

WHO Lunchtime Talk

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I have been asked to speak about IAHPC's global palliative care advocacy work, so will try to do that in ten minutes! IAHPC's vision is universal access to high-quality palliative care, integrated into all levels of healthcare systems in a continuum of prevention, diagnosis, treatment, and rehabilitation, to ensure that any patient's or caregiver's suffering is relieved to the greatest extent possible. To this end, one of our programs provides traveling scholarships to palliative care workers in low and middle-income countries to help them develop their skillsets in these areas and connect with other professionals.

We do this because our members and our donors are convinced that when governments systematically relieve suffering by integrating palliative care into primary health care, they renew the face of public health and social care systems. It is important not to think of palliative care as an added cost and burden, but as an added *benefit* and strengthener for health systems. The fact that studies now show that integrating palliative care *saves* health systems and institutions money by reducing expensive hospitalisations and futile treatments – should be seen not as an incentive to add it, but as a fringe benefit. Until now, palliative care has been the missing element of the UHC continuum, thereby exponentially increasing serious health related suffering.

Because the *quality* of integration is paramount, IAHPC provides partners with technical guidance and expertise on access to medicines, education, research, and service delivery. We facilitate collaborations through real time meetings and electronic platforms. The IAHPC Advocacy Program is anchored in these programs and functions as a bridge between all stakeholders, including the WHO and its member states. We convene advocacy and opioid availability workshops around the world on the request of national palliative care associations, to educate partners about the global context and state of play regarding international narcotics control and human rights law.

Integrating palliative care requires specific attention to workforce development and narcotics control policy in particular, as it involves the use of medications listed in the schedules of the three international drug conventions. These medications are still unavailable to at least 70% of the world's patients who need them, largely as a result of stigma and fear of punishment associated with strict traditional drug control laws. In order to increase access, we have to improve prescriber and pharmacist training.

We support the Secretariat's collaboration with the UN Office of Drugs and Crime and the International Narcotics Control Board in Vienna in the effort to train ministry staff to draft and implement balanced drug policies. The opioid overdose crisis in a few high-income countries is once again tipping the scale toward policies that restrict legitimate availability for patients in the vast majority of low and middle-income countries. These countries don't call any funding shots at WHO, and desperately need technical support from Headquarters and Country Offices. IAHPC is working with our partners in member states to remind their governments that there is not just one "opioid overdose crisis" in

high-income countries, but an opioid medications *absence* crisis in the majority of lower and middle income countries.

We are co-sponsoring a ministerial level side event with the International Narcotics Control Board on controlled medicines, led by the government of Ecuador, at the Commission on Narcotic Drugs meeting in March. It will be very important for Dr. Tedros to attend this event, with his counterpart Mr. Yuri Fedetov, and INCB President, Dr. Viroj Sumyai. Civil society speakers will present the findings of the Lancet Commission on Palliative Care and Pain Relief, as well as reports from the front in Sudan and Latin America.

IAHPC is particularly pleased to have participated in an innovative joint program with the Service Delivery and Safety Program last year, teaching our members to write evidence based policy briefs. Participants were from all WHO regions, and we were able to train two entire clinical cohorts in skills that are the basis of advocacy and policymaking. We are slowly consolidating these cohorts into a new community of practice, and have requested the colleagues at Service Delivery and Safety to help with by providing some staff and intern time. The policy briefs and short videos produced are on our website.

We were happy that WHO Expert Committee on Drug Dependence provided space for our presentation of evidence about the importance of keeping tramadol out of any schedule of the drug control conventions. The public hearing preceding the ECDD meeting allowed for the voices of palliative care providers to be heard, gave us the opportunity to present a survey of members who regularly prescribe tramadol, given the *unavailability* of morphine, an internationally controlled essential medicine on the WHO Model List.

Fortunately, the Committee was convinced by evidence based argumentation from providers, who agreed with IAHPC experts that placing tramadol under international control would deepen the abyss in access to internationally controlled essential medicines, leaving millions *more* patients around the world with no access to adequate pain relief.

Along with suggesting that ECDD ensure that a palliative care expert is routinely included in the Committee, we are requesting that the Secretariat change the name of the Expert Committee on Drug Dependence to conform with WHO's own language guidelines. These opt for precise and neutral language, a standard the word 'drug' does not meet. It is a word that often arouses fear and prejudice in providers and patients with no knowledge of the benefits of medical opioids prescribed and dispensed by properly trained professionals. This historically entrenched fear of 'drugs' constitutes a formidable barrier to improving global access to opioids used for medical purposes. The very name "Expert Committee on Drug *Dependence*" reinforces this barrier to the balanced policies called for in the UNGASS, Astana, and Agenda 20130 normative frameworks.

As you well know, approved WHA resolutions such as that on palliative care, and even national policies developed on the basis of those resolutions, do not automatically result in fully funded implementation. We know from our key informants that providers and some governments are making progress developing palliative care and implementing the resolutions, but we still lack systematic reporting based on standardized indicators. This is an area we need to refine in coordination with our focal points at WHO.

It will help our advocacy to learn from *you* how to request that palliative care integration be included in the Country Collaboration Strategies and how we can encourage Country Offices to work with palliative care associations on the ground. (Give example of Georgia).

In closing, we have a lot of work ahead if we are to help countries make good on their commitments to the SDGs and the 2018 Declaration of Astana, which now, thanks to the Secretariat's open consultation, includes palliative care as an integral part of primary health care.

We are rolling up our sleeves and doing this work along with our partners and focal points at WHO, so look for us at the EB meeting, and please review our Advocacy Note.