel responses from both health systems and communities (239 240 241). The Lancet Commissions on the Value of Death and Global Access to Palliative Care and Pain Relief openly acknowledged that bereavement has been historically overlooked and called for the integration of bereavement into national health strategies (242). They urged governments and institutions to build systems that re-humanize care, strengthen social support, and recalibrate the balance between medicalized and community-rooted approaches at the end of life (242). This shift has given rise to a broad recognition that bereavement care must be addressed at multiple levels: in health systems, community structures, policy frameworks, and public health initiatives.

This recognition is beginning to translate into action, and bereavement is increasingly moving from the limited appendage of palliative care to a vital component in discussions of policy, practice, and system design. As evidence of unmet need and the public health toll of bereavement has grown, in part spurred by the heightened attention on grief support and cracks in the bereavement care system revealed by the COVID-19 pandemic, (243 244 245) two interconnected forces are both reflective of and further driving changes in this arena:
1) emergence of national bereavement frameworks and initiatives in countries such as Wales, (246) Scotland, (247) the United Kingdom more broadly, (248) Canada, (246) and the United States; (249) and
2) increasing adoption of tiered public health models of bereavement care (239 240).

Indeed, the implementation of public health models of bereavement care has been one of the most influential developments in the global palliative care landscape in recent years. A three-tier model was originally developed in Australia, (239 240) stratifying individuals into according to their level of risk for poor bereavement outcomes. Support needs are ideally matched to the griever's risk level, commonly depicted as a pyramid. At the base of the pyramid is most grievers, an estimated 60% of the population, who are considered low risk for poor bereavement outcomes and adapt to their losses with informal support from family, friends, workplaces, schools, and faith communities. The middle of the pyramid represents approximately 30% of grievers who are at moderate risk of adverse post-loss outcomes and could benefit from more structured programmes such as peer support, psychoeducation, non-clinical grief counselling, and/or bereavement support groups. Finally, at the top of the pyramid is the subset of grievers considered at highest risk for poor outcomes, representing an estimated 10% of the population, who require specialized mental health care. (239 240) These prevalence rates are simply estimates that warrant additional empirical investigation and are expected to vary across subpopulations. This model broadly offers a way of conceptualizing the range of support needs that grievers may have and punctuates the point that not all grievers need professional support. Importantly, assessment of risk and provision of the appropriate level of grief support should begin before the patient's death (250). While it is important to not misuse this framework and overgeneralize, the public health model of bereavement care has undoubtedly played a significant role in shaping bereavement policy and program design in several regions. In Ireland, the Irish Hospice Foundation's four-tiered Adult Bereavement Care Pyramid has become a national framework guiding competencies, service development, and referral pathways. In the European Union, the Bereavement Network Europe put forth a three-tier framework defining universal, selective, and indicated supports (251).

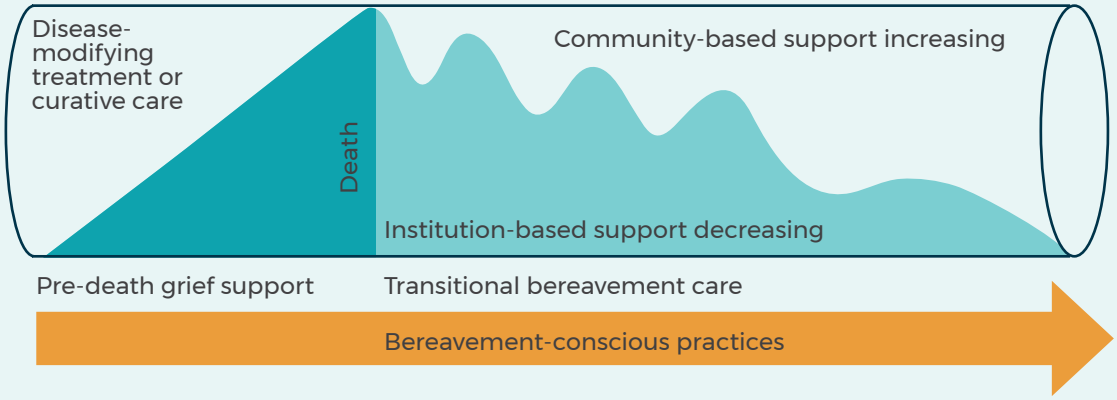
The public health model views bereavement not solely as an individual clinical issue but as a population-level phenomenon that requires both system-level infrastructure and strong community engagement. Around the world, palliative care programmes increasingly recognize that their responsibility for families does not end with the patient's death. But with limited resources, they cannot and arguably should not be the sole providers of bereavement support. This led to the development of the Transitional Model of Bereavement Care, (241) **(See Figure 49)** which posits that healthcare systems should provide continuity of care into bereavement and ensure no family is abruptly left unsupported but also acknowledges that grievers ultimately will need to reintegrate into their communities. The model therefore advocates for institutions to build community capacity, grief literacy, and compassionate community structures that allow bereavement care to be sustained locally over time. (241) **Figure 48** details the components of this model. Organizations in Australia, (229) Ireland, (232) India, (228) the UK, (231) and Africa (252 253) have already operationalized variations of this approach, offering structured follow-up while building partnerships with community groups, volunteer organizations, and trained lay supporters. India's Kerala palliative care movement demonstrates how institutional care and community volunteer networks can collaborate to offer sustained, culturally grounded bereavement support at scale (254).

Despite these efforts, significant implementation gaps of evidence-informed bereavement care initiatives remain, especially in low- and middle-income countries. In addition, there have been notable deficits in research examining the effects of extending family care through bereavement in paediatric palliative care settings (255). Unfortunately, studies evaluating the effects of comprehensive grief and bereavement support programmes on health outcomes are limited. Most studies on bereavement in palliative and hospice care settings have focused on evaluating the presence of bereavement support rather than the quality of support, mechanisms of change, or the impact of more complete systems of care. Research in these areas using state-of-the-art dissemination and implementation science methods will be critical to advance the field.

That said, the increasing attention to bereavement care is undeniable. By addressing the needs of grieving family members across the serious illness care continuum, palliative care programmes have the potential to shift societal views on bereavement and to build more grief-literate communities. As countries move toward universal access to palliative care, integrating sustainable bereavement support systems both through the healthcare setting and within the communities that the grieving family returns will be essential to mitigating the global health impact of bereavement.

The public health model views bereavement not solely as an individual clinical issue but as a population-level phenomenon that requires both system-level infrastructure and strong community engagement.

Figure 49:
Transitional Bereavement Care Conceptual Model



	Establishment of institutional supports	Development of community supports
Preventive bereavement care	Health-care teams engage in bereavement-conscious practices, mindful of pre-death grief and the potential effect of end-of-life experiences on the bereaved family and of the importance of their relationships with the family of the dying patient	Compassionate communities are mindful of the emotional and practical needs of the family of the dying patient
Ownership of bereavement care	Institutions provide bereavement services and have dedicated personnel to educate clinicians and staff, conduct bereavement risk screening, reach out to bereaved individuals, develop bereavement resources, and provide counselling or grief support	Bereavement care centres are sustained in the community and bereavement care champions are identified for universal bereavement care within relevant organisations (eg, workplace, schools, religious institutions, or care facilities for older people)
Resource allocation for bereavement care	Resources, including dedicated, funded personnel, are allocated to offer universal outreach and resources for all bereaved individuals (eg, condolence calls, memorial services, educational and web-based resources, and peer to peer and group support) and to provide targeted support to those in need	Bereaved stakeholders provide input to institutions, communicate needs, and liaise with groups in the community to identify barriers and facilitators to bereavement support and to determine needed resources, integrating intersecting social identities (eg, religion, ethnicity, or class)
Upskilling of support providers	Bereavement care education is integrated into medical and health worker training programmes; institutions provide continuing bereavement care education to all staff as well as dedicated bereavement specialists	A workforce of trained bereavement specialists in the community who are accessible (eg, accept insurance); community education about how to compassionately support the bereaved and increase grief literacy
Implementation of evidence-based care	Bereavement care is evidence based; research funding is available for the development of effective grief assessments, interventions, and training programmes	Research is designed and implemented in partnership with grievers and communities to co-create best practices to support the bereaved

Figure: Conceptualising transitional bereavement care
Although institution-based support is expected to decrease over time as community-based supports increase, this decrease is not expected to be linear, but rather be wave-like, as grievers might need to reconnect with the patient's treating medical team or access broader institutional resources intermittently and unpredictably (eg, to answer questions about the cause of death, attend annual memorials, or participate in drop-in bereavement support groups).

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Chapter 5

What are the existing models of palliative care development in different resource settings

In this chapter we will highlight some examples of how hospice and palliative care services are delivered throughout all regions of the world. We are holding up some of the model programmes that have developed in different cultural contexts, often with close community involvement. There are examples of programmes from every region of the world. Each story includes a description of the model, levels of support from the local health care system, innovative aspects, and descriptions of sustainability. Together these programmes are examples of where hospice and palliative care has found a way to be successful in diverse settings and often with limited resources.

We also include a section with voices from people living with palliative care needs. These individuals teach us what is most important about palliative care what is needed to ensure dignity and quality of life in different cultural and diverse settings.



"Go around and see what is being done and then see how your own circumstances can produce another version; there is need for diversity in this field.

Dame Cicely Saunders
Founder St. Christopher's Hospice

SOUTHEAST ASIA REGION

The Rural Palliative Care Initiative in Nepal: The Makwanpur Model

Situational Context

Nepal, a country of around 30 million people, is largely characterized by mountainous and hilly terrain, which poses significant challenges to healthcare accessibility. Palliative care was first introduced in Nepal in 2000 with the establishment of Hospice Nepal, a non-profit organization that operates free eight-bed unit in the Kathmandu Valley and offers free community-based services. Over the years, palliative care services have expanded in the country, particularly in cancer centers. Additionally, a fellowship program has been initiated at Patan Academy of Health Sciences (PAHS) to develop human resources dedicated to palliative care.

Despite these advances, rural communities continue to face significant barriers in accessing palliative care. The challenges include difficult terrain that hinders transportation to healthcare facilities, the migration of younger populations for employment—leaving elderly individuals in villages with limited support—and a lack of palliative care training among rural health workers.

Nepal has made noteworthy strides in improving health outcomes, largely due to its robust primary health system. Female Community Health Volunteers (FCHVs) play a critical role at the community level, while mid-level health workers—Health Assistants (HA) and Community Medical Assistants (CMA)—serve at health posts and primary health centers throughout rural areas.

Description of the model

Delivering palliative care in rural areas presents a unique challenge: patients are often unable to travel to health centers, and rural health workers primarily provide care to those who visit their facilities. This gap calls for a proactive approach—health workers must provide care directly in patients' homes.

Hospice Nepal, in collaboration with PAHS, piloted a rural palliative care model in Makwanpur district, approximately five hours by bus from Kathmandu. The first step involved orienting municipal leaders on the importance of palliative care and the urgent need for services in rural villages. Local officials were then asked to nominate health workers for training and facilitate home visits. Additionally, FCHVs received short training sessions to help identify patients in need of palliative care within their communities.

Level of support from the existing health system

The Health Ministry of Bagmati Province, one of the seven Provinces of Nepal, recognized the success of the program and signed a Memorandum of Understanding (MoU) with PAHS. As a result, palliative care is now integrated into the provincial health program with allocated funding.

To date, 252 health workers have been trained, and 7 out of 13 districts in Bagmati Province—Nepal's second most populous province—have implemented the program. In the last fiscal year (2023/24) in three districts, 4,179 home visits and 3,275 telephonic support sessions were conducted, benefitting 999 patients of which 36 % had malignant conditions.

> The Makwanpur Model demonstrates how rural palliative care can thrive through home visits, community partnerships, and strengthened primary healthcare systems.

Innovations – The Training Program

The training program consists of two weeks of intensive learning at Patan Hospital and Hospice Nepal. Sessions included interactive lectures, discussions, and patient visits. Health workers are also trained to use an online platform to record patient data via mobile devices.

Following this, trainees spend two weeks in the local community, where they undertake several essential tasks:

- Orienting community leaders, fellow health workers, FCHVs, and mothers' groups in local wards (their catchment areas)
- Identifying and assessing patients in need of palliative care
- Developing comprehensive management plans

One of the key challenges was shifting health workers away from a strictly disease-focused approach toward holistic care, encompassing psychosocial and spiritual dimensions. To address this, the training incorporated patient narratives from rural areas, discussions on the concept of a "good death," personal reflections on death and dying and communication skill development through role-playing—particularly for handling difficult conversations.

Encouraging preliminary results led to the rapid expansion of the model across the entire Makwanpur district. The process was replicated in multiple locations, starting with municipal leader orientation, followed by health worker training and subsequent FCHV engagement.

Sustainability

The Makwanpur Model leverages Nepal's existing primary healthcare system and its workforce, minimizing the need for extensive financial investments. The initial costs of training have been shared by PAHS, the Health Ministry, and local governments. Once fully integrated into provincial and municipal health programmes, the initiative is expected to sustain itself.

To enhance peer support and ongoing education, trained health workers have formed WhatsApp groups for collaboration. Additionally, PAHS and Hospice Nepal conduct regular virtual meetings, both group and individual, to provide guidance and professional development. Annual district-wide review meetings bring together all palliative care workers to ensure continuity, knowledge-sharing, and the advancement of skills.



Photos Courtesy of Hospice Nepal

Hyderabad Hospital & Hospice for Children

Situational Context

In India, despite progress made in recent years, childhood mortality has remained high. India contributes 14% of the global burden of under-five mortality. The overall five-year survival rate for childhood cancer is less than 40%. It is estimated that approximately 1.6 million children require paediatric palliative care at any given time. The majority belong to lower socio-economic groups and access health in the public healthcare system. Palliative care should be considered a key component of the care for all children with serious illnesses, but the reality is that this care has not found enough space in either public or private healthcare facilities.

Description of the model and Level of support from the existing health system

The paediatric palliative care program in Hyderabad, India, has evolved to become one of the largest in the region consisting of a well-integrated children's palliative care program in a public tertiary cancer hospital for children with cancer and at a 2400 bed tertiary referral Children's Hospital for those with non-cancer conditions. The program operates in partnership with a non-governmental organization (NGO) called the Pain Relief and Palliative Care Society. The NGO supports the program in hospitals by providing additional resources and ensures a continuum of care in the community through paediatric home-based palliative care and a 10-bed children's hospice called 'MandaraHospice'.

Within the MNJ Institute of Oncology, paediatric palliative care is seamlessly integrated into the oncology program, adhering to a zero-tolerance approach to pain. Each child admitted for cancer treatment is evaluated by a dedicated paediatric palliative care team from day one, facilitating a seamless transition to palliative care if curative treatment is not achievable. Children are screened for pain on a daily basis and are responded to accordingly. Niloufer Hospital has the distinction of providing the entire range of perinatal, neonatal, and paediatric palliative care. Annually, approximately 400 children at the MNJ Institute and 500 children with non-cancer conditions at Niloufer Children's Hospital are registered for paediatric palliative care.

Once discharged from the hospital, children are enrolled in the home-care service. On any given day, 300 children are enlisted in this service. A dedicated team of doctors, nurses, physiotherapists, and counsellors conducts an average of 15-20 home visits per day. Mandara Hospice is a dedicated children's hospice caring for children requiring support with difficult symptom management and nursing care, end-of-life care, and respite care.

The program is also linked to a district-based palliative care network, comprising palliative care centres established in all governmental district hospitals across the state of Telangana, for children preferring to go back to their homes in the districts for their end-of-life care.

800 children
Registered annually for paediatric palliative care across two tertiary hospitals

Innovations

1. The presence of an integrated model of paediatric palliative care within a public tertiary referral children's hospital ensures early referrals, seamless transition to palliative care when cure is not possible, and efficient care transition from hospital to home, and, if required, to a hospice.
2. The establishment of a unique perinatal palliative care program within the obstetrics department at the tertiary government children's hospital. The obstetrics department of the tertiary government children's hospital has developed a care pathway to provide care and support to every mother with an antenatal diagnosis of a serious birth defect by engaging the perinatal palliative care team during the antenatal period.
3. The successful collaboration between the public health system and non-governmental organizations to meet high demand and ensure optimal resource utilization. This approach is cost-effective and scalable.
4. The centre's evolution into a nodal hub for training and research in the South Asian region includes the provision of a one-year hybrid fellowship in paediatric palliative care by the Hyderabad Centre for Palliative Care in partnership with Two Worlds Cancer Collaboration (TWCC), endorsed by the RCPCH. Additionally, a leadership course offered in collaboration with TWCC, ICPCN, and St. Jude's Children's Research Hospital exemplifies a successful collaboration, making a significant impact in the region.

Sustainability

The key learning point is the embedded model of care where paediatric palliative care is integrated into a public health system, complemented by community-based support from non-governmental organizations (NGOs). This collaborative model of a public health system and NGOs has been shown to have a wider reach and impact, ensuring that care is accessible to the most vulnerable populations.



Photographs published with the permission of the patients and their families.

AFRICAN REGION

Hospice Ethiopia: Palliative Care Model Overview

Situational Context:

Hospice Ethiopia, based in Addis Ababa, is a non-governmental organization providing palliative care for cancer patients, people living with HIV/AIDS, and those with chronic conditions. Founded in 2003 by Sr Tsigereda Yisafowessen, it was the country's first palliative care organization. Initially, Ethiopia had almost no structured palliative care, but through advocacy and partnership with the Ministry of Health, government services began in 2015. Now, multiple hospitals and health centers offer palliative care.

Model Description:

The core service is home-based care delivered by a small interdisciplinary team (nurses and a social worker), essential for patients unable to travel. Care includes physical symptom management, psychosocial and spiritual support, counseling, and bereavement support for families. Hospice Ethiopia also provides day care programmes for symptom management, respite, and social support. Additional services include medicines (pain relief), basic needs, sanitary materials, food, PPE, and a "Comfort Fund" for financial assistance. All services are free and patients are referred from both public and private facilities.

Integration and Support:

Hospice Ethiopia has worked to integrate palliative care into the national health system through partnerships with public hospitals and government bureaus. Training for healthcare professionals at referral and general hospitals has helped embed palliative care capacity within mainstream care.

Innovations:

- Partnered with the Ministry of Health to develop national guidelines, policies, and training materials.
- Helped create the latest 5-year National Palliative Care Plan.
- Collaborated with traditional community groups (iddirs) for community-based care, blending modern hospice care with local support systems.
- Supported local and international research to promote culturally appropriate care.
- Training religious leaders for spiritual counseling tailored to palliative care, with plans to launch pediatric palliative care in 2026.

> Initially, Ethiopia had almost no structured palliative care. Today, multiple hospitals and health centres across the country offer palliative care services through Hospice Ethiopia's advocacy, partnerships, and training initiatives.

Sustainability:

- Diversified services and integrated training build a network of providers beyond the core staff.
- Partnerships with government, hospitals, and community groups embed palliative care into existing institutions.
- International support and fundraising (from Hospice Ethiopia UK, Ethiopia Hospice Care USA, and other donors) sustain operations.
- Training and outreach in regional health facilities expand access and support long-term sustainability.

Summary

Hospice Ethiopia's model demonstrates how palliative care can be effectively delivered and scaled in low-resource settings through home-based care, integration with health systems, community partnerships, and ongoing innovation. The approach is holistic, sustainable, and culturally sensitive, aiming to change perceptions and delivery of end-of-life care in Ethiopia.





Photos Courtesy of Hospice Ethiopia

Hospice Ethiopia demonstrates how culturally sensitive, community-based palliative care can thrive in low-resource settings.

Umduduzi - Hospice Care for Children

Situational Context

Umduduzi - Hospice Care for Children operates in KwaZulu-Natal, South Africa, providing palliative care to children diagnosed with life-threatening or life-limiting illnesses. The organisation addresses the gap in paediatric palliative care, which remains underdeveloped in South Africa, with less than 5% of children in need receiving adequate support. Many families face economic hardships, exacerbated by high unemployment rates and the lingering effects of COVID-19, making access to healthcare even more challenging.

Description of the model

Umduduzi follows a holistic palliative care model, offering physical, emotional, social, and spiritual support to children and their families. The organisation provides direct patient care, mentorship, caregiver empowerment, training, and advocacy. Services are delivered through hospital visits, outpatient clinics, and home visits, ensuring that children receive care in familiar environments. The team includes specialist doctors, nurses, and social workers, who work closely with families to manage pain, improve quality of life, and provide emotional support.

Level of Support and Integration from the Existing Health Care System

Umduduzi collaborates with **nine state hospitals** in KwaZulu-Natal, integrating palliative care into the broader healthcare system. While paediatric palliative care is still a **neglected area of medicine**, Umduduzi works to **train healthcare providers** and raise awareness about the importance of early intervention. The organisation also facilitates **referrals from hospitals**, ensuring that children receive continued care even after being discharged.

Innovations

One of Umduduzi's key innovations is its **home visit programme**, which allows caregivers to provide **personalised support** in the child's home environment. This approach not only ensures continuity of care but also helps families cope with the emotional and financial burdens of hospitalisation. Additionally, Umduduzi provides **educational resources**, toys, and emotional support to children who are bedridden, helping them maintain a sense of normalcy.

Sustainability

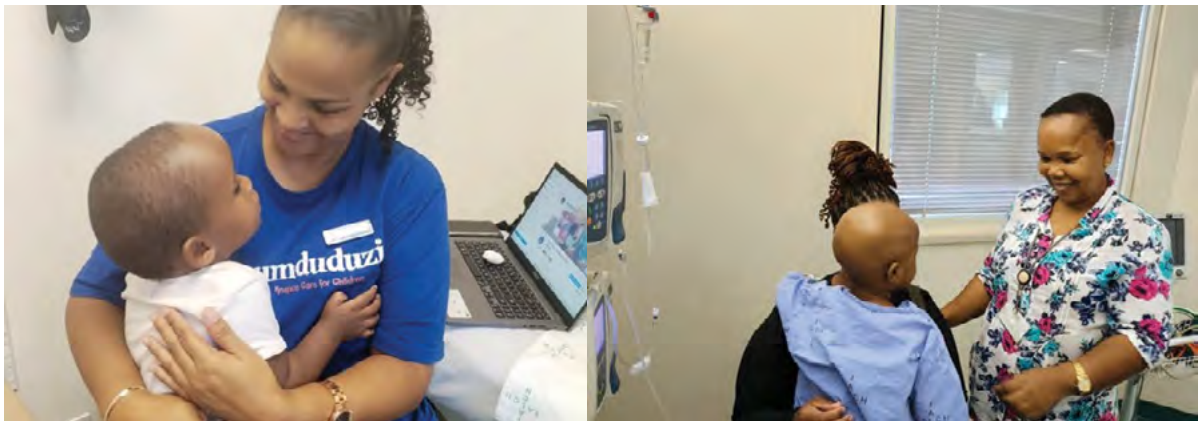
Umduduzi relies on **donations, partnerships, and advocacy** to sustain its operations. The organisation actively engages with **local and international donors**, ensuring continued funding for medical supplies, food parcels, and caregiver training. By integrating palliative care into **existing** healthcare structures, Umduduzi strengthens its long-term sustainability and impact.

Home visits reduce the burden on hospitals while improving access for vulnerable families.

Key Lessons Learned

- **Early intervention** in palliative care significantly improves the quality of life for children and their families.
- **Holistic care**—addressing physical, emotional, and social needs—is essential for effective paediatric palliative care.
- **Community-based support** and home visits enhance accessibility and reduce the burden on hospitals.
- **Training healthcare providers** in paediatric palliative care is crucial for expanding services and improving patient outcomes.

Umduduzi's work highlights the **importance of compassionate**, **integrated palliative care**, ensuring that children with life-limiting and life-threatening illnesses and their families receive **dignified and meaningful support** throughout their journey.



Photos Courtesy of Umumduduzi Hospice

Less than 5%
of children in need of palliative care in South Africa receive adequate support

9 state hospitals
partner with Umduduzi to integrate paediatric palliative care across KwaZulu-Natal

EUROPEAN REGION

St Christopher's Hospice

Development background

St Christopher's Hospice is acknowledged by many to be the world's first modern hospice, established in 1967 by Dame Cicely Saunders. It is located in South-East London, a part of the UK acknowledged to be highly diverse and densely populated in nature. It is, in many respects an area that is characterised by extremes – high wealth and poverty; inner city and suburban; culturally diverse and young in some areas and much older and white in others. Much of the effort and resource of the hospice lies in its aspiration to provide high quality palliative and end of life care to the people and communities that live in this area. Their needs for such care are broad and often challenging to deliver. Like the rest of the UK and many other countries, its population is ageing, needs are multiple and complex in nature and the National Health Service, part of the system in which St Christopher's works is at capacity and struggling to respond to the demands being made of it.

Unlike many other hospices in the UK the local picture is not the only context in which St Christopher's operates. It has enduring connections across the UK – with other hospices, the Government and academic teams through the provision of education and training, research and policy influence. It also has a global role, consistent with its vision of a world in which all dying people and those close to them have more equitable access to palliative care. Over the course of the last 50 or so years, many thousands of professionals have visited the hospice from around the world for insights, inspiration, training and support. Clinicians, researchers and educationalists have also travelled from St Christopher's to work alongside colleagues in other settings. Today, the hospice provides training for up to 10,000 learners a year, of which a significant proportion work outside the UK. Its contemporary approach acknowledges the value of enduring connection and reciprocal learning across settings.

St Christopher's Care in Numbers

32 inpatient
admissions accommodated at any one time across three hospice wards

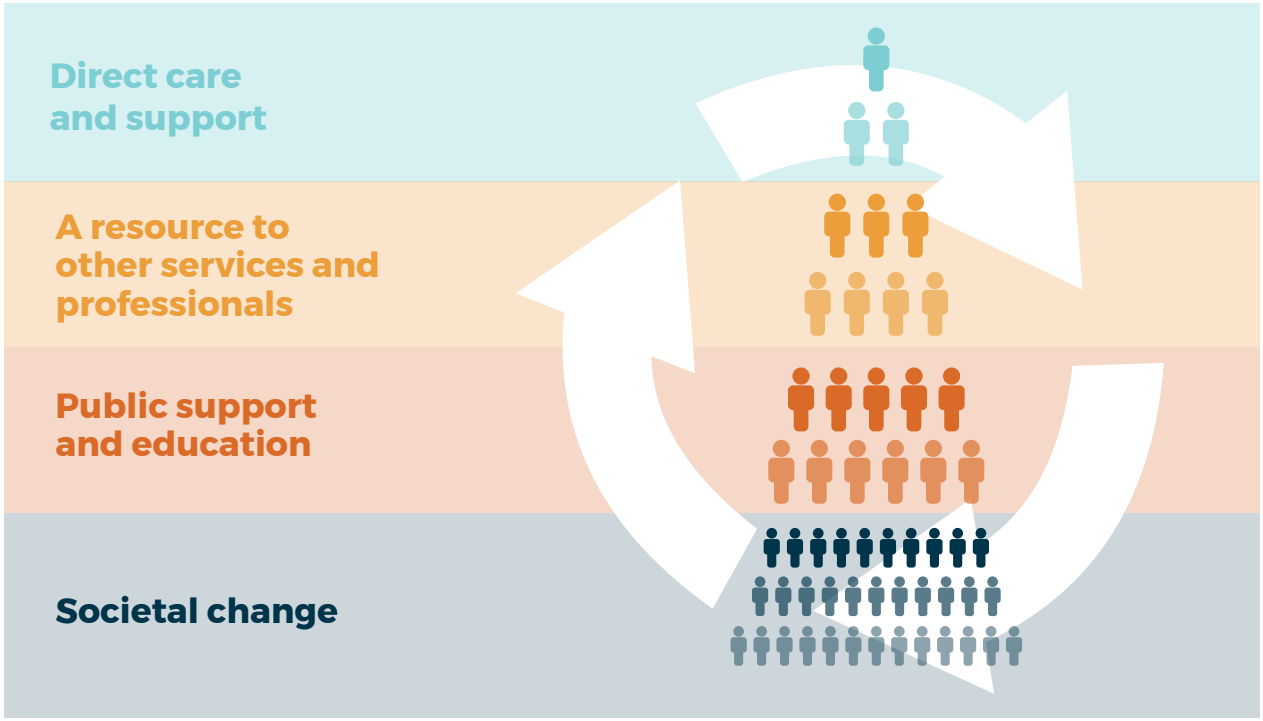
1,900 people
receiving specialist care each day in homes and community settings

262 individuals
receiving peer support each month through local community networks

Programme model

St Christopher's model draws on nearly 60 years of operation, with ongoing scrutiny and amendment to reflect contemporary drivers. From the beginning, Dame Cicely envisaged an organisation that invested in research and education alongside the practice of palliative care. She recognised the valuable inter-relationship between the three and was keen that each element informed the others. This aspiration has been enduring and the current model of operation is one where care and learning are closely connected. The whole picture is underpinned by a desire for evidence-based practice, education and training. In recent years, additional investment has been made in the activities of public education, health/death literacy and community action alongside professional support to identify and respond to people's needs and preferences at end of life.

At its apex is the delivery of direct care and support. At St Christopher's, this is increasingly community based and delivered in partnership with primary care, other community services and local people
Patient profiles look very different today to the make-up of those cared for historically. The hospice is increasingly concerned for people with a condition other than cancer, including people who live into late old age with frailty and dementia. It also has an enduring commitment to reduce historical inequalities of access to hospice care, resulting in shifts on the characteristics of its patients such as ethnicity, migrant status, sexuality and more.



People Supported in 2024/25

4,766
patients received specialist palliative care support

1,724
carers and family members supported alongside loved ones

760
adults attended in-person bereavement counselling sessions

364
children supported through the Candle Bereavement Service



Photo www.magnific.com

Level of support from the wider systems of health and social care

The relationships that St Christopher's has with other providers/players/funders in the local systems of health and social care are important for strategic and operational purposes. The hospice, an independent charity funded by local people and also in receipt of funding from the NHS, sits in a powerful and valued position. It can operate as both community asset and player in the local health and social care systems. Its leverage extends across both. Its daily work focused on the delivery of care and support for people dying and grieving each year would be deeply compromised if delivered in isolation of local health and social care. It depends on strong relationships with primary and secondary care; with other specialist services including mental health and cardiac care; and with other providers including care homes. Unless well integrated into the local systems, the reach and impact of the hospice would be hugely reduced. In 2024/25 the hospice received 34% of its costs from statutory sources, the rest being met via community and other fundraising efforts.

Innovations

The hospice has a long history of being innovative, much of this being possible through its independent status and its relationships and position across community and formal systems of health and social care.

Examples of innovation in the last few years include:

1. Supporting community action – alongside professional services to meet local needs and preferences
2. Development of care for people with heart failure approaching the end of life
3. Work in care homes to enable more people to die in that setting where this is their wish
4. Work in a local prison to support healthcare providers involved with prisoners who may be approaching the end of life
5. End of life Doula working alongside one of the community palliative care teams supporting people living with inequity at the end of life

The long-term future of St Christopher's, like many hospices in the UK is in many respects uncertain. Those leading the organisation and indeed its commissioners acknowledge the vital role that it plays, yet funding is uncertain and there are other challenges around long term role and performance that must be addressed also. Our clinical workforce is ageing and succession planning is key. A possible change in the law around assisted dying could also make significant new requirements of the hospice. All this needs careful consideration.



Photos Courtesy of St. Christopher's Hospice

Taskin Children's Hospice – Uzbekistan's First Paediatric Hospice

Situational Context

In Uzbekistan, paediatric palliative care has long been underrepresented in the national healthcare system. Families of children with life-limiting illnesses often lacked access to adequate pain management, psychosocial support, and coordinated care. In response to this unmet need, a group of paediatric oncologists, palliative care professionals, and civil society leaders joined forces to establish the first dedicated children's hospice in the country.

Model of Care and Programme Description

Taskin Children's Hospice, founded in 2022 in Tashkent, provides free, comprehensive palliative care to children with advanced oncological and genetic conditions. The care model is interdisciplinary and family-centred, combining medical, nursing, psychosocial, and social support. The hospice includes a 20-bed inpatient unit and home-based services for children unable to travel. The care team consists of doctors, nurses, psychologists, and social workers who work together to create individual care plans for each child.

Integration with the Health System

Though initiated by civil society, Taskin now works closely with the Ministry of Health, the National Centre for Paediatric Oncology, and regional health institutions. Children are referred from across the country, and the hospice has also become a training site for paediatric palliative care for healthcare professionals



Photos Courtesy of Taskin Children's Hospice

Innovations

Taskin introduced the first structured pain and symptom management protocols for children in Uzbekistan, based on the EPEC-Paediatrics curriculum. The team translated and adapted paediatric pain assessment tools such as the Wong-Baker and FLACC scales into local languages. The program also includes art therapy, bereavement support, and a warm, volunteer-supported environment.

Thanks to Taskin's advocacy, Uzbekistan began using oral morphine tablets for paediatric pain management for the first time, marking a milestone in national pain relief accessibility.

The positions of psychologist and social worker at the hospice are fully funded by the Ezgu Amal Charitable Foundation, ensuring stable, continuous psychosocial support for children and their families.

Sustainability

Taskin is supported by the Ezgu Amal Foundation and local philanthropic partners. Efforts are ongoing to integrate paediatric palliative care into the national health system and to secure government funding in the future. Advocacy, education, and collaboration are key to the program's long-term sustainability.

Key Lessons Learned

- Building trust with families and medical institutions is essential for successful integration and sustainability.
- Embedding training into service delivery raises awareness and builds capacity.
- Community and family engagement play a vital role in shaping culturally relevant care models.



Taskin Children's Hospice stands not only as a pioneer in Uzbekistan, but as a symbol of compassionate, innovative paediatric care in Central Asia. Photos Courtesy of Taskin Children's Hospice

REGION OF THE AMERICAS

Canuck Place Children's Hospice

Paediatric Palliative Care Outreach into the Home Communities of Children Living with Serious Illness across British Columbia and the Yukon, Canada

Situational Context

Canuck Place Children's Hospice (CPCH) program provides interdisciplinary care to children aged 0-19 with serious illnesses and their families across British Columbia (BC) and the Yukon. Family support, pain and symptom management, advance care planning, respite and end-of-life care, as well as grief and bereavement support, are provided free of charge. BC has a population of 5.65 million with a landmass of 944,735 square kilometres (<5 persons/km2). Each year, ~200 children die of natural causes in BC, with a further 2500 living with the most serious illnesses. The single tertiary care children's hospital is located in the major urban centre (Vancouver). Both children's hospices are also located in the urban/suburban areas of Vancouver. Thus, many children and families are required to travel outside their local community to receive specialist paediatric services, including in-hospice children's palliative care. There are no community-based paediatric palliative care specialist services in BC.

Description of the Model

We identified a need for community-based and outreach support to support children and families who desire to stay in their home and/or community. In 2018, CPCH launched the Enhanced Community Care Program so children and families could remotely receive high-quality, needs-based paediatric palliative care. Expert paediatric palliative care nurses and nurse practitioners provide ongoing pain and symptom assessment, management and treatment, care coordination and planning, family counselling, and supported home deaths. The care delivery and surveillance are done through virtual contact (phone and video consultation) and when possible, home visits. This team also augments care delivery through on-going care planning and integration of interprofessional PPC team members (e.g. social work, spiritual care) and community/hospital health care providers who may not have any PPC experience but have access to the child and are open to guidance (e.g., community nurses, paediatricians, family physicians, pharmacists).

Level of Support from the Existing Health Care System

CPCH is an independent, non-profit organization that works alongside provincially organised public healthcare systems. Our clinicians partner with the tertiary children's hospital, community healthcare services and public sector services to meet the individual needs of a child and their family.



Photo Courtesy of Canuck Hospice

Each year, ~200 children die of natural causes in British Columbia, with a further 2500 living with the most serious illnesses.

Innovations

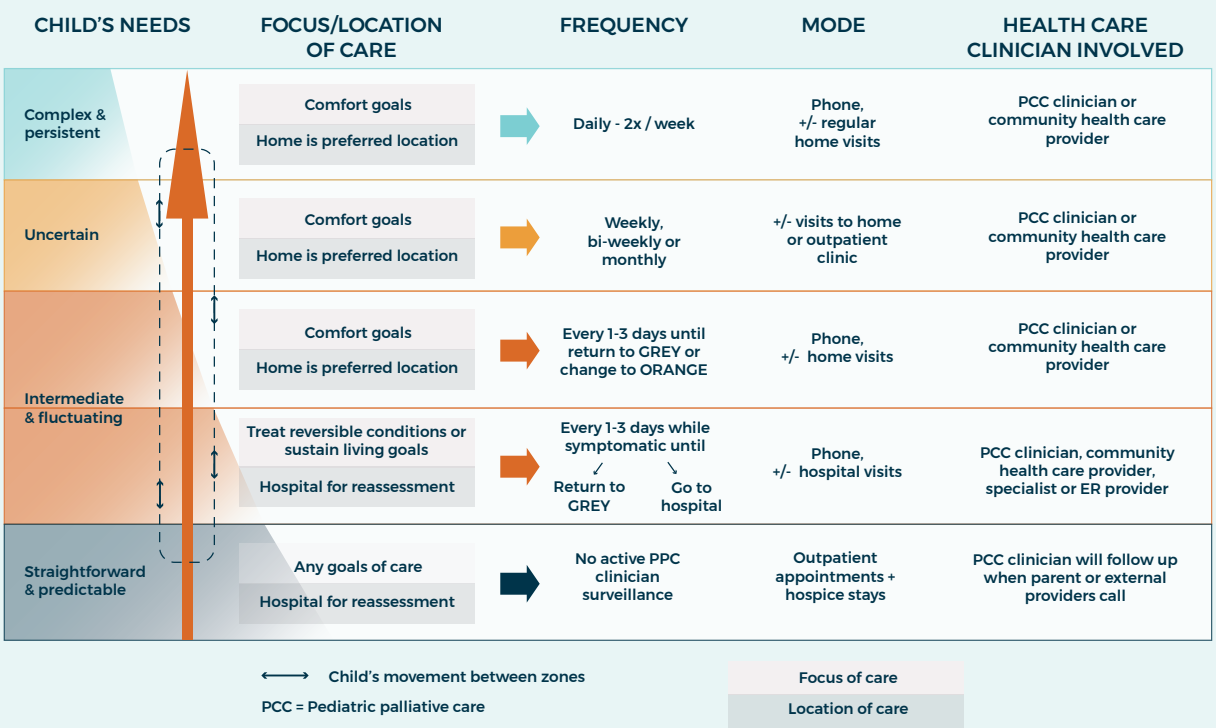
CPCH has evolved from being a site-based service with finite hospice beds to being able to potentially support a dying child living anywhere in BC and Yukon. The enhanced community care program uses a needs-based approach, based on the child's health status, goals of care, and family preferences to proactively allow for monitoring (surveillance) and planning to meet care needs, balanced with a responsive system that recognizes the unpredictability of children's disease progression and the need to support the entire family **(Figure 50)**.

The high usage of virtual health care, mostly telephone, is a key factor in enabling a small, centralized team to reach children and families, and partner with local healthcare providers, no matter where they live in this vast province. In addition to scheduled care and follow-up by the enhanced community care team, there is 24/7 telephone support available. Expert paediatric palliative care nurses, working in the hospice, are able to respond, provide advice and guidance and seek consultation from a paediatric palliative care specialist physician. This program supports equity in access and a sustainable use of resources.

Sustainability

Given the growing complexity of paediatric palliative care and the population growth in BC , healthcare programmes must adapt to meet the evolving needs of the child/family. The enhanced community care program leverages resources and technology to improve equity in access and integrates family and clinician voices in evaluation and feedback to improve service and remain relevant. Continuing to use a needs-based approach and remaining clear on delivering paediatric palliative care and not filling additional gaps that exist will be foundational to the sustainability of the program.

Figure 50: Community Care and Outreach Engagement



Elisa Castro Noriega, Harold Siden and M. Ruth Lavergne. (2023) Infants, children, youth and young adults with a serious illness in British Columbia: a population-based analysis using linked administrative data. December 05, 2023 11 (6) E1118-E1124; DOI: https://doi.org/10.9778/cmajo.20220181

Child Mortality in British Columbia 2017-2021 Child Death Review Unit, BC Coroners Service Release Date: February 15, 2024

Instituto Perdizes – Sao Paolo, Brazil

Situational Context

Instituto Perdizes is a public post-acute and transitional care facility within the Hospital das Clínicas of the University of São Paulo Medical School (HCFMUSP), the largest academic health complex in Latin America. HCFMUSP performs more than one million outpatient medical visits per year, employs over 22,000 professionals, and receives patients from all regions of Brazil, many of whom arrive with advanced stages of illness.

Within this structure, the Palliative Care Service originated from the Núcleo de Cuidados Paliativos in 2012 and currently delivers specialized Palliative Care through three kinds of service: a hospital-wide inter-consultation service that identifies patients with palliative needs across multiple institutes, a 28-bed inpatient Palliative Care Unit and an outpatient clinic offering multidisciplinary follow-up for eligible patients. It provides care for approximately 500 inpatient admissions and more than 7,000 outpatient appointments annually, including telehealth and in-person. It is also connected to the broader care network through primary care, home-care services, and long-term care facilities.

As a major teaching centre, the service trains more than 200 residents from different health professions each year, contributing to the development of palliative care competencies across the academic health system.

Description of the model & level of support

Instituto Perdizes is a publicly funded institution under Brazil's Unified Health System (SUS) managed by a Social Health Organization (OSS), and all services are provided at no cost. The institute's model emphasizes coordinated care for clinically complex and socially vulnerable patients, strengthened by multidisciplinary collaboration and institutional policies aimed at improving continuity of care and reducing avoidable readmissions.

The identification of patients is carried out by the multidisciplinary palliative care consultation team. When patients meet eligibility criteria, they may be transferred to the inpatient Palliative Care Unit. Those who are discharged home are followed in the outpatient clinic, where they receive ongoing longitudinal care and can be readmitted whenever necessary.

Referrals are guided by clinical complexity, functional decline, and palliative needs rather than prognosis alone. The close integration between Palliative Care teams and other hospital units supports early identification of patients who may benefit from symptom management, psychosocial support, and advance care planning.

Innovations

This institution has progressively incorporated innovative approaches to Palliative Care within a large academic hospital network. The integration of needs-based referral, early identification through inter-consultation, and the coexistence of inpatient, outpatient, and transitional care within the same facility represent a unique model in Brazilian public health system. The development of a multi-skilled interdisciplinary team, including physicians, nurses, psychologists, social workers, physiotherapists, occupational therapists, nutritionists, and other allied professionals, has strengthened collaborative practice and improved care coordination across units.

The service has invested in structured clinical education to build palliative care competencies among residents, students, and hospital professionals, contributing to cultural change in a highly specialized health system. Process innovations, such as standardized screening tools and family meetings, shared-care pathways with other institutes, and strengthened discharge planning, have improved the identification of patients with palliative needs.

Institutional support for research, quality-improvement initiatives, and data-driven decision-making has advanced the development of evidence-based practices. The integration with the hospital's electronic medical record system enables systematic documentation of palliative needs, supports clinical audits, and enhances the visibility of palliative care within the broader HCFMUSP complex.

Sustainability

Sustainability relies on strong integration with the Unified Health System (SUS) and institutional support from HCFMUSP. As a publicly funded service that does not depend on private insurance or philanthropic donations, long-term sustainability requires alignment with health system priorities, efficient resource use, and clear demonstration of its value for patients and families. The recently established Brazilian National Palliative Care Policy reinforces the strategic importance of expanding palliative care within the public health system and helps justify sustained funding for our service. This policy framework strengthens advocacy efforts and supports the consolidation of Palliative Care as an essential component of comprehensive healthcare in Brazil.





Photos Courtesy of Instituto Perdides

Sydney Children's Hospitals Network

Situational Context

Sydney Children's Hospitals Network (SCHN) Palliative Care is represented by the 2-hospital based paediatric services located at The Children's Hospital at Westmead (CHW), Sydney Children's Hospital (SCH) Randwick and Bear Cottage Hospice. CHW palliative care service is the larger service which cares for approx. 200 and SCH approx. 140 palliative patients annually each year.

Description of the model and Level of Support from the Existing Health Care System

The hospital based palliative care teams have received significant government funding enhancements over the past 2 years to provide a comprehensive multidisciplinary specialist team. This includes the introduction of new clinical roles and increased hours to existing staff which is a milestone to securing a permanent paediatric palliative care workforce. The multidisciplinary team now consists of the following positions:

- Medical
- Nurse Practitioners, Clinical Nurse Consultants, Nurse Educator
- Occupational Therapists
- Physiotherapists
- Child Life Therapists
- Music Therapists
- Speech Therapist
- Pharmacist
- Grief counsellor and Bereavement Coordinator
- Social workers
- Volunteer Coordinator
- Aboriginal Health Worker

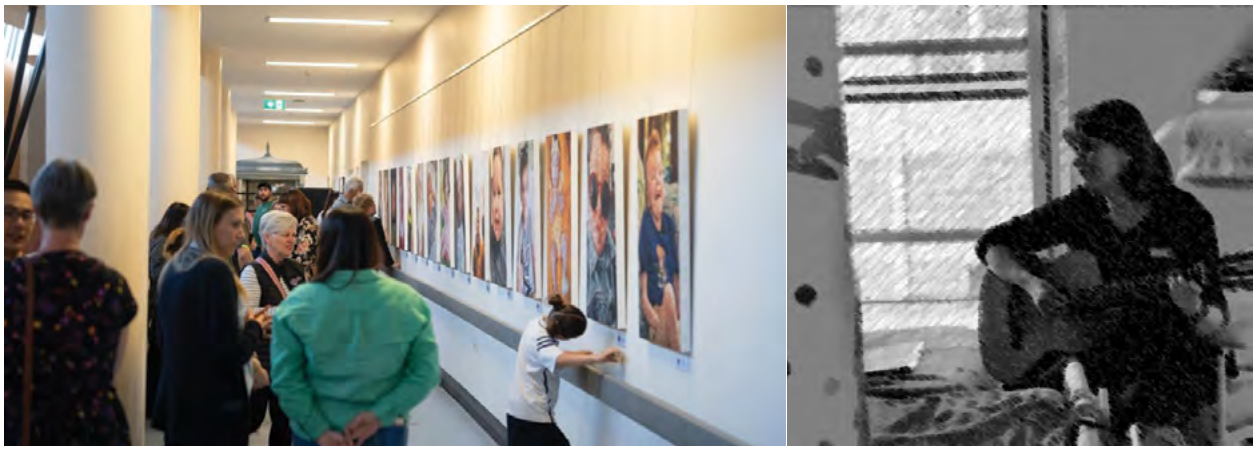
SCHN Pal Care is a consultative service that provides inpatient, outpatient and community-based care. We work with community-based health services to support a child and family at home; this includes adult community palliative care for deteriorating patients heading towards end of life. The community outreach is supported through a "Pop-up Model of Care" that is initiated by the specialist paediatric palliative care service with the aim of increasing local health service capacity to care for children and their families. It requires the paediatric palliative care (PPC) team to provide intime training and education that is guided by an individualised management plan to support symptom management and goals of care, aimed at keeping the child at home.

Innovations

The introduction of a second children's hospice (Mounty's Care Cottage) has recently been announced. Mounties Care Cottage will be located on the CHW campus and designed to complement Bear Cottage, providing an additional location of care that will be like a home-like environment offering respite, symptom management, and end of life care families located in Greater Western Sydney and Western New South Wales.

Other SCHN Palliative Care innovations that are offered to support families include:

- **Gathering Hands Program:** was introduced to provide small acts of kindness to patients and families who are having prolonged hospital admissions or other difficult circumstances in addition to caring for their unwell child. It is donor funded, and the initiative came from a bereaved parent.
- **Biography/Story:** Is a volunteer-based program that provides families (or the child themselves when possible) an opportunity to write the child's story. This is gifted to the family once published.
- **A Little Piece of Me:** Is a creative program supported by an artist who uses several pixelated photos that are selected by a parents/carers to capture all the meaningful and important things in a child's life that shape their personalities and identity. This is then displayed in an exhibition and gifted to the family once the exhibition has ended.



Photos Courtesy of Sydney Children's Hospitals

Western Pacific Region

Department of Palliative Medicine of Sichuan University in P.R. China

Situational Context

The Department of Palliative Medicine (DPM) at West China Fourth Hospital of Sichuan University, established in 1995 with the support of Dr Robert Twycross of Oxford University, is a leading institution for palliative and hospice care in China. It operates two wards (70 beds), a home care unit, and 18 community sub-institutions (300 beds total). The DPM utilizes a three-stage model integrating home, primary, and hospital-based palliative care, supports educational initiatives, and provides services to over 100,000 end-of-life patients since its inception.

Description of the Model

DPM's palliative care policy aligns with WHO guidelines and Chinese regulations, embedding palliative services into all levels of healthcare. Its education programmes cover all medical and nursing professionals, students, patients, families, and the broader community, training over 130,000 individuals. The department provides comprehensive access to essential medications, including opioids and adjuncts for symptom management, and has developed numerous guidelines and tools for clinical practice.

A notable initiative is the Li Ka Shing Foundation–funded home care program, offering free cancer pain relief services to over 10,000 patients. DPM also manages extensive inpatient and outpatient care, focusing on pain control and dignity at end-of-life, supported by 18 sub-institutions across Chengdu.

Integration and Support

Palliative care at DPM is officially recognized and integrated into local and national health systems, with ongoing support from government and philanthropic organizations. Essential medicines are included in national social security schemes. To date, the program has received substantial funding from both governmental and charitable sources.

Innovations

Since 2012, DPM has been a designated key discipline, advancing integration of palliative care into national health services. Innovations include the creation of a three-stage service linkage, establishment of an Educational and Training Centre (training over 130,000 participants), and formation of a Specialty Committee in 2024 to standardize and expand palliative care, improve quality assessment, and enhance academic exchange.

Sustainability

China's national policy supports palliative care through pilot projects spanning 137 national and over 400 provincial cities. DPM continues to contribute via professional training, needs assessments, guideline development, research, advocacy for medicine accessibility, and international collaboration, especially with WHO and within low- and middle-income countries in the Western Pacific Region.







Photos Courtesy of Sichuan University Hospital

EASTERN MEDITERRANEAN REGION

King Fahad Medical City – Riyadh, Saudia Arabia

Situational Context

Palliative care in Saudi Arabia has evolved significantly over the past 25 years, emerging as a critical component of healthcare amid an aging population and rising chronic diseases. Initially introduced in 1992 at King Faisal Specialist Hospital, structured expansion began in 2016 under Vision 2030, supported by the 2018 National Palliative Care Strategy and 2021 Standards. These strategic documents have played a crucial role in shaping the development of palliative care in the country, setting standards for care delivery and guiding policy decisions. Despite progress, early challenges included limited access, with only 12 consultants by 2014, highlighting the need for workforce developments.

Description of the Model

The Kingdom's model of palliative care is comprehensive, integrating various forms of care. However, the key to its success lies in the pivotal role of training initiatives. The Palliative Medicine Fellowship (2001), expanded to two years in 2014, was the first in the GCC/Arab region, producing skilled clinicians and leaders. Multidisciplinary training (2018) at King Fahad Medical City prepared 21 healthcare teams. Nursing programmes like Makken and the Palliative Care Nursing Certification (PCNCP) have graduated 84 specialists, addressing workforce gaps. These initiatives and government backing through Vision 2030 and SCFHS accreditation ensure standardization and quality in palliative care, despite disparities in regional access and medical education integration. (Alshammary et al., 2024; Saudi Commission for Health Specialties [SCFHS], 2023).

Level of support and integration into the existing health care system

Palliative care in Saudi Arabia has achieved notable integration into the national healthcare system, driven by top-down policy support, institutional partnerships, and strategic funding. Key pillars of this integration include:

1. Government Commitment & Policy Frameworks

- Vision 2030 and the National Transformation Program (NTP) prioritize palliative care as part of Saudi Arabia's healthcare modernization, with explicit targets for service expansion and workforce training (Ministry of Health [MOH], 2018; Saudi Vision 2030, 2016).
- The National Palliative Care Strategy (2018) mandates the establishment of palliative care units in all tertiary hospitals and integration into primary healthcare centers by 2025 (MOH, 2021).
- The Saudi Commission for Health Specialties (SCFHS) accredits training programmes (e.g., fellowships, nursing certifications), ensuring alignment with international standards (SCFHS, 2023).

2. Institutional Collaboration



Photos Courtesy of Sichuan University Hospital

The Kingdom's model of palliative care is comprehensive, integrating various forms of care. However, the key to its success lies in the pivotal role of training initiatives

- King Fahad Medical City (KFMC) is the national hub for palliative care training and research. It partners with King Faisal Specialist Hospital and Ministry of Health hospitals to standardize care protocols (KFMC Annual Report, 2023).
- Regional disparities persist, but mobile palliative care teams and telemedicine initiatives (e.g., the Seha Virtual Hospital) are improving rural access (Alshammary SA., 2025).

3. Financial and Workforce Support

- Dedicated funding through the Health Sector Transformation Program (HSTP) supports infrastructure, including hospice facilities and paediatric palliative care units (MOH, 2022).
- Workforce growth—from 12 consultants in 2014 to over 120 today—reflects investments in training (e.g., Palliative Medicine Fellowship, PCNCP nursing program) (Alshammary et al., 2024).

Innovations to Highlight

Key innovations include the region's first fellowship program, specialized nursing certifications (PCNCP, Makken), service expansion into hospice and paediatric care, and workforce growth, from 1 graduate in 2017 to 120 consultants today. (KFMC Annual Report, 2023).

Sustainability

The success and future of palliative care in Saudi Arabia hinge on sustained investment. This investment is not just financial, but also in terms of policy continuity, accredited training, and research leadership. However, future efforts must focus on bridging gaps in education and equity to meet the growing demand for palliative care. Saudi Arabia now leads the region in palliative care, but this position can only be maintained with continued investment in training, services, and policies. (Alshammary SA., 2025; MOH, 2023).

The success and future of palliative care in Saudi Arabia hinge on sustained investment.



Photos Courtesy of King Fahad Medical City

Balsam - The Lebanese Centre for Palliative Care

Situational Context

Lebanon, a small middle-income country in the Eastern Mediterranean. It's privatized healthcare system only recognized palliative medicine as a specialty in 2013. Since the first palliative care (PC) services launched in 2010, development has grown steadily through increased providers, professional associations and education. Yet integration remains weak due to economic challenges, limited resources, and inadequate policy support.

Description of the Model

Balsam, established in 2010, provides free home-based PC to patients of all ages, regardless of diagnosis or prognosis. It operates through a nurse-led multidisciplinary team including physicians, social workers and mental health professionals. The team provides care for about 250 patients yearly, 24/7. We have two programmes, the Home-Based Support Program for patients that live within the Greater Beirut Area and are accessible for routine home visits, and the Distant Support Program for patients outside Greater Beirut Area. Beyond clinical services, Balsam advances PC through education, advocacy and research. Balsam is Lebanon's only community-based paediatric palliative care program.

Level of support from the existing health system

The growth of palliative care (PC) in Lebanon faced policy and funding barriers until 2023, when PC was integrated into the National Cancer Plan under the Ministry of Public Health (MOPH). In 2024, the National Social Security Fund (NSSF) issued a landmark decree recognizing PC as a clinical subspecialty and approving coverage for inpatient PC service – a critical step toward systemic integration. Balsam helped drive these reforms with stakeholders and is a key contributor to their implementation.

Innovations

Telehealth for Expanded Access:

Balsam's Distance Support Program delivers palliative care via telehealth, an innovative model improving access across Lebanon and the region. Research confirms its effectiveness and value in supporting patients and families, particularly in underserved area.

Local Morphine Production—A Response to Crisis:

During Lebanon's financial and political crises, inconsistent opioid access threatened patient care. Balsam led advocacy efforts, engaging the Minister of Public Health and key stakeholders to establish local production of immediate-release morphine—achieved in 2024. This milestone ensures reliable pain relief for patients in need.

Photos Courtesy of Balsam



Nurse Alia Tabsh on one of her home visits.

Sustainability

Since its founding, Balsam has operated entirely through donations upholding its commitment to provide care regardless of patients' ability to pay. A core focus of advocacy has been securing long-term funding solutions, including pushing for Ministry of Health coverage and insurance reimbursements to ensure sustainability for palliative care nationwide. Teaming with the Children's Cancer Center of Lebanon (CCCL) in 2022 offered the opportunity to deliver home-based palliative care to children with cancer as well as a sustainable source of income. This partnership also opened the door to membership in the St. Jude Global Alliance and leveraging the expertise and support of the American Lebanese Syrian Associated Charities (ALSAC) in optimizing sustainability strategies.

Lessons learned

Strategic partnership and collaboration are essential for sustainability and growth.



Clinical Nurse Specialist (CNS) Janane Hanna providing care to Jana in the comfort of her home in line with her

Strategic partnership and collaboration are essential for sustainability and growth.



Team members in their weekly interdisciplinary team meeting to discuss patient plan of care



Photo Courtesy of Dr Helena Davies

Dr Helena Davies

Lived Experience of Palliative Care – WHPCA Advocacy Officer

I am a 63-year-old woman with complex chronic health problems due to an auto-inflammatory disorder. I previously worked as a paediatrician in a Children's Hospital but had to take ill-health retirement in 2007 because of my health problems. I live in the UK and am fortunate enough to have had all my health carefree under the NHS. As a result of my underlying disorder, I have nerve and muscle damage which means I have impaired mobility and need to use a powered wheelchair which is provided by the NHS.

I have several other health problems in addition to nerve and muscle damage which include arthritis, inflammatory bowel disease, chronic liver disease, osteoporosis, gluten cerebellar ataxia, severe immune deficiency and impaired swallowing. I am also a breast cancer survivor having been treated with surgery, chemotherapy and radiotherapy in 2009/2010. As a result of my many health problems I experience severe pain if I don't have appropriate pain relief.

I am supported by professional, paid carers on weekdays and in the evenings and at weekends by my husband. I have input from many healthcare professionals but one of the most important teams that care for me is the palliative care team. Their input began in 2009 when I was having treatment for breast cancer and has continued since then despite my cancer having been in remission since 2010. Palliative care input has been invaluable for my physical, psychological and psychosocial wellbeing. My palliative care has largely been provided through the multidisciplinary team at the local hospice but during prolonged hospital admissions the hospital palliative care team have been involved as well.

An important part of both hospice and hospital input has been pain management; pain medication and its efficacy is regularly reviewed, and I can access help if I need it at any time. A short acting synthetic opiate is an important part of my medication regimen. Nerve blocks and acupuncture have also been used to ensure optimal pain management. Living with extensive disability and multiple co-morbidities produces significant stress both for the affected individual and their family/carers. I have benefitted from psychological therapy provided by the palliative care team both individually and as a couple with my husband who has a significant caring role for me.

Other input from the palliative care multidisciplinary team has included physiotherapy, occupational therapy and social work. In addition, the palliative care specialist has advocated for me with other specialist services where their input has been needed. I have been very fortunate to have had optimal palliative care provided for free through the NHS over several years for complex chronic health conditions.

The palliative care team input is ongoing and essential to my quality of life. Palliative care is part of the essential health services that comprise UHC but unfortunately most of the world are not as fortunate as me and do not have access to palliative care at all – it is estimated that only 14% of the more than 70 million people who need it get palliative care. My story of optimal palliative care is an example of what can be done and a model to be aspired to.

It is estimated that only 14% of the more than 70 million people who need it get palliative care. My story of optimal palliative care is an example of what can be done and a model to be aspired to.

A Greek Mother and Child, George

In September 2017, our second child, George, was born. None of us were prepared for him to be transferred to the neonatal intensive care unit and remain there for forty days, intubated for the first ten days of his life. An MRI scan revealed severe brain damage that would affect his basic functions such as breathing, movement, swallowing, and cognitive ability. Our child's health condition required months of hospitalization in an intensive care unit at a public hospital. In fact, during his hospitalization, Merimna's paediatric palliative home care team was introduced to us by the attending physicians. We returned home having been trained in his care and in the management of the equipment that would support his life at home.

Throughout all these years, Merimna's team has consistently supported our entire family and systematically monitored our son's health by training us on how to cope with emergencies as they arise. Team members were also present throughout our child's two-year hospitalisation, have been instrumental in the development and implementation of a care plan and its adjustment whenever necessary, and trained us in nursing and other care practices, in communicating with physicians of various specialties, in mediating with public services and hospitals, and in jointly finding solutions to any problems or obstacles that arise.

The team's visits to monitor our son's health often turn into a small celebration. They are present for us during important events, such as our eldest daughter's first dance performance or our son's midnight transfer to the hospital emergency department. Our photo album and mementos testify to how many moments we have shared together. The handmade Christmas decorations from Merimna's social worker, which once hung on the IV stand in the hospital, now stand at the top of the Christmas tree in our home. The fairy tales that the Merimna psychologist read to our son, occupy a special place in our library. Merimna's professionals are companions in our particularly complicated but also very challenging life!



Photos Courtesy of Merimna

The team's visits to monitor our son's health often turn into a small celebration.



Chapter 6

What is the way forward?

Helena Davies
Stephen Connor
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London, UK 2020
www.thewhpca.org

Misconceptions about palliative care are common among healthcare professionals as well as the general population. Palliative care is not just for the dying or those without hope of cure, and it is not only for those with cancer. Access to palliative care as a fundamental component of national health systems and the essential services that comprise Universal Health Coverage (UHC) has been repeatedly called for by advocates, providing a platform for engagement and focus on the international stage.

Palliative care is highly effective at reducing serious health-related suffering and optimizing quality of life throughout the course of disease, especially at the end of life. Palliative care is also about caring for the carers of those with serious illness – the families, communities, and social networks - including the bereaved. With an ageing global population and rising incidence of communicable and non-communicable diseases (NCDs), the need for palliative care is increasing with now over 73.5 million needing care annually both before and near the end-of-life.

Although provision of palliative care services globally has increased significantly in the years since the last Global Atlas was published, the rising incidence of NCDs means that the gap between need and access remains essentially the same. An estimated 14.4% of those in need receive specialised palliative care globally and only 4% in LMICs where 80% of the need exists. Furthermore, within country disparities persist in all income groups.

There has been some criticism of the 14% figure as it does not take into account the numbers of people who receive palliative care from their primary or other specialist providers. We do not have any means to estimate the number who receive such care although it is likely much more substantial in higher income countries. While this disparity is an important part of the picture we need not focus only on numbers. Palliative care as an important and growing part of the health care system and we should also celebrate the many innovative ways that palliative care is being integrated into care in many countries See workforce **chapter 5**

As countries progress with their healthcare reforms, it is vital palliative care is recognized as being part of the essential services that comprise UHC defined as promotion, prevention, treatment, rehabilitation, and importantly palliative care. An ageing population with an increased prevalence of NCDs means there will continue to be a growing and urgent need to plan for a way forward.

In 2014 the World Health Assembly (WHA) called for all Member States to develop, strengthen and deliver palliative care as an essential component of UHC. The 2024 WISH report (256) highlighted the slow progress towards full adoption of resolution 67.19 and made comprehensive multi-sector recommendations (See **appendix 3**) across the WHO conceptual model of palliative care development: provision of palliative care, empowering people and communities, research, education and training, use of essential medicines, health policies, and implementation and integration of services in health systems (257). The WISH report also reiterates the need to address common misconceptions about palliative care if we are to improve care provision.

In each global region, there are countries that have shown how palliative care can be made available to those who need it, including through its integration into UHC. As national leaders strive to improve health care systems to ensure essential health services for all those who need it, it is crucial that people with palliative care needs are not neglected and that we learn from examples of good practice.

Important recommendations for national governments to ensure access to palliative care for all those that need it are:

1. Embed palliative care within core health financing mechanisms at national levels

The financing of palliative care should be integrated into national health system budgets at all levels of care including primary health care (PHC). Currently much of palliative care financing is provided through out-of-pocket expenditure (OOPE) by families, which needs to be addressed through the expansion of financial protections. Mechanisms should be put in place to support financial information on budgeting and expenditure on palliative care within health systems to be made transparent.

Value for money

There is a need for consensus on how best to assess value for money. Measuring value for money is dependent on effective outcome measures and accurate recording of costs including costs that are incurred by families. The availability of big data as palliative care is integrated into health insurance programmes may facilitate assessment of value for money of palliative care but this is currently not a solution. Evidence to date suggests that palliative care does represent value for money when compared with standard care for individuals at the end of life but data is limited and study quality variable. In addition, much of the available evidence comes from high-income settings while the majority of need is in low and middle-income countries (LMICs). Prospective measurement of costs and outcomes to enable measurement of value for money and high quality research in low-resource settings should be priorities.
See **chapter 1**

2. Ensure timely and consistent access to essential medicines

Palliative care medications as outlined in the recently updated WHO essential palliative care medications list for adults and for children (258 259) should be available to all those who need them. This is particularly important for opioids which are crucial for pain relief and managing severe respiratory distress. Essential medicines, including opioids, form part of the low-cost essential palliative care package published by the Lancet Commission on Global Access to Palliative Care and Pain Relief in 2018 and costed at just $2.16 per capita per year in LICs (260). (See **chapter 3** for a new set of packages of essential and extended palliative care goods and services for adults and children). Access to inexpensive immediate and sustained release morphine is necessary for palliative care patients. To achieve this, countries can work with the International Narcotics Control Board (INCB) , United Nations Office on Drugs and Crime (UNODC), WHO and civil society partners to address regulatory barriers and improve medication supply and management systems. Currently opioid consumption is concentrated in high-income countries (HICs) with access to opioids in many LMICs being very limited. Models of good practice that leverage the health system and workforce, such as essential medicine management in Uganda, exist and can inform how best to optimize availability of essential medicines, particularly opioids, in other parts of the world.

3. Promote palliative care governance within health systems

Palliative care should be included in the policies and structures of national health systems at all levels with accompanying accountability mechanisms. The WHO have developed a set of 14 indicators (261) to measure access to palliative care services which has been used to inform a recently published global ranking of palliative care services at a country level (262). Based on a survey tool derived from the indicators, countries were classified into four development levels: Emerging, Progressing, Established and Advanced. HICs have a disproportionate number of established and advanced services when compared to LMICs. Globally 40% were at an emerging level and 28% at a progressing level with only 14% classified as advanced and 17% as progressing. However, there were examples of countries that reached an advanced level despite limited resources, (i.e., Chile, Uruguay, Thailand and Uganda), exemplifying the provision of high-quality care in an LMIC context. Accountability using relevant, robust measures is key to ensure equitable palliative care access, especially for the most vulnerable and marginalized across societies.

4. Build palliative care capacity among the health and social care workforce

Educating the workforce

Palliative care should be integrated into the curricula of all new health care professionals and community health care workers training at an undergraduate or postgraduate level and form part of continuing professional development. In addition, all existing health care professionals and workers should be trained in primary palliative care as a matter of urgency, at least at a basic level. Patients with palliative care needs are often cared for in a generalist setting and the ability to recognize a patient's palliative care needs is essential to addressing them both efficiently and effectively. Addressing the training gap in those delivering social care to individuals in need of palliative care is also of high importance to ensure a holistic approach to alleviating health-related suffering. See workforce **chapter 3**

Managing workforce numbers

Even if the existing workforce has their training needs addressed there remains the issue of inadequate numbers within the palliative care workforce. There is an urgent need not only to expand delivery of education and training in palliative care but also to expand the number of personnel within the workforce both in specialist settings and the community. Integrating palliative care into Primary Health Care is an important part of effectively closing the gap between need and current provision in terms of delivering a service that represents value for money and provides optimal, high quality care. Although increasing the palliative care workforce has financial implications, it is essential if the gap between need for, and provision of, care is to be narrowed and ultimately closed.

5. Develop effective data collection and information systems

Monitoring of access to palliative care should be undertaken at all levels of care. Understanding where these services are provided, the nature of those services and their quality and outcomes is essential to minimize inequities in care access. This means ensuring the use of appropriate and universally agreed indicators, such as the WHO indicators, (262) robust data collection mechanisms, and accessible reporting at local, national and global levels. While collecting data in many contexts may be challenging (e.g., home-based care), prospective data collection integrated into care delivery should be utilized wherever possible. Regular scrutiny and publication of data output is essential. Palliative care providers must be accountable for monitoring the care they deliver and have appropriate systems in place for facilitation. Including adoption of standardized measures such as the **EoLinPlace** project an international classification of dying places.

6. Procure palliative care delivery and safety

Place of palliative care delivery

Palliative care should ideally be available where the person receiving care chooses, whether that is in the home, hospital, or community settings such as care homes and hospices. Ensuring that people with palliative care needs are safe and cared for with dignity and respect is a crucial responsibility of national health systems. Consideration of where palliative care and death take place is important and influences clinical outcomes. Asking patients and their family caregivers about preferred place of caregiveing and death should be a part of routine palliative care provision. Most patients express a preference to die at home, with some wishing to die in a hospital or hospice/palliative care facility. Very few published studies explore such preferences in LMICs, highlighting another substantial palliative care literature gap. Recognising that such preferences are predicated on many factors including social, ethical, cultural, religious, economic, geographical and personal perspectives is key. Despite a person's preference, dying at home may not be possible and, in HICs, most deaths take place in health care facilities. Lack of congruence between preferred and actual place of death is an area for future research Patients may also change their preferences over time; thus, such inquiry must be conducted iteratively and over time. To realize equitable access globally, palliative care provision must include those who are systematically left behind including children, older people, prisoners, sex workers, drug users, refugees, people experiencing homelessness, people living with disabilities, marginalized racial, cultural, and ethnic groups, and LGBQTIA+ communities.

7. Support community action, including the expansion of compassionate communities.

Palliative care is a shared responsibility and communities play an important role. Such responsibility may be enacted through providing care, e.g. volunteer community caregivers, family members, and community members who engage others to improve their understanding and importance of palliative care aims and services. Compassionate communities represent a public health model of palliative care with care led by communities supported by health and social care networks (263). A central aspect of compassionate communities is improving palliative care, end-of-life and death literacy across populations. There is an increasing recognition of the importance of compassionate communities but much more is needed in practical terms to ensure their widespread implementation. However, as with essential medicines there are models of good practice such as that of Taipei in Taiwan that can be learnt from (264). In the context of community delivered palliative care it is especially important to recognize and address the gendered nature of caregiving which falls disproportionately on women and girls in communities and families often without recompense, support and equipment, contributing to continued gender inequalities.

8. Engage people with lived experience of serious illness in meaningful ways.

There must be an explicit commitment to the meaningful engagement of people with lived experience (PWLE) of serious illness, whether recipients of palliative care or carers, including the bereaved. PWLE have a unique perspective on palliative care which gives them crucial personal expertise that is equal to, though different from, technical expertise. PWLE should contribute to policy development at local, national and global levels. Their input should also be sought in other aspects of palliative care including education and training, research, information sharing and service development. PWLE play a particularly important role in palliative care advocacy where the voice of someone with lived experience can have significant impact. It is important that PWLE are provided the opportunities for both financial remuneration and ongoing partnership across these forms of engagement not only to provide them with validation but also to ensure that the value of their input is optimized. The WHO framework on meaningful engagement of people with NCDs, mental health and neurological disorders (265) has much useful, transferable content that can be used to inform the meaningful engagement of PWLE of palliative care.

9. Move palliative care research forward

Continuing to establish a robust evidence base is an important component of supporting greater access to palliative care. The case for evaluating service delivery and high-quality research is dependent on robust outcome measures for the area of interest whether they be clinical outcomes or non-clinical outcomes. Research to date has been focused on HICs and there must be increased research focus on palliative care in LMICs although obtaining funding for this is challenging. Priority areas for research include value for money, home based vs hospice or specialist in-patient provision of palliative care, and how to most effectively influence policymakers. Key research stakeholders including PWLE, healthcare workers, policy makers, and communities should have input into the design, implementation, evaluation and dissemination of research. The research agenda should be funded to continue to examine the access, outcomes, and cost-effectiveness of palliative care and its impact on people's lives and health systems.

10. Increase Access to children's palliative care

Continued advocacy is essential to advance the development of children's palliative care globally. While there is significant overlap between the above recommendations and those aimed at ensuring equitable access to palliative care for children and their families, it is critical to explicitly address the distinct needs of neonates, infants, young children, adolescents, and young adults. This includes a strong emphasis on a life-course approach including the provision of care within humanitarian, fragile, and conflict-affected settings. Integrated service models that encompass children and young people are vital, supported by clear referral pathways, effective transitions between care systems, and an embedded public health approach to children's palliative care. In particular, sustainable education and training pathways are required, alongside equitable access to age-appropriate palliative care medicines and formulations. Supportive transitions—such as from neonatal to paediatric services and from paediatric to adult services—must be prioritised. Strategies should also ensure that the voices of children themselves are recognised, alongside those of parents, siblings, and the wider family, in service development, education, and research. A coordinated effort is needed to expand research in children's palliative care, particularly in LMICs, where evidence remains limited (266). Finally, effective communication strategies are required to address persistent misconceptions and to highlight the importance and value of palliative care for children and young people.

Further recommendations

Technical agencies

- All technical agencies who are leading on global health initiatives, including UHC technical assistance and reform support, should review their existing guidance, programmes, funding and monitoring to ensure palliative care is included as an essential part of the spectrum of healthcare services.
- The draft political declaration from the 4th UN High level meeting on NCDs contains reference to palliative care and this should be used to inform palliative care advocacy in the context of NCDs.
- Cross-technical agency initiatives should ensure that health systems are strengthened and cover the life-course from prevention, promotion, treatment, rehabilitation and palliative care.
- INCB should continue and reinforce its efforts to ensure that countries guarantee adequate availability of controlled substances for medical use, as required by the UN drug conventions.
- UNICEF should take a leadership role in promoting and extending the inclusion of palliative care for children by developing palliative care guidance, monitoring access to children's palliative care, and promoting palliative care educational development.

Bilateral donors, funders and foundations should

- Provide global leadership on palliative care ensuring allocation of funds to palliative care as a fundamental component of the health-care system, UHC reforms and a basic human right for people living with life-limiting conditions of all causes and their carers.
- Ensure monitoring and evaluation of funded programmes include assessment of both access to palliative care and the quality of life of people living with life-limiting conditions.
- The Global Fund on HIV, TB and Malaria should strengthen its health systems strengthening strategic objective to ensure that health systems are providing the spectrum of essential health services including palliative care. Enhanced services should benefit all people with chronic and life-threatening conditions including those with HIV and MDR/XDR TB.

Civil society and communities should

- Build demand for and understanding of palliative care in homes, communities and countries and support accountability from government, donor agencies and technical agencies to ensure access to care.
- Ensure that the voices of the most marginalized and vulnerable are integrated into decision-making and palliative care initiatives at all levels.

Conclusion

While there has been progress in palliative care since the WHA 67.19 resolution on palliative care in 2014 there is much work still to be done across a range of areas. Education of community, healthcare professionals and policy makers is essential to ensure the eradication of palliative care inequities globally. There is a particular and urgent need to address the inequality between LMICs and HICs. Collective action and collaborations between governments, technical agencies, philanthropists, academia, civil society and communities is necessary to ensure that everyone accesses the palliative care they need when they need it. Robust research is necessary to inform further development and implementation of palliative care. Accountability is crucial and agreed indicators such as the 14 WHO indicators should be used to evaluate provision and quality of all types of palliative care including home-based care. Evidence-based advocacy by professionals, PWLE, and communities is needed to influence policy makers at local, national and global levels. As UHC reforms take place, it is critically important that palliative care services are included as an integral part of the healthcare spectrum. It is time to invest in our health systems globally and radically rethink them to meet the needs of those with chronic conditions. Those with palliative care needs, who are some of the most hidden and vulnerable in our societies, cannot continue to be left behind.

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APPENDIX 1

Methodologies for the Global Atlas of Palliative Care, 3rd Edition

The data used in this Atlas comes from existing published data. Some estimates are derived from existing databases, studies, and methodologies.

Chapter 1: Published articles, and studies on the cost effectiveness of palliative care are summarized **here.**

Chapter 2: The methodology to measure serious health-related suffering (SHS) was first published in the Lancet Commission on Global Access to Palliative Care and Pain Relief available **here**. The SHS methodology has been iteratively refined and subsequently published in 2024 available **here**. Using the refined methodology, all estimates of palliative care need from 1990 to 2021 were published in 2025 here, with specific estimates for children's SHS published in 2026 and available **here**. Institute for Health Metrics & Evaluation Global Burden of Disease 2023 data was used for the calculations. Mortality, and Prevalence of diseases/ conditions, as well as Population data used in Palliative Care Need and SHS estimations were extracted from: Global Burden of Disease Study 2023 (GBD 2023 from IHME) data resources available **here**.

Chapter 3: Published literature on barriers for opioid usage utilized data from INCB data summarized by the WHO Access to Controlled Medicines Programme. Per capita mapping data came from the INCB 2024 report available here. This data is also compiled by the Walther Centre for Global Palliative Care at Indiana University in cooperation with the International Narcotics Control Board. The data through 2020 is published online at: **http://painpolicy.iu.edu**

Chapter 4: We used published results of WHO's Report, "Palliative Care for Noncommunicable Diseases: A global snapshot 2024." We also used the results from a paper titled, "First-ever global ranking of palliative care: 2025 World Map under the new WHO Framework to report the four levels of palliative care development globally available **here.** Calculation of the numbers of palliative care service providers and patients served comes from a paper titled, "Estimating the Number of Services & Patients Receiving Specialized Palliative Care Globally in 2025" available **here.** Children's palliative care development estimates came from data published in the following 2025 article: "Mapping of Children's Palliative Care Development Globally in 2023," available **here.**

Chapter 5: We invited select palliative care services to submit descriptions of different models of palliative care programming. These reports highlighted innovations in financing and sustainability. We also included individual stories submitted by selected people living with palliative care needs.

Chapter 6: Summarizes the previous sections and provides narrative conclusions and recommendations.

APPENDIX 2

Organizational resources

Resources for palliative care development are limited worldwide. In spite of this, considerable private efforts, goodwill and community support have sustained and helped build palliative care worldwide.

Financial resources devoted to palliative care

Exact figures on the funds dedicated to the provision of hospice and palliative care services are not known. There are some examples of resource allocation, mainly in Western countries, that provide a partial picture of the need for resources.

Several studies have estimated the cost of care in the last year of life to between 25-30% of all medical expenditures. (108 109 110). The US Medicare programme for those over 65 years spent a total of $1.1 trillion US dollars in FY 2024, including $27.5 billion for hospice care. Palliative care outside of hospices in the USA is mostly hospital-based consultancy services. There are reportedly 2160 hospitals in the US that have palliative care services, though the amount of money spent in these programmes is not known. In Canada hospice palliative care is 50% funded by charitable donations. On average, adult charitable hospices in England receive approximately one-third of their costs from the government or National Health Service (NHS), although the actual amount of state funding for local charitable hospices around the United Kingdom varies considerably. Children's hospices receive far less funding support from government or the NHS. **Is palliative care cost effective?** Studies have demonstrated the cost–effectiveness of hospice and palliative care services. Overall, the utilization of both hospital-based and in-home hospice and palliative care services significantly reduced the cost of care, while providing equal if not better-quality care. However, studies to date are primarily from developed countries. See **Chapter One**

Philanthropic

Many charitable organizations have a history of supporting hospice and palliative care development locally. There are very few that remain active in supporting global palliative care. The most prominent one, Open Society Foundations has phased out its International Palliative Care Initiative along with many other notable international funders such as the Diana Princess of Wales Memorial Fund, the US Cancer Pain Relief Committee and others. New philanthropic support for global palliative care is urgently needed.

Multilateral and Bilateral Support

Government support for international health includes some support for palliative care and related health-care services though recently many of the following groups have made major cuts to overseas aid or phased out entirely. The largest of these agencies includes the Global Fund, the President's Emergency Plan for AIDS Relief (PEPFAR), the United Kingdom's Department for International Development (DFID), and individual country commitments to palliative care development. Exact funds committed towards palliative care are not available. Currently USAID has been closed and most overseas aid programmes have been curtailed.

Research support

Every specialized component of health care needs a growing body of research to advance its field. Though hospice and palliative care is gaining recognition in many countries and there is a growing body of knowledge and literature, there has been very limited funding for research. The following are a few examples of palliative care research initiatives:

- In the USA less than 1% of government research funding is directed towards topics relevant to palliative care. The National Palliative Care Research Centre (www.npcrc.org) advocated in the US for palliative care research but is now closed..
- The European Association for Palliative Care has a strong focus on palliative care research through its research network. http://www.eapcnet.eu/Themes/Research.aspx
- The Cicely Saunders Institute of Palliative Care, Policy, and Rehabilitation at Kings College London has a well-developed research and teaching program https://www.kcl.ac.uk/cicelysaunders/about/index
- The Lien Centre for Palliative Care has research programmes looking into clinical, social and cultural aspects of palliative care in Singapore and Asia. It also focuses on palliative care education and the development of health-care professionals. http://www.duke-nus.edu.sg/research/Centres/lien-centre-palliative-care

Major Palliative Care Organizations

African Palliative Care Association
https://www.africanpalliativecare.org/
APCA's mission is to promote and support affordable and culturally appropriate palliative care throughout Africa.

American Academy of Hospice and Palliative Medicine
www.aahpm.org
The Academy is the professional organization for physicians specializing in hospice and palliative medicine.

Asia Pacific Hospice Palliative Care Network Singapore
www.aphn.org
The Asia Pacific Hospice Palliative Care Network was established to empower, and support individuals and organizations committed to alleviating suffering from life-threatening illness in the Asia Pacific region.

Association for Death Education & Counselling
www.adec.org
The Association for Death Education and Counseling is a professional organization dedicated to promoting excellence and recognizing diversity in death education, care of the dying, grief counseling and research in thanatology.

Canadian Hospice Palliative Care Association
www.chpca.net
The Canadian Hospice Palliative Care Association is the national association that provides leadership in hospice palliative care in Canada.

Centre to Advance Palliative Care
www.capc.org
The Centre to Advance Palliative Care (CAPC) provides health-care professionals with the tools, training and technical assistance necessary to start and sustain successful palliative care programmes in hospitals and other health-care settings

Cicely Saunders International
www.cicelysaundersfoundation.org
Cicely Saunders International focuses on carrying out quality research to improve the care and treatment of all patients with progressive illness and to make high-quality palliative care available to everyone who needs it.

Elisabeth Kubler-Ross Foundation
www.ekrfoundation.org
The EKR Foundation is a non-profit organization inspired by the life of psychiatrist, humanitarian, and hospice pioneer Dr. Elisabeth Kübler-Ross. Chapters worldwide work to help develop palliative care in their countries.

European Association for Palliative Care
https://www.eapcnet.eu/
The aim of the EAPC is to promote palliative care in Europe and to act as a focus for all of those who work, or have an interest, in the field of palliative care at the scientific, clinical and social levels.

Hospice Foundation of America
www.hospicefoundation.org
Promotes education on death, dying, and bereavement through publications and teleconferences.

Hospice and Palliative Nurses Association
www.hpna.org
A membership association for nurses working in hospice and palliative care; offers national boards for certification of hospice nurses.

International Association for Hospice and Palliative Care
www.hospicecare.com
Our mission is to collaborate and work to improve the quality of life of patients with advanced life-threatening conditions and their families, by advancing hospice and palliative care programmes, education, research, and favourable policies around the world.

International Children's Palliative Care Network
http://www.icpcn.org.uk/
The International Children's Palliative Care Network (ICPCN) is a worldwide network of individuals and agencies working with children and young people with life-limiting conditions.

Latin American Association for Palliative Care
www.cuidadospaliativos.org
Our mission is to promote the development of palliative care in Latin America and the Caribbean, through its communication and integration of all stakeholders in improving the quality of life of patients with progressive incurable diseases and their families.

National Alliance for Care at Home (Formerly the National Hospice and Palliative Care Organization & the National Assoc for Home Care & Hospice)
www.nhpco.org https://allianceforcareathome.org/
These two organizations recently merger to become a trade association for the majority of home health and hospice agencies in the United States.

National Hospice Foundation
www.nationalhospicefoundation.org
The national charity for end-of-life care in the United States.

Palliative Care in Humanitarian Aid Situations and Emergencies Network
www.pallchase.org
An informal organization bringing together leaders networking to advocate for palliative care integration in humanitarian situations or emergencies.

Palliative Care Australia
https://palliativecare.org.au/
Palliative Care Australia is the national peak body for palliative care. Working closely with consumers, our Member Organisations and the palliative care workforce, we aim to improve access to, and promote the need for, palliative care.

Public Health and Palliative Care International
https://www.phpci.org/
Death, dying, loss and care is everyone's responsibility. Home for compassionate communities.

St. Christopher's Hospice
www.stchristophers.org.uk
The first modern hospice; St Christopher's exists to promote and provide skilled and compassionate palliative care of the highest quality.

Worldwide Hospice Palliative Care Alliance
www.thewhpca.org
The Worldwide Palliative Care Alliance (WPCA) is a global action network focusing exclusively on hospice and palliative care development worldwide.
Its members are national and regional hospice and palliative care organizations and affiliate organizations supporting hospice and palliative care.

World Health Organizational Resources

This is a list of the main WHO publications related to palliative care as well as a few additional key resources.
Link to **Google Drive Folder with these documents and more**

Foundational Global Publications

WHA Resolution 67.19. Strengthening of palliative care as a component of comprehensive care throughout the life course. May 2014. Available **here**.
The Lancet Commission Report: Alleviating the access abyss in palliative care and pain relief-an imperative of universal health coverage. April 2018. Available **here**.
Disease Control Priorities 3rd ed. World Bank. Chapter 12 on Palliative Care & Pain Control. Available **here**.

Palliative Care Atlases

Global Atlas of Palliative Care, 2nd Edition. 2020. Worldwide Hospice Palliative Care Alliance. Available **here**.
Asia: APHN Atlas of Palliative Care in the Asia Pacific Regions. 2025. Available **here**
Europe: EAPC Atlas of Palliative Care in Europe. 2025. Available **here**.
Eastern Mediterranean: Atlas of palliative care in the Eastern Mediterranean Region. 2025. Available **here**.
Africa: APCA Atlas of Palliative Care in Africa. 2025. Available **here**.
Americas: ALCP Atlas of Palliative Care in Latin America. 2025. Available **here**.
Direct links for the Atlases:
Asia Pacific: https://dadun.unav.edu/entities/publication/99f1301c-35e3-4774-8399-59bf63f95946
Africa: https://hdl.handle.net/10171/117004
Americas: https://dadun.unav.edu/entities/publication/b9c73d83-b8c8-4312-8616-27a389245e77
Eastern Med: https://dadun.unav.edu/entities/publication/5f776b5c-f84a-457c-97c4-ec1d1135b10e
Europe: https://dadun.unav.edu/handle/10171/56787

WHO Guidance for Specific Topics

- **Pain in Children:** Guidelines on the management of chronic pain in children. December 2020. Available here.
- **Pain in Adults/Adolescents:** WHO Guidelines for the pharmacological and radiotherapeutic management of cancer pain in adults and adolescents. January 2019. Available here.
- **Controlled Medicine Access:** WHO guideline on balanced national controlled medicines policies to ensure medical access and safety, 2025. Available here.
- **Older People:** Integrated care for older people (ICOPE): guidance for person-centred assessment and pathways in primary care, 2nd ed. 2025. Available here.
- **NCDs:** WHO package of essential non-communicable (PEN) disease interventions for primary health care. September 2020. Chapter 2.7 on palliative care. Available here.
- **COVID-19:** Clinical management of COVID-19: Living guideline. Section 3.12 on Palliative Care. Available here.
- **HIV prevention, testing, treatment, service delivery and monitoring:** recommendations for a public health approach. July 2021. Section 6.17 on Palliative Care. Available here.
- **Tuberculosis**: WHO operational handbook on tuberculosis: module 4: treatment: tuberculosis care and support. Chapter 6 on Palliative Care. July 2022. Available here.

Health System Planning for Palliative Care

- **Universal Health Coverage:** WHO Palliative Care Reference Filter on Service Planning Delivery and Implementation (SPDI) tool. Sept 2025. Available here.
- **General:** Assessing the development of palliative care worldwide: a set of actionable indicators. September 2021. Available here.
- **General:** Planning and implementing palliative care services: a guide for programme managers. February 2016. Available here.
- **General:** Report of the WHO South-East Asia Regional workshop on expanding availability and access to palliative care. 2023. Available here.
- **General:** Quality health services and palliative care: practical approaches and resources to support policy, strategy and practice. October 2021. Available here.
- **Pediatrics:** Integrating palliative care and symptom relief into paediatrics. A WHO guide for health care planners, implementers and managers. August 2018. Available here.
- **Humanitarian Emergencies**: Integrating palliative care and symptom relief into the response to humanitarian emergencies and crises. February 2018. Available here.
- **Primary Care:** Integrating palliative care and symptom relief into primary health care. A WHO guide for planners, implementers and managers. October 2016. Available here.
- **Rehabilitation:** Policy brief on integrating rehabilitation into palliative care services. WHO EURO. 2023. Available here.
- **NCDs:** Addressing noncommunicable diseases in emergencies: a regional framework for action. Regional Committee for the Eastern Mediterranean Seventieth session. 2023. Available here.

Additional WHO Technical Documents relating to Palliative Care

- **WISH Report:** Palliative Care- How Can We Respond to 10 years of Limited Progress? Nov 2024. Available here.
- **Medicines:** WHO Model List of Essential Medicines - 24rd list, 2025. Available here.
- **Pain Medicines:** Left behind in pain: Extent and causes of global variations in access to morphine for medical use and actions to improve safe access. June 2023. Available here.
- **General:** WHO regional technical briefing: strengthening palliative care in the WHO European Region. WHO EURO. 2022. Available here.
- **General:** Commercial and Social Determinants in Palliative Care. WHO EURO. 2022. Available here.
- **General:** Integrated Management of Adolescent and Adult Illness (IMAI) -Palliative Care. 2004. Available here.
- **Older People:** Better palliative care for older people. WHO EURO. 2014. Available here.
- **Primary Care:** Why palliative care is an essential function of primary health care. August 2018. Available here.
- **NCDs:** Palliative Care for Non-Communicable Diseases: A global snapshot. Feb 2019. Available here.
- **NCDs:** Tackling NCDs: 'best buys' and other recommended interventions for the prevention and control of noncommunicable diseases. 2017. Available here.
- **Cancer:** WHO report on cancer: setting priorities, investing wisely and providing care for all. February 2020. Available here.
- **Cancer:** WHO global survey on the inclusion of cancer care in health-benefit packages. Section on Palliative Care (p. 56-59). 2024. Available here.
- **Cervical Cancer:** WHO framework for strengthening and scaling-up services for the management of invasive cervical cancer. December 2020. Chapter 2.1.3 on palliative care. Available here.
- **Cervical Cancer:** Global strategy to accelerate the elimination of cervical cancer as a public health problem. November 2020. Available here.
- **TB:** Review on palliative care with focus on 18 high tuberculosis priority countries. 2020. Available here.
- **TB:** WHO Operational Handbook on Tuberculosis: Module 4: Treatment and Care (2025). Available here.

WHO Courses and Social Media Materials on Palliative Care

- **WHO Academy Course:** National Cancer Control Planning for Programme Managers. Available here.
- **WHO Academy Course:** Care and self-care competences for informal caregivers - Caring for yourself and others. Available here.
- **WHO Academy Course:** Universal health coverage service planning with WHO's SPDI Platform – Available here [Note: the Palliative Care SPDI course will be released in early 2026]
- **WHO Academy Course:** Palliative Care Models of Service Delivery and Symptom Management (From SEARO). Available here.
- **Course:** PAHO Virtual Course on Fundamentals of Palliative Care. Available here.
- **Course:** PAHO Paediatric Palliative Care- 9 modules for family caregivers. Available here.
- **Video:** UHC Service Planning, Delivery, & Implementation (SPDI) Platform. Available here.
- **Video:** Introducing Palliative Care. October 2021. Available here.
- **Video:** What is Palliative Care and How can it be assessed. Dec 2021. Available here.
- **Video:** increasing access to Palliative Care. English, French, Arabic versions available.
- **Video:** Palliative Care and Caner Diagnosis. Available English, French, and Arabic versions.
- **Video:** Opioid Access (linked to report "Left Behind in Pain"). Nur's Story from Malaysia here. Neil's story from UAE here. Uganda's story here.
- **Infographics:** on Palliative Care (global). Available here.
- **Infographics:** on Palliative Care (EMRO). Available here.

Publications from WHO Collaborating Centres focused on Palliative Care

1. All India Institute of Medical Sciences. Research Institute for Hospice/Palliative Care, College of Nursing. Information available here.
2. ATLANTES Global Observatory of Palliative Care. University of Navarra, Spain. Publications lists available here.
3. Catholic University of Korea. College of Nursing. Research Institute for Hospice/Palliative Care. Publications List available here.
4. ECHO Institute, University of New Mexico. Publications list available here.
5. Institute of Palliative Medicine, India. Publications (including course training manuals) list here.
6. Kings College London. Publications lists available here.
7. Sechenov University (Russia).
8. St Jude Children's Research Hospital. Publications list available here.
9. Trivandrum Institute of Palliative Sciences (TIPS). (Pallium India). Publications list Available here.
10. University of Toronto. Department of Family and Community Medicine. Information available here.

Publications from Non-State Actors

- International Association for Hospice and Palliative Care (IAHPC). Publications list available here.
- International Children's Palliative Care Network (ICPCN). Publications list available here.
- World Association of Family Doctors (WONCA). Publication list available here.
- Worldwide Hospice Palliative Care Alliance (WHPCA). Publications list available here.
- International Council of Nursing (ICN).
- International Association for the Study of Pain (IASP).

External Publications:

Regional Associations and Networks:

- African Palliative Care Association. Publications list available here.
- Rolling out Rwanda's national palliative care programme. WHO Health Bulletin. 2018. Available here.
- Asociacion Latinoamericana de Cuidados Paliativos (ALCP). Publications list available here.
- Asia Pacific Hospice Palliative Care Network (APHN). Publication list available here.
- European Association of Palliative Care (EAPC). Publication list available here.

Eastern Med Region Expert Advisory Group on Palliative Care

- Resolution, Technical Paper and Framework on Palliative Care- for Regional Meeting 2025.
- Strengthening palliative care in the WHO Eastern Mediterranean Region. 2022. Available here.
- Region-specific macro-indicators for palliative care development in the Eastern Mediterranean Region: a Delphi study. 2022. Available here.
- Expert meeting to develop a regional roadmap for palliative care in the Eastern Mediterranean Region. 2022. Available here.
- Integrating locally attuned palliative care into health care systems in the Eastern Mediterranean Region. 2022. Available here.
- Special Topics: Integration of Palliative Care into Primary Health Care: Publications available here.
- Why palliative care is an essential function of primary health care. August 2018. Available here.
- WHO Operational Framework for Primary Care. 2020. Available here.
- A Palliative Care Approach for Primary Care and PC Toolkit (Cancer Care Ontario, Canada). Available here.
- Inter-Professional Palliative Symptom Management Guidelines (British Columbia, Canada). Available here.
- Primary Palliative Care Guidelines (New Zealand). 2020. Available here.
- Palliative Medicine: Special Issue (Primary Palliative Care). Sept 2024. Entire Issue available here.
- Defining and developing primary palliative care as an essential element of primary health care.
- Evaluation of the integration of palliative care in a fragile setting amongst host and refugee communities.
- Primary palliative care in low- and middle- income countries: A systematic review and thematic synthesis of the evidence for models and outcomes. Available here.
- Developing an integrated model of community-based palliative care into the primary health care (PHC) for terminally ill cancer patients in Iran. 2021.

- Integration of Palliative Care into the Primary Health Care in Health System of Iran: A Document Analysis. 2021
- Explaining health care providers' perceptions about the integration of palliative care
- with primary health care; a qualitative study. 2022
- Transitional Cancer Care Program from Hospital to Home in the Health Care System of Iran. 2021

WHO collaborating centres focused on Palliative Care

1. ATLANTES Global Observatory of Palliative Care. University of Navarra, Spain. Publications lists available here.
2. Catholic University of Korea. College of Nursing. Research Institute for Hospice/Palliative Care. Publications List available here.
3. ECHO Institute, University of New Mexico. Publications list available here.
4. Institute of Palliative Medicine, India. Publications (including course training manuals) list here.
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9. University of Toronto. Department of Family and Community Medicine. Information available here.

Additional WHPCA Resources

These resources are to help, support and inspire you to take action

These resources are focussed on supporting the development of hospice and palliative care. They are likely to be of most interest to those working, or interested in working, in palliative care, health and development.

If you are a member of the public and you are looking for patient and carer support and resources, contact your national association or local hospice or palliative care service.

For global news, views and inspiration relating to hospice and palliative care, visit www.ehospice.com

Free Book: Building Integrated Palliative Care Programmes and Services (1)
Covid-19 Resources (40)
World Hospice and Palliative Care Day 2019 (42)
Global Atlas of Palliative Care at the End of Life (3)
Laws, regulations and national strategies (33)
Disease specific plans and guidance (20)
Country reports and needs assessments (19)
Standards, clinical guidelines and protocols (50)
UN guidelines, documents and strategies on palliative care (5)
National association strategic plans (2)
Advocacy resources (40)
Media resources (11)
Fundraising resources (4)
WHPCA publications and reports (24)
WHPCA position statements (7)

World Hospice and Palliative Care Day Resources
http://www.thewhpca.org/world-hospice-and-palliative-care-day

The International Association for Hospice and Palliative Care resources:

Publications

- Book Reviews Archive
- Euthanasia and Physician Assisted-Suicide
- Getting Started
- Manual of Palliative Care, 3rd Edition
- Manual on the Use of Essential Palliative Care Medicines for Adults
- Pallinews

Catalogue

- Calendar of Events
- Global Directory of Educational Programmes
- Global Directory of Institutions and Organizations
- Pallimedicines
- Pallinet: The IAHPC Membership Network
- What's New

International Children's Palliative Care Network resources:

- ICPCN's website where you can find news, information about ICPCN, children's palliative care, resources, events and ongoing activities https://icpcn.org
- ICPCN's Education and Membership Hub - https://www.elearnicpcn.org where there are a range of free courses available on children's palliative care, as well as access to ICPCN's monthly webinar series.
- ICPCN's Publications and Resources https://icpcn.org/resources/publications-resources/ including the ICPCN Charter, children's palliative care text books and published papers that the ICPCN team have contributed to or led.
- Heart Strings – Stories of Children's Palliative Care – bringing together stories from families and organisations from around the world. https://heyzine.com/flip-book/0b44b8774d.html
- A wide range of resources on different aspects of children's palliative care https://icpcn.org/resources/
- News stories and article on children's palliative care through ICPCN's website - https://icpcn.org/news/ and the International Children's Edition of ehospice https://ehospice.com/international-childrens/.
- Throughout the website you can find links to other websites with information about children's palliative care e.g. the magnify tool, regional resources, etc

PallCHASE (Palliative Care in Humanitarian Aid Situations) Resources

List of Links for The Need for Palliative Care in Humanitarian Emergencies

- ICRC website/s http://www.icrc.org
- ICRC Fact Sheet https://www.icrc.org/sites/default/files/document/file_list/health-care-law-factsheet-icrc-eng.pdf
- WHO Integrating palliative care and symptom relief into the response to humanitarian emergencies and crises https://www.who.int/publications/i/item/9789241514460
- Lessons from countries and humanitarian aid organization in facilitating the Timely Supply of Controlled Substances during Emergency Situations https://www.incb.org/documents/Publications/Guidelines/21-05399_Factsheet_EN_ebook.pdf
- UNODC Technical Guidance: Increasing Access and Availability of Controlled Medicines (2018)
- MODEL GUIDELINES for the INTERNATIONAL PROVISION OF CONTROLLED MEDICINES for Emergency Medical Care https://www.incb.org/documents/Narcotic Drugs/Guidelines/medical_care/Guidelines_emergency_Medical_care_WHO_PSA_OCR.pdf
- INCB, UNODC, WHO Joint Statement Access to controlled medicines in emergencies https://www.incb.org/incb/en/news/news_2021/incb--unodc-and-who-joint-statement-on-access-to-controlled medicines-in-emergencies.html
- OCHA Office for the Coordination of Humanitarian Affairs https://www.unocha.org/
- Global Humanitarian Overview 2025 OCHA https://ocha.org/globalhumanitarianoverview2025
- OCHA Relief web https://reliefweb.int/
- Core Humanitarian Standards on Quality and Accountability https://spherestandards.org/handbook/
- PallCHASE website http://www.pallchase.org
- Medecins sans Frontieres http://www.msf.org
- UNHCR United Nations High Commissioner for Refugees http://www.unhcr.org
- UNHCR Global Law and Policy Database Refworld http://www.refworld.org
- Doherty M., Khan F. Neglected suffering: the unmet need for palliative care in Cox's Bazar. . Available at: https://reliefweb.int/sites/reliefweb.int/files/resources/Neglected%20Suffering.pdf. Accessed May 6, 2021.
- Powell R.A., Schwartz L., Nouvet E., Sutton B., Petrova M., Marston J. et al. Palliative care in humanitarian crises: always something to offer. Lancet 2017; 389(10078), 1498–1499. http://www.pallchase.org

- Waldman E., Glass M. A Field Manual for Palliative Care in Humanitarian Crises. Oxford University Press, 2020. http://www.pallchase.org

Resources and tools to aid professionals measuring progress with timely palliative care in primary care

Step 1. Identification of declining health (individual or population screening)

- Supportive & Palliative Care Indicators Tool (SPICT) (Available in multiple languages and as a version for low income settings) https://www.spict.org.uk/
- Proactive Identification Guide (PIG) https://goldstandardsframework.org.uk/cd-content/uploads/files/PIG/ProactiveIdentificationGuidance(2022).pdf
- Palliative Care Needs (NECPAL) https://www.catedrapaliativos.com/media/42/media_section/8/3/5483/INSTRUMENT-NECPAL-4.0-2021-ENG-Complete-Final.pdf
- SENS Structure (Switzerland) https://sens-plan.com/wp-content/uploads/2023/02/SENS-Pocket-Card_EN.pdf
- Clinical Frailty Scale (Canada) https://www.dal.ca/sites/gmr/our-tools/clinical-frailty-scale.html
- Electronic Frailty Index (UK) https://www.england.nhs.uk/ourwork/clinical-policy/older-people/frailty/efi/

Step 2. Multidimensional assessment (patient and carer)

- Daffodil Standards (Royal College of General Practitioners, UK) https://www.rcgp.org.uk/learning-resources/daffodil-standards/introduction
- Integrated Palliative Care Outcome Scale (IPOS) (UK) https://pos-pal.org/
- Gold Standards Framework (GSF) https://www.goldstandardsframework.org.uk/
- Comprehensive Geriatric Assessment (CGA) https://www.bgs.org.uk/resources/resource-series/comprehensive-geriatric-assessment-toolkit-for-primary-care-practitioners
- Frailty indexes based on a CGA (Frail-VIG index) https://pubmed.ncbi.nlm.nih.gov/29373968/
- Palliative Care Phase (Australia) https://www.uow.edu.au/ahsri/pcoc/palliative-care/assessment-forms/
- Carer Support Needs Assessment Tool Intervention (CSNAT-I) (UK) https://csnat.org/

Step 3. Planning (shared decision making)

- Healthcare Improvement Scotland Future Care Planning Toolkit https://ihub.scot/project-toolkits/future-care-planning-toolkit/future-care-planning-toolkit/
- Using REDMAP (Royal College of Physicians & Surgeons of Glasgow, UK) https://www.youtube.com/watch?v=bLWeQua8ZV0&t=7s
- ReSPECT process (UK) https://www.resus.org.uk/respect

Step 4. Coordination (record, share, review)

- Key Information Summary (Scotland) https://www.scimp.scot.nhs.uk/key-information-summary#:~:text=The%20Key%20Information%20Summary%20(KIS,specifically%20created%20for%20each%20patient.
- POLST process (USA) https://polst.org/

Educational Programmes

The following educational institutions offer graduate educational programmes in palliative care:

Edge Hill University – Ormskirk, UK

- MSC Integrated Palliative and End of Life Care https://www.edgehill.ac.uk/cpd-modules/transforming-integrated-palliative-end-of-life-care-hea4197/

Flinders University – Adelaide, South Australia
http://www.flinders.edu.au/courses/postgrad/ppc/ppc_home.cfm

- 6 month certificate
- 1 year diploma
- 1.5 year masters

Kings College – Cicely Saunders Institute – London, United Kingdom
http://www.csi.kcl.ac.uk/study-with-us.html

- Doctorate in Palliative Care Research
- MSc in Palliative Care
- PG Diploma and PG Certificate

Lancaster University – United Kingdom https://www.lancaster.ac.uk/study/postgraduate/postgraduate-courses/palliative-care-phd/
Doctorate in Palliative Care

Makerere University and the Institute of Hospice and Palliative Care in Africa (IHPCA) at Hospice Africa Uganda, Kampala, Uganda

- Bachelor of Science in Palliative Care https://courses.mak.ac.ug/programmes/bachelor-science-palliative-care

Newcastle University, Medical Sciences Graduate School

- Palliative Care – MSc/PG Dip/ PGCert https://www.ncl.ac.uk/medical-sciences/study/postgraduate/palliative-care-pg/

Norwegian University of Science and Technology – Trondheim, Norway

- Doctorate in Palliative Care https://www.ntnu.edu/studies/phpalc

Queen Margaret University, School of Health Sciences - Edinburgh, Scotland

- MSc Person-Centred Practice (Palliative Care) https://www.qmu.ac.uk/study-here/postgraduate-study/2026/msc-pgdip-pgcert-advancing-practice-in-palliative-care-advancing-professional-practice-framework

Trinity College Dublin, Ireland

- Masters in Palliative Care https://www.tcd.ie/courses/postgraduate/az/course.php?id=DPTNM-PCAR-1P09

University of Cape Town, South Africa
School of Public Health and Family Medicine

- Diploma in Palliative Medicine http://www.publichealth.uct.ac.za/phfm_ postgraduate-diploma-palliative-medicine
- Masters of Philosophy in Palliative Medicine http://www.publichealth.uct.ac.za/ phfm_master-philosophy-palliative-medicine

University of Cardiff – Wales, United Kingdom

- Masters in Palliative Medicine for Health Care Professionals https://www.cardiff.ac.uk/study/postgraduate/taught/courses/course/palliative-medicine-for-health-care-professionals-msc-part-time

University of Dundee School of Medicine, Dundee, Scotland

- Public Health (Palliative Care Research) MPH **https://www.dundee.ac.uk/postgraduate/public-health-palliative-care-research**

University of South Wales Faculty of Life Sciences and Education

- PGCert Palliative Care (Distance Learning) **https://www.southwales.ac.uk/courses/postgraduate-certificate-palliative-care-distance-learning/**

An international listing of education and certificate programmes in palliative care is maintained by the International Association for Hospice and Palliative Care at: **https://iahpc.org/resources/catalogue/global-directory-of-educational-programmes/**

APPENDIX 3

APPENDIX. WORLD HEALTH

Assembly (WHA) Resolution 67.19 on palliative care

WHA Resolution action item	Progress since 2014
For Member States	
1. To develop, strengthen and implement, where appropriate, palliative care policies to support the comprehensive strengthening of health systems to integrate evidence-based, cost-effective and equitable palliative care services in the continuum of care, across all levels, with emphasis on primary care, community and home-based care, and universal coverage schemes.	• In 2019, 50% of countries reported having palliative care within an operational national noncommunicable diseases policy or strategy (355). • Between 2005 and 2019, 82% of countries in Europe increased their number of specialist palliative care services. High-income countries showed significant increases in the number of home care teams, inpatient services, and hospital support teams, while low- and middle-income countries (LMICs) only showed significant increases in inpatient services.356 • In the same time period in Latin America, the number of palliative care teams increased, but most services were offered outpatient, and there were very few inpatient beds added (357). • By 2019, 19 of 51 (37.3%) surveyed European countries had set standards for pediatric palliative care, 22 (43.1%) had a national association, and 14 (27.5%) offered education for either pediatric doctors or nurses (358). • A 2020 review of palliative care policy development found that 55 countries (28%) had any national policy plan for palliative care.359 • The Tracking Universal Health Coverage: 2023 Global Monitoring Report did not include any specific palliative care indicators (360). • Regional atlases of palliative care show that there is still a great need for the development of children's palliative care globally, and that its development lags significantly behind that for adults (361–364). • World Health Organization (WHO) developed an Essential Package of Palliative Care for Primary Health Care that represents the minimum services, medicines and human resources that should be available in district or community primary care clinics around the world (365). • European Association for Palliative Care Reference Group • in Primary Care produced a toolkit to help countries implement palliative care in the community. It includes policy, education, medication availability, and best practices including policy, education, essential medicines and implementation (366).

WHA Resolution action item	Progress since 2014
2. To ensure adequate domestic funding and allocation of human resources, as appropriate, for palliative care initiatives, including development and implementation of palliative care policies, education and training, and quality improvement initiatives, and supporting the availability and appropriate use of essential medicines, including controlled medicines for symptom management.	• A 2017 estimate of palliative care workforce requirements suggests that only 400,000 healthcare workers deliver palliative care globally, falling short of the estimated 2 million needed (367). • In 2021, 69% of countries reported funding for palliative care, representing little change from the last report in 2019 (368). • WHO's Global Survey on the Inclusion of Cancer Carein Health-benefit Packages 2020–2021 found that only 28% of countries surveyed had public sector packages that included palliative care services. These were mainly in upper-middle and high-income countries (369).
3. To provide basic support, including through multisectoral partnerships, to families, community volunteers and other individuals acting as caregivers, under the supervision of trained professionals, as appropriate.	• In 2017, global estimates suggest that more than 1.2 million people volunteer in palliative care around the world (370).
4. To aim to include palliative care as an integral component of the ongoing education and training offered to care providers, in accordance with their roles and responsibilities, according to the following principles: • Basic training and continuing education on palliative care should be integrated as a routine element of all undergraduate medical and nursing professional education, and as part of in-service training of caregivers at the primary care level, including healthcare workers, caregivers addressing patients' spiritual needs, and social workers. • Intermediate training should be offered to all healthcare workers who routinely work with patients with life-threatening illnesses, including those working in oncology, infectious diseases, pediatrics, geriatrics and internal medicine. • Specialist palliative care training should be available to prepare healthcare professionals who will manage integrated care for patients with more than routine symptom management needs.	• A 2020 review of palliative care education in undergraduate and graduate nursing programmes in Europe found that 56% of surveyed countries did not identify palliative care as a mandatory subject (371). • In 2020, no countries in Latin America had palliative care as a mandatory subject in nursing or medical schools (372). • A 2021 report found that only eight countries in Latin America recognized palliative medicine as a medical specialty (373). • A 2023 report from WHO South-East Asia Region showed that 40% of reporting countries had any palliative care included in medical or nursing curricula, and that 30% had any palliative care certificate, diploma or degree programmes for health professionals (374). • A 2023 global review of education programmes on children's palliative care identified 114 programmes, 75% of which were generalist level and 25% were specialist level. By WHO region, 31% came from Europe, 26% from the Americas, 16% from Africa, 16% from the Western Pacific, 10% from Southeast Asia and just 1% from the Eastern Mediterranean (375).

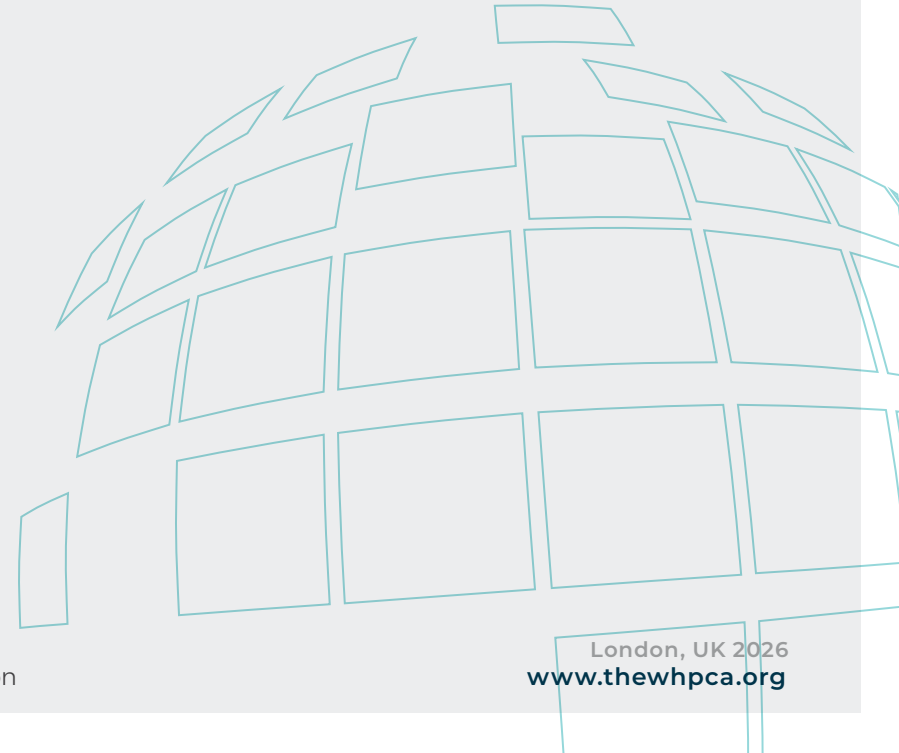
WHA Resolution action item	Progress since 2014
5. To assess domestic palliative care needs, including pain management medication requirements, and promote collaborative action to ensure adequate supply of essential medicines in palliative care, avoiding shortages.	• Several global and regional Atlases of Palliative Care that describe palliative care need, provision and development indicators at a country level have been published since 2014 (376–380). • The Lancet Commission on Palliative Care and Pain Relief developed and released methodology to measure and predict serious health-related suffering in 2018,381 which was updated in 2024 (382). • In 2021, WHO released a set of actionable indictors to assist countries in assessing palliative care development and gaps in service provision (383). • In 2022, World Health Organization Regional Office for the Eastern Mediterranean (WHO EMRO) and the palliative care experts network for the region developed region-specific macro-indicators to track the progress of national palliative care programmes in the Eastern Mediterranean (384).
6. To review and, where appropriate, revise national and local legislation and policies for controlled medicines, with reference to WHO policy guidance, on improving access to and rational use of pain management medicines, in line with the United Nations international drug control conventions.	• A 2023 International Narcotics Control Board report showed that 19.8% of the global population consumed 86.1% of the globally produced morphine, highlighting the extreme, persistent global inequity of opioid access (385). • The 2023 WHO report Left behind in Pain highlights persistent regional barriers to safe and timely access to morphine for medical use for adults and children, including national policies overly focused on preventing illicit use, restrictive administrative requirements for prescribing or dispensing morphine, and unpredictable and insufficient financial and human resources (386).
7. To update, as appropriate, national essential medicines lists in the light of the recent addition of sections on pain and palliative care medicines to the WHO Model List of Essential Medicines and the WHO Model List of Essential Medicines for Children.	• A 2022 comparison of WHO's Model List of Essential Medicines and 137 country level lists found that there were substantial gaps in adopting WHO's official guidance (387). • A related report found that country-level lists included significantly more opioids that the WHO list (388). • A 2023 WHO South East Asia Region (SEAR) publication showed that just one out of 10 reporting countries had included oral opioids in their list of essential medicines (389).

WHA Resolution action item	Progress since 2014
8. To foster partnerships between governments and civil society, including patients' organizations, to support, as appropriate, the provision of services for patients requiring palliative care.	• In 2021, WHO formed a palliative care working group comprised of experts from clinical practice, academia, government, non-governmental organizations, and patient advocates to foster cross-sectoral partnerships, form international networks and collaborate to progress the mission of the WHA Resolution. • A 2021 review of collaborative partnerships between governments and civil society organizations found that civil society's role in policy progress at global and national levels has been significant, with advocacy leading to collaborations in policymaking, service development and education (390).
9. To implement and monitor palliative care actions included in WHO's Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2030.	• WHO reports on multinational capacity for the prevention and control of non-communicable diseases have been published in 2018, (391) 2020392 and 2023, (393) all of which include palliative care development indicators.
For the WHO Director General	
10. To ensure that palliative care is an integral component of all relevant global disease control and health system plans, including those relating to non-communicable diseases and universal health coverage, as well as being included in country and regional co-operation plans.	• In 2017, the definition of universal health coverage (UHC) was updated to include palliative care in the continuum of essential health services (394). • In 2021, the consolidated guidelines for HIV prevention, testing, treatment, service delivery and monitoring included palliative care (395). • The Tracking Universal Health Coverage: 2023 Global Monitoring Report did not include any specific palliative care indicators (396).

WHA Resolution action item	Progress since 2014
11. To update or develop, as appropriate, evidence-based guidelines and tools on palliation, including pain management options, in adults and children, including the development of WHO guidelines for the pharmacological treatment of pain, and ensure their adequate dissemination.	Multiple WHO guidelines have been developed and updated for various aspects of palliative care delivery, including: • Planning and implementing services for program managers (397) • Pharmacological and radiotherapeutic management of cancer pain in adults and adolescents (398) • Improving palliative care service quality (399) • Integrating rehabilitation into palliative care services (400)
12. To develop and strengthen, where appropriate, evidence-based guidelines on the integration of palliative care into national health systems, across disease groups and levels of care, that adequately address ethical issues related to the provision of comprehensive palliative care, such as equitable access, person-centered and respectful care, and community involvement, and to inform education in pain and symptom management and psychosocial support.	Multiple WHO guidelines have been developed to help ethically integrate palliative care into national health systems, including: • Integrating palliative care and symptom relief into primary care (401) • Integrating palliative care in the response to humanitarian crises (402) • Launched in 2024, WHO developed the UHC Service Package Delivery & Implementation (SPDI) tool to help local, regional and national teams build, implement and cost UHC packages. (403)
13. To continue, through WHO's Access to Controlled Medicines program, to support Member States in reviewing and improving national legislation and policies with the objective of ensuring balance between the prevention of misuse, diversion and trafficking of controlled substances and appropriate access to controlled medicines, in line with the United Nations international drug control conventions.	• In 2019, WHO's Ensuring balance in national policies on controlled substances and WHO guidelines on the pharmacological treatment of persisting pain in children with medical illnesses were discontinued based on concerns for conflicts of interest. (404) • Revised guidelines for managing pain in children were published in 2020. (405) • New adult guidelines are due for publication in December 2024.
14. To explore ways to increase the availability and accessibility of medicines used in palliative care through consultation with Member States and relevant networks and civil society, as well as other international stakeholders, as appropriate.	• A 2021 report found that global opioid consumption declined from 216.3 to 151.5 morphine milligram equivalents per 1,000 inhabitants per day between 2009 and 2019. (406) • A 2022 International Narcotics Control Board report found that 9.9% of the morphine available globally was directly consumed, an increase from the previous decade. (407) • The amount of opioid analgesics consumed in South America tripled between 2002 and 2021. (408) • As of 2024, WHO's non-communicable diseases emergency health kits do not include medicines for pain and symptom management due to regulatory concerns. (409)

WHA Resolution action item	Progress since 2014
15. To work with the International Narcotics Control Board, the United Nations Office on Drugs and Crime, health ministries and other relevant authorities in order to promote the availability and balanced control of controlled medicines for pain and symptom management.	• According to International Narcotics Control Board data, global morphine consumption decreased from 6.1671 in 2014 to 4.4768 mg/capita in 2021. (410) • Global consumption of all opioids (excluding methadone) decreased from 43.05 mg/capita in 2014 to 28.559 mg/capita in 2021. (411)
16. To further co-operate with the International Narcotics Control Board to support Member States in establishing accurate estimates in order to enable the availability of medicines for pain relief and palliative care, including through better implementation of the guidance on estimating requirements for substances under international control.	• International Narcotics Control Board publishes yearly technical reports on global narcotic drug requirements, most recently in May 2024 using data from 2022. (412)
17. To collaborate with UNICEF and other relevant partners in the promotion and implementation of palliative care for children.	• In 2023, WHO and UNICEF collaborated to create the Operational Framework for Primary Health Care: Transforming vision into action which highlights the urgent need to integrate palliative care into primary care, and establish robust monitoring and evaluation frameworks (413).
18. To monitor the global situation of palliative care, evaluating the progress made in different initiatives and programmes in collaboration with Member States and international partners.	In collaboration with the Worldwide Hospice Palliative Alliance, WHO published two Global Atlases of Palliative care, one in 2014, (414) and one in 2020 (415). A WHO global survey from 2021 found: • 43% of countries reported general palliative care availability (reaching at least 50% of patients in need) in a community-or home-based care setting, and 42% reported general availability in the primary care setting (416) • Services were much more likely to exist in high-income countries compared to LMICs (417)

WHA Resolution action item	Progress since 2014
19. To work with Member States to encourage adequate funding and improved co-operation for palliative care programmes and research initiatives, in particular in resource-poor countries, in line with the program budget 2014–2015, which addresses palliative care.	• There are 14 professional journals with a focus on palliative care (418). • By 2020, 141 of the 195 countries had published at least one palliative care paper, leaving 27.7% of countries (primarily LMICs) that have never published any palliative care related research (419). • A 2022 bibliometric analysis of published palliative care research found that minimal international co-operation occured across countries (420). • In the US and UK, palliative care research studies receive just 0.2% and 0.3% of all research funding, respectively (421). • There has been a significant increase in research and publications on children's palliative care in the past 10 years, including an increase in countries publishing research with the Cancer and Palliative Care Outcomes Centre (422).
20. To encourage research on models of palliative care that are effective in low-and middle-income countries, taking into consideration good practices.	• Between 2000 and 2020, India and China were the only LMICs in the top 15 most productive countries in palliative care research (423).
21. To report back to the Sixty-ninth World Health Assembly in 2016 on progress in the implementation of this resolution.	• In 2016, a brief report was published by the WHO Secretariat outlining some aspects of global palliative care progress since the WHA Resolution (424).



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