The development of outpatient palliative care in Ukraine: The role of non-governmental and charitable organizations

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Original Article

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Abstract:

This study presents a retrospective evaluation of outpatient palliative care delivered by the "SVOI" Charitable Foundation in Ukraine from 2019 to 2025. Against the backdrop of health system reforms and wartime disruptions, the study highlights the critical role of non-governmental actors in providing decentralized, multidisciplinary support to patients with life-limiting conditions. The research focuses on service volume, patient demographics, diagnoses, and types of support provided.

Methods: a total of 4661 anonymized patient records were analyzed using descriptive statistics. Data covered gender, age, diagnosis, and forms of care - medical consultations, psychological support, household assistance, oxygen therapy, and supplies. Services were provided both through home visits (Kyiv and Kyiv region) and remote consultations across Ukraine.

Results: patients were predominantly older adults (mean age 69,7), with 74,6 % over age 66. Although cancer was the most frequent diagnosis (31,8%), nearly half of patients had non-oncological conditions, including COPD, dementia, and neurodegenerative diseases. Pain was underreported, especially in dementia cases. Household support was mostly provided to those aged 76+, while psychological services were concentrated among oncology patients. Regional coverage was skewed toward Kyiv, but remote demand grew annually.

Conclusion: outpatient palliative care in Ukraine remains unevenly distributed, with psychosocial and geriatric needs often unmet. NGO-led models have proven effective and adaptable but require formal recognition, sustainable funding, and integration with state servises. Expanding mobile teams, improving pain assessment (especially in non-verbal patients), and scaling telemedicine could help ensure equitable access and continuity of palliative care in both peacetime and crisis settings.

Introduction

Palliative care is increasingly conceptualized as a paradigmatic innovation within global health and social policy frameworks. The contemporary model incorporates four interrelated domains: 1) clinical management of symptoms, 2) psycho-emotional and spiritual support, 3) caregiver and family assistance, and 4) bereavement care. International health governance standards now explicitly recognize access to palliative and hospice care as a core human right. Ensuring universal, equitable access irrespective of socioeconomic status, ethnicity, or geographic context is a normative imperative. Furthermore, timely availability must be assured across all points of care, without imposing prohibitive financial burdens—especially upon socioeconomically vulnerable populations (Tománek, Radková, Buzalová, 2024; Barkasi, Kenderešová, 2021, 2023).

In Ukraine, the institutional maturation of palliative care has accelerated over the past decade, underpinned by a series of legal enactments and regulatory frameworks. Key instruments include the Law of Ukraine "Fundamentals of Health Legislation" (1992, No. 2801-XII) and its amendments (2011, 2020, 2022) [1]; the Law of Ukraine "On State Financial Guarantees of Medical Services to the Population" (2017, No. 2168-VIII) [2]; and the Law of Ukraine "On Social Services" (2019, No. 2671-VIII, revised in 2024) [3]. Implementation is further structured by executive directives from the Cabinet of Ministers of Ukraine and ministerial orders from both the Ministry of Health of Ukraine (MOHU) and the Ministry of Social Policy. Buzalová et al. (2024, 2025) confirmed

In 2020, the National Health Service of Ukraine formally incorporated palliative care into the Medical Guarantees Program, enabling reimbursement for essential services and medications through public funds. This policy shift was operationalized through a revised national protocol for palliative care provision (MOHU Order No. 1302, July 4, 2022) [4], subsequently modified by MOHU Order No. 2216 (December 27,

2023) [5] and expanded in scope by MOHU Order No. 1853 (November 4, 2024), which broadened patient eligibility criteria in line with ICD-10 guidelines [6].

Despite these reforms, significant systemic disparities persist. These include regional inequities in service access, insufficient interdisciplinary workforce capacity, and fragmented cooperation between healthcare and social sectors. Similar structural gaps have been observed in post-pandemic Slovakia and Czechia, where poverty, demographic aging, and weakened social support systems have intensified the need for holistic models of long-term and palliative care (comapre studies by Radkova et al. 2022, 2024; Ludvigh Cintulová et al., 2022; Ludvigh Cintulová et al., 2024; Buzalová et al., 2025, Makan et al. 2023).

At the international level, palliative care is firmly situated within the framework of Universal Health Coverage (UHC) and is upheld as a fundamental human right (WHO, 2018) [7]. Within the international framework of Universal Health Coverage (WHO, 2018), the **European Association for Palliative Care (EAPC)** underscores the importance of integrating palliative services at all system levels through evidence-based, interdisciplinary collaboration [8]. This is reflected in the Vincentian tradition of person-centered care (Hamarová et al., 2024a,b), emphasizing dignity and spiritual accompaniment in hospital and community settings (Noga, 2024).

Within the context of armed conflict, the exigency for decentralized and mobile palliative care services in Ukraine has become markedly pronounced. Wartime destruction of healthcare infrastructure, mass displacement, and cumulative psychological trauma have significantly heightened demand for localized, home-based interventions. In this environment, non-governmental and charitable organizations have emerged as indispensable providers of not only clinical care, but also psychosocial and logistical support. One illustrative example is the "SVOI" Charitable Foundation, which since 2019 has delivered outpatient services in Kyiv and surrounding regions, while maintaining nationwide remote outreach capacity. Their multidisciplinary model reflects integrated medical, psychological, and social support—paralleling broader trends in frontline psychosocial services (Murgová et al., 2022; Judák et al., 2022; Noga, Kenderešová, Jurašek, 2025).

This investigation aims to systematically analyze operational data from the "SVOI" Foundation spanning 2019–2025, with attention to service volumes, typological patterns, and longitudinal dynamics. The study offers an empirical basis for evaluating current trends in outpatient palliative care and contextualizes the evolving role of third-sector actors within Ukraine's palliative care landscape (Tomanek et al., 2024). By situating this analysis within broader Central and Eastern European experiences—such as therapeutic support for persons with disabilities (Radková, Buzalová, Kenderešová, 2024), the impact of caregiver burnout (Buzalova, Vansač, Tománek, 2024), and minority care challenges (Buzalová et al., 2025)—this work contributes to a richer understanding of the evolving role of civil society and social workers in palliative ecosystems.

Moreover, the integration of spiritual and psychosocial accompaniment has emerged as a vital component of effective palliative strategies, particularly post-COVID-19 (Králik et al., 2023; Hamarova et al. (2024a, 2024b). The involvement of trained volunteers, often operating in emotionally and logistically complex situations such as refugee care or border crises (Radková et al., 2022; Kenderešová 2017, Kenderešová 2021), demonstrates the depth of civil resilience and the value of culturally and spiritually competent care (Barkasi, Noga, 2024; Kobylarek et al., 2022).

Methodology

This research is based on a retrospective analysis of empirical data collected by the "SVOI" Charitable Foundation between January 2019 and March 2025. The foundation maintains an internal registry of patients who received outpatient palliative care from mobile teams operating in Kyiv and the Kyiv region. In other regions of Ukraine, patients were supported remotely via teleconsultations and distance-based care delivery.

The dataset comprises demographic variables (gender, year of birth), primary diagnoses, disability status, and categories of services provided, including medical consultations, psychological support, oxygen therapy, provision of consumables, pain management, and household assistance. In total, the sample includes 4,661 patients who received at least one outpatient intervention during the study period.

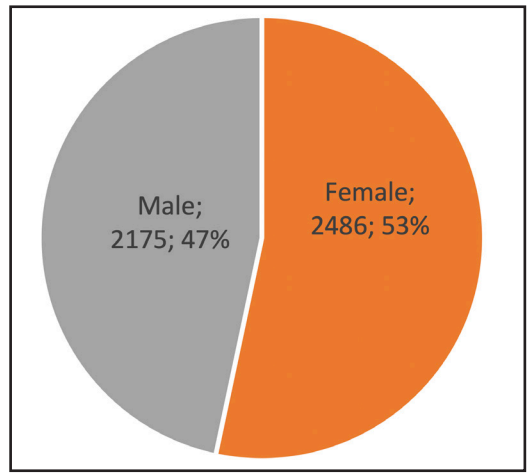
Descriptive statistical analysis was conducted using Microsoft Excel. Age was calculated based on year of birth, and diagnoses were aggregated into broader categories (e.g., oncological diseases, chronic obstructive pulmonary disease [COPD], dementia) to facilitate analytical generalization. All data were anonymized prior to analysis.

Given that the study utilized de-identified internal records without any direct patient contact or identifiable information, formal approval from an ethics review board was not required.

Results

Between 2019 and 2025, the "SVOI" Charitable Foundation provided outpatient palliative care services to a total of 4661 patients, of whom 53,3% were female (n = 2486) and 46,7% were male (n = 2175) (Figure 1).

Figure 1 Gender Distribution of Patients (N = 4661)



The mean age across the cohort was 69,7 years. The largest demographic segment fell within the 66-86+ age range, constituting 74,6 % of the total sample (Figure 2), consistent with prevailing epidemiological profiles of patients requiring long-term palliative support.

Figure 2 Age Distribution of Patients

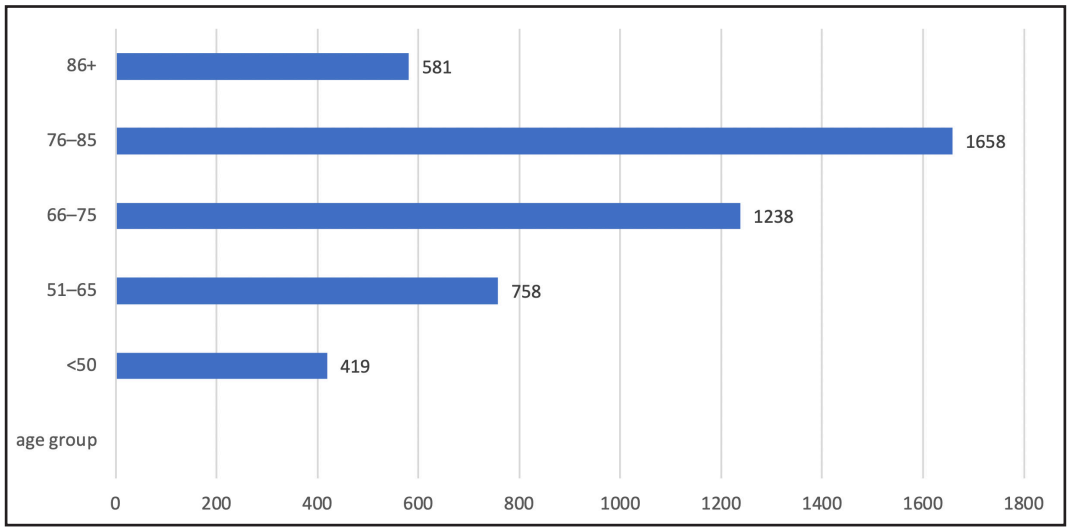
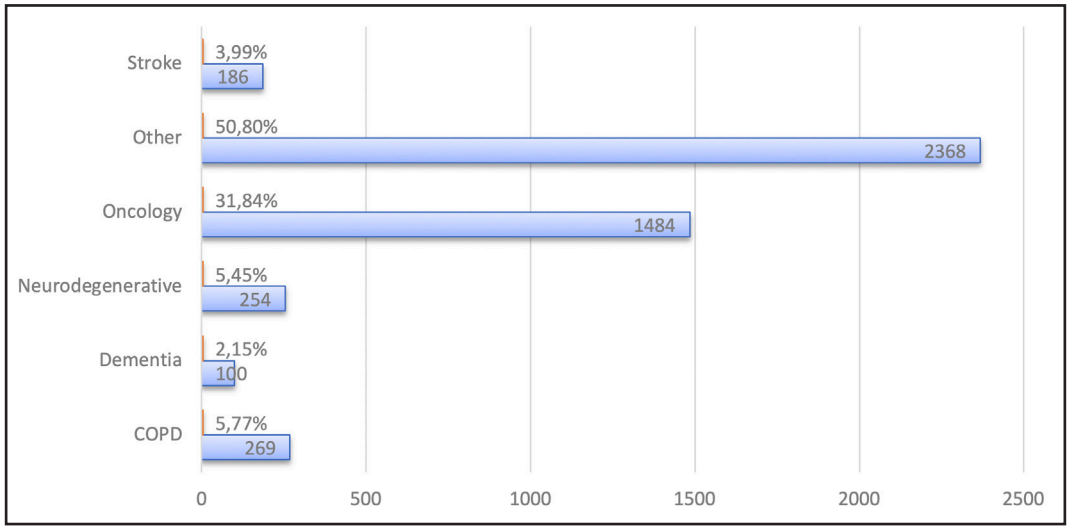


Figure 3 Distribution of Primary Diagnoses



Diagnoses and Pain Syndromes

Among patients with recorded diagnostic data, malignant neoplasms represented the most prevalent pathology (n = 1484), followed by chronic obstructive pulmonary disease (COPD; n = 269), dementia (n = 176), cerebrovascular accident (stroke; n = 119), and congestive heart failure (n = 115) (Figure 3). A substantial proportion of cases (48,9%) were classified under the "other" category, reflecting the clinical heterogeneity characteristic of advanced-stage chronic conditions within palliative populations.

Chronic pain syndromes were documented in 5,2% of oncology patients, in approximately 3% of individuals diagnosed with diabetes mellitus, and in less than 1% of patients with COPD, stroke, or amyotrophic lateral sclerosis (ALS). Notably, no cases of chronic pain were recorded among patients with dementia, which may suggest underreporting or diagnostic challenges associated with cognitive and communicative impairments in this subgroup (Table 1).

Types of Support and Associations with Age and Diagnosis

The most frequently provided forms of assistance included:

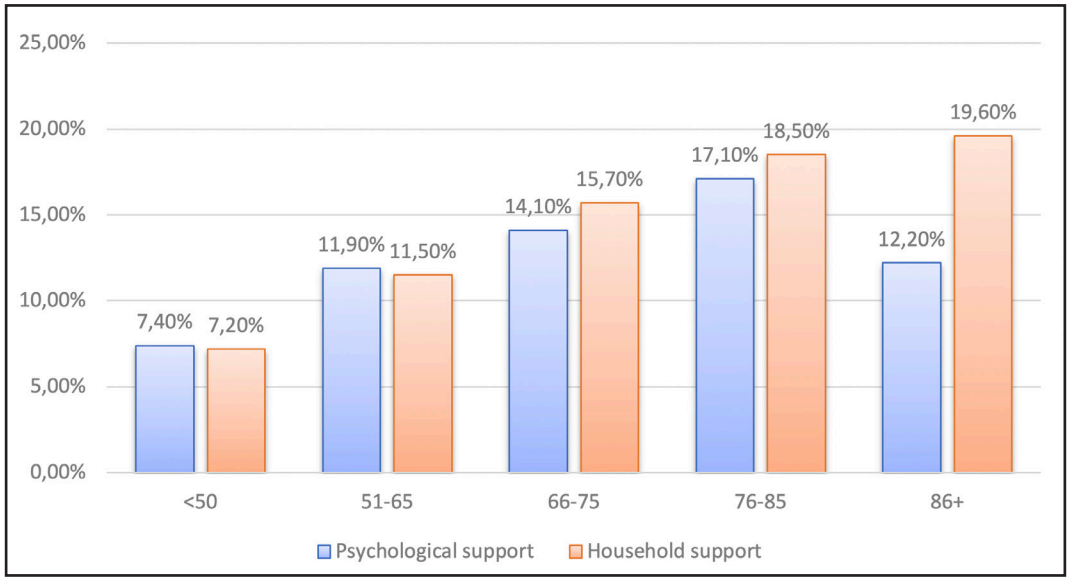
- provision of consumable medical supplies (n = 3059),
- medical consultations (n = 2436),
- psychological support (n = 1341),
- household assistance (n = 1099),
- oxygen therapy (n = 668).

Disaggregated analysis revealed significant correlations. Psychological support was most frequently provided to oncology patients (over

Table 1 Pain by Diagnosis Group

Diagnosis group	Pain Present	Pain Absent	Total Pacients	Pain %
Other	69	2299	2368	2,91%
Oncology	77	1407	1484	5,19%
COPD	1	268	269	0,37%
Neurodegenerative	2	252	254	0,79%
Stroke	1	185	186	0,54%
Dementia	0	100	100	0,00%

Figure 4 Psychological and household support by age group



35%), whereas the proportion was minimal among patients with dementia. Household assistance was most commonly delivered to individuals aged 76-85 years (35,7%) and those aged 86 and older (31,4%), indicating a strong relationship between functional decline and the need for non-medical support services (Figure 4).

Age was also a determinant in the type of assistance received: patients receiving oxygen support had a lower mean age (64,3 years), whereas those requiring consumable supplies were older (mean age 71,3 years), suggesting different trajectories of disease burden across age cohorts (Table 2).

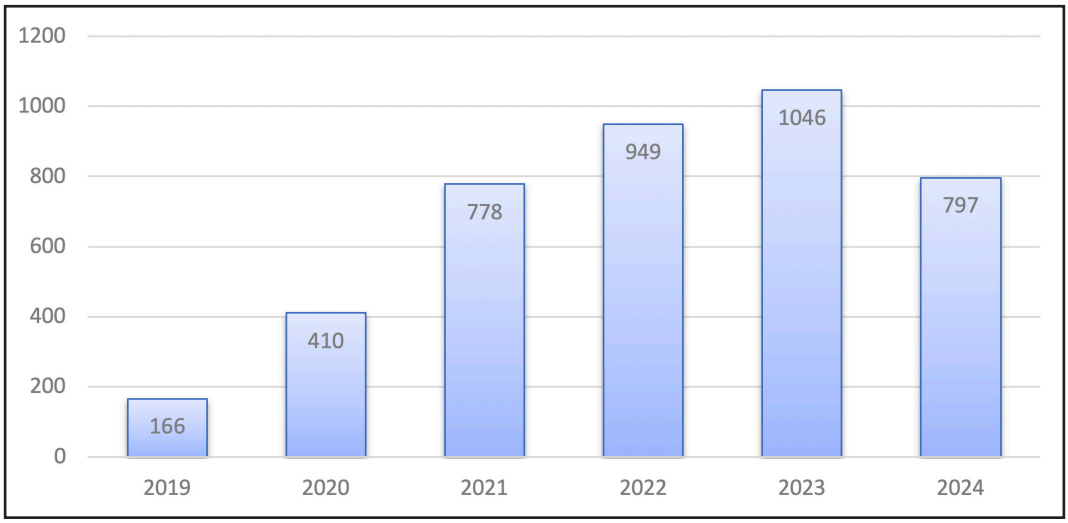
Regional and Temporal Trends

The highest concentration of patients was recorded in Kyiv (n = 2841) and the Kyiv region (n = 610), while other regions were served primarily through remote consultation and support services. The annual patient count demonstrated steady growth - from 166 in 2019 to a peak of 1046 in 2023 - followed by a moderate stabilization in 2024 (n = 797) (Figure 5). Notably, in the first quarter of 2025 alone, the number of patients had already reached 515, which constitutes over 64% of the total for the entire year of 2024.

Table 2 Summary by Diagnosis Group

Diagnosis group	Total Patients	Pain %	Oxygen %	Psych Support %	Household Support %
COPD	269	0,4	58,7	5,2	7,1
Dementia	100	0	4	13	20
Neurodegenerative	254	0,8	19,7	32,3	38,6
Oncology	1484	5,2	16,5	16,3	17,1
Other	2368	2,9	26,3	11,3	12,9
Stroke	186	0,5	9,7	17,2	20,4

Figure 5 Annual number of pacient served



Discussion

This retrospective analysis of 4661 patients who received outpatient palliative care from the "SVOI" Charitable Foundation between 2019 and 2025 highlights several significant trends with implications for community-level healthcare and social protection. First, the data confirm the predominance of older adults in the structure of home-based palliative care, with a mean age of 69,7 years and nearly 74,6 % of patients over the age of 65 (Figure 2). This pattern aligns with global trends, wherein population aging constitutes a major driver of increased palliative care needs. The gender distribution (53,3% female, 46,7% male) corresponds to the broader demographic trend of greater longevity among women (Figure 1).

Importantly, the cohort demonstrated marked diagnostic diversity: while cancer remained the leading cause for referral (n = 1484), nearly half of the patients had alternative diagnoses. This supports the contemporary paradigm shift in palliative eligibility, expanding beyond oncology to include conditions such as COPD, dementia, and heart failure.

In the subgroup of patients with dementia, no documented cases of chronic pain were reported (Table 1). A notable observation was the association between pain and oxygen therapy: patients with documented pain were twice as likely to receive oxygen (6,3%) compared to those without pain (2,4%) (Table 2), suggesting an integrated approach to symptom management.

The provision of psychological support ap-

Table 3 Support by diagnosis

Diagnosis group	Total Patients	Pain Cases	Oxygen Cases	Psychology Support	Household Support
COPD	269	1	158	14	19
Dementia	100	0	4	13	20
Neurodegenerative	254	2	50	82	98
Oncology	1484	77	245	242	254
Other	2368	69	623	268	306
Stroke	186	1	18	32	38
Total	**4661**	**150**	**1098**	**651**	**735**

Table 4 Support by age

Age group	Total Patients	Psychological Support	Psychological Support %	Household Suppor	Household Suppor %
<50	419	31	7,4	30	7,2
51–65	758	90	11,9	87	11,5
66–75	1238	174	14,1	194	15,7
76–85	1658	284	17,1	307	18,5
86+	581	71	12,2	114	19,6

peared highly dependent on diagnosis. It was most frequently administered to patients with cancer, whereas those with dementia were rarely recipients (Table 3). Given the heightened emotional and psychological burden on both patients and caregivers in neurodegenerative conditions, this discrepancy warrants critical attention.

Household assistance was predominantly provided to the oldest age cohorts (Table 4), emphasizing the urgent need for structured home care support, particularly for individuals aged 75 and older. These findings underline the necessity of reinforcing the social component of palliative services and fostering interagency collaboration between healthcare institutions and social protection entities.

Another noteworthy aspect concerns the age profile of home-based palliative care recipients: patients who received oxygen support were typically younger (mean age 64,3 years), while those receiving consumable supplies and psychological support were generally older (mean age over 71 years). This suggests distinct clinical trajectories - namely, respiratory insufficiency among younger cohorts and conditions such as cancer or dementia in the elderly (Kralik et al., 2022).

The regional analysis confirmed that although Kyiv accounted for the majority of patients (n = 2841), demand from other regions has been steadily increasing. The annual growth in patient numbers, peaking in 2023 (n = 1046) (Figure 5), reflects both trust in mobile care services and the relevance of scaling such interventions. The temporary decline in coverage observed in 2024 was likely due to the need to optimize service delivery, avoid overextension of mobile team capacity, and concentrate efforts within Kyiv and the Kyiv region.

Taken together, these findings highlight the need for palliative care to be age- and symptom-sensitive, as well as socially integrated. The involvement of NGOs such as the "SVOI" Charitable Foundation emerges both as a strength and a challenge: while such care models offer flexibility, they require sustainable funding, professional training, and formal state recognition (Mlynarčík 2017, 2022, 2024).

The delivery of high-quality palliative care in Ukraine is gradually evolving. Faced with suffering, pain, the fear of death, and existential despair, the role of the multidisciplinary team becomes crucial - where the compassion, professionalism, and presence of physicians, nurses, and social workers are paramount. One can affirm that mercy remains the cornerstone of care for terminally ill and dying patients. Compassion, respect, and love are among the most powerful forms of care, and when coupled with clinical expertise, they offer the most meaningful hope for upholding dignity at the end of life. "While we may not be able to add more days to the patient's life, we can add more life to their remaining days." Though we cannot cure our patients, we can help them live their final days with dignity, free from pain and suffering, and accompany them on their final journey through life. The urgent need for structured home care support, particularly for individuals aged 75 and older. These findings underline the necessity of reinforcing the social component of palliative services and fostering interagency collaboration between healthcare institutions and social protection entities.

Conclusion

The global trend of rapid population aging, including in Ukraine, has led to a rising prev-

alence of severe, often incurable age-related chronic illnesses, thereby increasing the need for palliative and hospice care. Findings from our retrospective study, which included 4661 patients receiving outpatient palliative care from the "SVOI" Charitable Foundation between 2019 and 2025, confirm that elderly individuals are the primary recipients of such care, with a mean patient age of 69,7 years and more than 74,6 % aged over 65+.

1. This underscores the need to develop integrated, geriatric-oriented palliative care models that address the physical, cognitive, and social vulnerabilities of the aging population.

2. The core objectives of palliative care - relief from pain and distressing symptoms, and provision of psychosocial and spiritual support - can only be achieved through multidisciplinary teams. Our findings show that only 31,8% of patients had a cancer diagnosis, while 48,9% suffered from COPD, dementia, heart failure, and neurodegenerative conditions (comp. Dávidová, Hardy, 2024). This distribution supports the updated eligibility criteria for palliative care established by the Ministry of Health of Ukraine chronic pain syndrome was documented in only 5.2% of oncology patients and in none of the patients with dementia. Despite the availability of tools for pain assessment in non-verbal patients, such as PAINAD and the Abbey Pain Scale, their use remains limited in outpatient settings. We recommend the mandatory implementation of these tools in home-based palliative care for patients with dementia, along with proper staff training (Kralik et al., 2023a; Kralik et al., 2023b; Petrovic et al., 2024; Jackulíková et al., 2021).

3. The type of support provided was significantly influenced by patient age and diagnosis. Oxygen therapy was more common among younger patients (mean age 64.3 years), likely due to COPD and respiratory failure; household assistance was most frequent among those aged 75 and older, indicating dependency and care needs; psychological support reached 35% of cancer patients but was almost absent among those with dementia. These disparities suggest the need for a more equitable allocation of psychosocial and supportive care resources, regardless of diagnosis (Horáčková et al., 2022; Šupolová et al., 2024; Laca et al., 2024; Poloňová et al., 2022).

4. Non-governmental and charitable organizations have substantially supported healthcare and social service institutions in Kyiv by supplying transdermal fentanyl patches, respiratory devices, and electric generators—critical resources amidst wartime budget constraints. The year-over-year growth in patients served by the *SVOI* Charitable Foundation, from 166 in 2019 to 1046 in 2023, demonstrates strong demand and the effectiveness of the mobile palliative care model. However, 84% of all patients resided in Kyiv and the surrounding region, indicating geographic disparities in access. (Trnková, 2025; Pavlíková et al., 2023). This highlights the urgent need to expand regional mobile palliative teams, including the use of telemedicine technologies. Compared studies by Budayová et al. (2024) and Budayová et al. (2023) indicate external factors such as digital accessibility and psycho-social support improve the quality of life for older people, while also pointing to the risk of burnout among social workers involved in palliative care (Budayová et al., 2023; Budayová et al., 2024; Ludvigh Cintulová & Buzalová, 2024).

5. The role of NGOs and charitable foundations has become increasingly vital under martial law, as public funding remains severely constrained. These actors have proven the efficacy of integrated, multidisciplinary, and cross-sectoral approaches. However, the sustainability of such models depends on investments from both the state and local communities to train and equip mobile multidisciplinary palliative teams, ensuring that outpatient palliative care in Ukraine evolves into an accessible and comprehensive system (Ludvigh Cintulová & Kafková, 2020; Shyshak et al., 2024; Kobylarek et al., 2023). These findings underline the necessity of reinforcing the social component of palliative services and fostering interagency collaboration between healthcare institutions and social protection entities (Budayová & Ludvigh Cintulová, 2025; Murgová et al., 2022; Barkasi & Bárta, 2024).

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