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Abstract

Background: There is a global agreement that palliative care should be universally accessible. However, in low- and middle-income countries and conflict zones, most people lack access to it. In the Eastern Mediterranean Region (EMR), no country has achieved integration of palliative care into its health care system, and only 4 countries have better-than-isolated palliative care provision.

Aims: To promote and guide palliative care improvement in the EMR, with case studies showing the successes and challenges of palliative care implementation from 4 countries in the Region.

Methods: We developed a structured, succinct, case-writing format and invited palliative care leaders in the EMR to use it to describe successes and challenges in palliative care implementation in their countries.

Results: Within the EMR, in addition to many challenges and needs, there are examples of successful palliative care policy development, community-based service creation, and paediatric palliative care implementation.

Conclusion: The experiences of the regional palliative care leaders documented in succinct, structured case studies, can help guide regional palliative care development in the EMR and other regions.

Keywords: Palliative care, EMR, integration, community-based service

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Introduction

World Health Assembly Resolution 67.19 expresses the unanimous conviction of the 194

Member States of the World Health Organization (WHO) that palliative care is “an ethical responsibility of health systems” and that universal access to palliative care is necessary for achievement of Universal Health Coverage (UHC) (1). There is global agreement that palliative care should be integrated with disease prevention and treatment and as an essential part of primary health care (2–5). The types of suffering and palliative care needs vary by geopolitical situation, socioeconomic condition and culture (6). In general, people in low- and middle-income countries (LMICs) and in conflict zones endure less healthy social conditions and have less access to disease prevention, diagnosis and treatment and to social support than people in high-income countries (HICs), and thus have greater palliative care needs. Yet, only a small minority of people in need of palliative care in LMICs have access to it (7, 8). None of the 22 countries of the Eastern Mediterranean Region (EMR) has achieved integration of palliative care into its healthcare system, and only 4 countries have better than isolated palliative care provision (7).

In 2019, an Eastern Mediterranean Region Palliative Care Expert Network (EMRPCN) was convened by the WHO Office for the Eastern Mediterranean (WHO/EMRO) in collaboration with the American University of Beirut Medical Center and Harvard Medical School with the long-term goal of developing strategies and pathways for integrating palliative care into the regional healthcare systems. There was agreement that the strategies should provide guidance on national palliative care policy development, accessibility of essential medicines including morphine, training of healthcare professionals in palliative care, implementation of palliative care services, and quality assurance (9). However, considering the large differences within the EMR in culture, economics and social stability, it was agreed that the strategies should remain general or contain different guidance for different cultural, economic or social conditions (10–12). Ideally, the strategies should be based upon studies of the types, severity, prevalence and duration of suffering in each country (8, 13) and informed by case reports of successes in palliative care integration. We present here such cases produced by EMRPCN.

Methods

Members of EMRPCN were invited to submit concise (750–1500 words) reports of specific palliative care models or innovations that were adapted to the needs of a specific population and to the country’s health system and potentially applicable elsewhere. Proposed topics included:

creation of laws, policies or regulations

financing

essential medicine accessibility, especially oral immediate-release morphine

education and training

implementation of clinical services

research / evidence building / measurement / quality improvement

community outreach and engagement of civil society

health system strengthening and promotion of UHC

Each writer was provided with a case-writing format and instructions adapted from those developed by the Case Writing Team of the Global Health Delivery Project at Harvard University (14). They were requested to tell the story of a palliative care model or innovation by responding briefly to a set of questions (Table 1). Submitted case reports were edited where necessary to conform to the prescribed structure and length.

Results

Full case reports were submitted by palliative care leaders from Egypt, Islamic Republic of Iran, Lebanon and Saudi Arabia (Table 2). One report addressed policy, 2 focused on community-based services, and 1 reported on paediatric palliative care.

Discussion

Access to palliative care is limited in LMICs worldwide (8,15) and in the EMR (7,16,17). Barriers to integration of palliative care into healthcare systems in the EMR include: absence of national policies on palliative care; lack of training and practice opportunities for physicians and other

healthcare professionals; inadequate staffing of existing palliative care services; lack of opioid analgesics; and lack of understanding of palliative care among policy-makers and the general public (10,15,16). Our case reports address several of these barriers and provide examples of methods to overcome these barriers.

Common barriers mentioned in the reports include lack: of national palliative care policy or strategy; of an official specialty in palliative care; of hospital and community-based palliative care programmes and community-based hospice programmes; of understanding of palliative care among healthcare providers and the public; of palliative care training for medical and nursing under- and post-graduates; and of opioid accessibility for patients in need.

While all 4 cases mentioned the necessity of government policies and regulations to enable implementation and scale-up of palliative care, the case from Lebanon focuses on 1 crucial policy: approval of an official medical specialty in palliative care. While most palliative care is provided by generalist clinicians and specialists in other disciplines, palliative care specialists are needed to serve as teachers, implementers, and leaders of palliative care departments and services (18). Recognition of palliative care as an official medical specialty and training accredited palliative care specialists, as has begun in Jordan and Saudi Arabia (18, 19), are critical and necessary steps in creating and scaling-up high-quality, sustainable palliative care training and services and obtaining health insurance coverage for these services. The case report from Lebanon provides an example of how determined and skilful advocacy can achieve this goal.

Two cases describe the inaccessibility of opioid analgesics due to overly restrictive regulations, lack of training in opioid therapy, or unjustified fear of opioids. While no cases specifically addressed strategies to overcome these barriers to palliative care, multiple case reports have been published by participants in the International Pain Policy Fellowship (20–25). Unfortunately, no countries from the EMR participated in this Fellowship. We propose creation of a similar 2-year fellowship to assist EMR countries to develop balanced national opioid policies using the International Pain Policy Fellowship as a model.

Three of the cases address the inseparability of palliative care service implementation and training in palliative care (26–28). Integration of sustainable, high-quality palliative care services into healthcare systems requires an enabling foundation in government policy as well as coordination of opioid accessibility and training, and establishment of clinical services (9). If opioids are made accessible before appropriate prescribing regulations and training, they may either expire on the shelf or be prescribed injudiciously. If training is provided before opioids are available and before there are places to practice, the training is wasted and the trainees may

become frustrated. If palliative care services are established before staff are trained and opioids are accessible, the quality of care may be poor.

In the EMR, as in other regions, most patients in need of palliative care are at home (3). For this reason, primary care physicians in the EMR have the potential to expand access to palliative care (29). Two cases have addressed integration of palliative care with primary health care as recommended by WHO (1, 2) and the importance of cultivating political support for palliative care integration.

The case from the Islamic Republic of Iran demonstrates the benefits of having a strong palliative care advocate within ministries of health to coordinate the key aspects of palliative care implementation. Based on government policy to enable palliative home care, the Nursing Deputy of the Iranian Ministry of Health and Medical Education led development of continuing nursing education courses in palliative and home care, and then advocated successfully for this training to be required for homecare nurses. The case from Saudi Arabia also indicates the importance of strong palliative care leadership within major medical centres. Based on government policy and the recognition that most palliative care needs are in the community, a palliative care leader at a major medical centre arranged to pilot integration of palliative care into primary care at an affiliated primary care centre, intensively trained family physicians in palliative care at the centre, and provided ongoing mentorship and supervision. This model of following training courses with long-term mentoring is more likely to improve trainees' behaviour than training without follow-up (30). The cases also demonstrate the crucial relationship between primary care providers who provide basic palliative care in the community and palliative care specialists in referral hospitals who can provide clinical mentoring and case consultation and receive transfers of patients with complex problems.

Conclusion

Structured case studies such as those described in this paper can provide important guidance for healthcare planners and managers. Given that palliative care needs vary by location, culture, and socioeconomic and clinical environments, we propose that easily accessible libraries of case studies be made available in the EMR and other regions around the world.

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WHO EMRO | Palliative care models and innovations in 4 Eastern Mediterranean Region countries: a cas

Modèles de soins palliatifs et innovations en la matière dans quatre pays de la Région de la Méditerranée orientale : étude de cas

Résumé

Contexte : Il existe un accord mondial sur le fait que les soins palliatifs devraient être universellement accessibles. Cependant, dans les pays à revenu faible et intermédiaire et les zones de conflit, la plupart des personnes n'y ont pas accès. Dans la Région de la Méditerranée orientale, aucun pays n'est parvenu à intégrer les soins palliatifs dans son système de soins de santé, et seuls quatre pays disposent d'une offre de soins palliatifs qui sont en voie d'intégration.

Objectifs : Promouvoir et guider l'amélioration des soins palliatifs dans la Région de la Méditerranée orientale, par le biais d'études de cas montrant les succès et les défis de la mise en œuvre des soins palliatifs dans quatre pays de la Région.

Méthodes : Nous avons mis au point un modèle de rédaction de cas structuré et succinct, et nous avons invité les responsables des soins palliatifs dans la Région de la Méditerranée orientale à s'en servir pour décrire les succès et les défis de la mise en œuvre de ces soins dans leurs pays.

Résultats : Dans la Région de la Méditerranée orientale, outre les nombreux défis et besoins, il existe des exemples de réussite concernant l'élaboration de politiques en matière de soins palliatifs, la mise en place de services communautaires et la mise en œuvre des soins palliatifs pédiatriques.

Conclusion : Les expériences réalisées par les responsables régionaux des soins palliatifs, qui sont documentées dans des études de cas structurées succintes, permettent de guider la mise en place des soins palliatifs au niveau régional.

نماذج الرعاية الملطِّفة وأوجه الارتقاء بها في أربعة بلدان بإقليم شرق المتوسط: دراسة حالة

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