It Takes a Pandemic
73rd World Health Organization Report
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A Virtual Assembly

The 73rd World Health Assembly was like none I have ever attended. For one thing, I attended virtually as a registered IAHPC delegate, rather than traveling to Geneva in person as I usually do. I joined heads of state, health ministers, civil society organizations and reporters around the world to watching the livestream from all the WHO member states, interpreted into all five UN languages and orchestrated masterfully by the staff at WHO Headquarters in Geneva, from my own home office. Rather than convening live in the impressive Salle des Assemblées in Geneva's Palais de Nations, and hobnobbing in the delegates dining room, the dignitaries all appeared on one another's personal screens, and even unanimously approved a key resolution entitled "COVID response." We did feel a loss, though, because for the first time, accredited civil society organizations were not given any airtime to present our submissions to the Assembly. At least we could upload written statements though, and ours is here.

Zambia and Bangladesh to the rescue. Thanks to the insistence of skilled negotiators from the permanent missions of Zambia and Bangladesh, delegations agreed to include "palliative care" in the resolution, along with safe testing and treatment, since it had been left out of the original (zero draft) proposed by the EU. Operative Paragraph 7.7, agreed by consensus, now instructs all WHO member to

> *Provide access to safe testing, treatment, **and palliative care** for COVID-19, paying particular attention to the protection of those with pre-existing health conditions, older persons, and other people at risk, in particular health professionals, health workers and other relevant frontline workers;*

This "agreed language" – agreed by consensus -- gives national, regional, and international palliative care associations more leverage with their governments to request ramped up service development now and for preparedness planning. Dr. Frances Bwalya, representative of the Permanent Mission of Zambia, who advocated for the inclusion of palliative care in the resolution, stated "we are duty bound to protect the interests of silent voices, those that cannot speak for themselves." It would be hard to find a more eloquent statement in defense of palliative care.

Since the UN has recognized palliative care as an essential service in the continuum of primary health care and universal health coverage (UHC), member states have no excuse for leaving it

out, particularly during a pandemic that is causing such acute suffering and distress. Surprisingly, the EU *opposed* the inclusion of palliative care language into what was originally their resolution. The final version of the consensus resolution recognized access to a COVID related vaccine as a "global public good" and called for an investigation of WHO's pandemic response.

The speeches of heads of state in the unprecedented "High Level Segment" (usually only health ministers attend WHA and give national statements on specific agenda items) reinforced the need for increased solidarity and multilateralism in the face of export bans of essential medicines and equipment, and attacks on WHO by a few member states. The otherwise predictable national statements focused almost exclusively on saving lives, which of course is important, but incomplete without palliative care, *which no member state mentioned*. Indeed, Dr Tedros reiterated in his closing speech that "our [WHO's] focus *is on saving lives*."

And IAHPC reiterates that, as the 67th World Health Assembly declared in 2014, patients whose lives *cannot* be saved, and their families, need basic palliative care. Moreover, WHO has published a Guide for Integrating palliative care and symptom relief into responses to humanitarian emergencies and crises. Of all the speakers at the Assembly, only the Order of Malta, a faith-based organization with observer status reported attending to the "terminally ill" along with the disabled, refugees, etc. These populations were notably missing from the official speeches, although they are the hardest hit by the pandemic.

The 147th Executive Board (EB) meeting of the WHO followed the World Health Assembly, and focused largely on procedural matters. Palliative care Associations in member states elected to the EB Member have a particularly good opportunity for advocacy. The IAHPC team is standing by to assist our members in countries represented at all UN treaty bodies. The terms of member states elected to the Board by this World Health Assembly are listed in the document link above and begin with the year "2020."

The fact that India will chair the EB could be interesting since the issue of access to medicines is always a hot one at the WHA. Indian manufacturing and raw materials, including for controlled medicines and opioids, are key links in the complex global medicines supply chain. COVID-related shutdowns and transportation issues have compromised supplies from India, resulting in medicine shortages even for High Income Countries, which are now running out of buffer stocks. As WHO member states re-examine their dependence on China and India for essential medicines, there is more policy "buzz" around strengthening regional pharmaceutical manufacturing and domestic cultivation of raw materials.

Indeed, the Ambassador for the Russian Federation told me at the last meeting of the Commission on Narcotic Drugs that his country was planning to grow poppy and manufacture its own opioids, an option legally open to states parties of the 1961 Single Convention on Narcotic Drugs provided the International Narcotics Control Board approves. IAHPC is staying tuned re this development and will keep you informed. For those of you who may not have

seen it, we published this article in the Journal of Pain and Symptom Management about COVID related medicines shortages.

The Next Steps: Education, Relationship Building, and Advocacy

IAHPC can facilitate the necessary collaborations between national palliative care associations and WHO to implement the resolution's palliative care mandate. Non-state actor status gives us the privilege to consult with the Secretariat and participate in meetings of member states (unless specifically restricted) as an officially registered delegation. Our 2020 delegation represented the palliative care associations of our six target countries. It included Kate Reed Cox, NP of Australia; Farzana Khan and Rumana Dowla, MDs from Bangladesh; Dr. Marvin Colorado from El Salvador; Dr. Zipporah Ali from Kenya, Dr. Abidan Chansa from Zambia, and Dr. Nisla Camano from Panama, for the Latin American Palliative Care Association. Once of their delegation "duties" was to forward the IAHPC written submission to the World Health Assembly to their health ministries and permanent missions in Geneva. They will follow up from their respective capitals and report back.

A practical advocacy "ask" for national associations is to request that, if their government is involved in the WHO evaluation required by the resolution, they ask why the original WHO Clinical Treatment Guideline published at the start of the pandemic *failed to include palliative care.* Although we are happy that the updated Guideline includes a palliative care module, this is a "response" issue to flag by civil society organizations holding their governments accountable for the work of UN organizations such as the WHO. In addition, advocates can leverage the palliative care language in the resolution by offering to help their health ministries train the human resources and build the palliative care services they need *alongside* the services for prevention and treatment of COVID19. They could suggest that their governments request the WHO Secretariat to provide a monitoring and evaluation framework with milestones. One of these could require integration of the Lancet Commission on Palliative Care's Essential Package, which can be adapted to the income level of the country (High, Middle, Lower, etc.).

Intervention: Essential Package

Medicines
Amitriptyline
Bisacodyl (Senna)
Dexamethasone
Diazepam
Diphenhydramine (chlorpheniramine, cyclizine, or dimenhydrinate, oral and injectable)
Fluconazole
Fluoxetine or other SSRI (sertraline and citalopram)
Furosamide
Hyoscine Butylbromide
Haloperidol
Ibuprofen (naproxen, diclofenac, or meloxicam)
Lactulose (sorbitol or polyethylene glycol)
Loperamide
Metoclopramide
Metronidazole
Morphine
Naloxone Parenteral
Omeprazole oral
Ondasetron
Paracetamol oral
Petroleum jelly

Medical Equipment
Pressure Reducing Mattress
Nasogastric drainage or feeding tube
Urinary catheters
Opioid lock box
Flashlight with rechargeable battery
Adult diapers/ Cotton and Plastic
Oxygen

Human Resources
Doctors (Specialty and General)
Nurses (Specialty and General)
Social Workers and Counsellors
Psychiatrist, psychologist or counsellor
Physical Therapist
Pharmacist
Community Health Workers
Clinical Support Staff
Non Clinical Support Staff

Aligned with Sustainable Development Goals (SDGs): Should be made universally accessible by 2030

The Essential Package would cost low-income countries about US$2.16 per capita per year at lowest reported international medicine prices or just over **1% of total LMIC per capita health expenditure**. In other words, pennies on the dollar! The fact that those prices may have gone up slightly owing to pandemic pressures on manufacturing and supply chains cannot be an excuse for failing to implement the package.

Moreover, the UN Committee on Economic, Social and Cultural Rights has determined that UN member states are obligated to respect the right to health and must not deny or limit equal access to preventive, curative, or palliative health services.[1] Access to essential medicines like morphine is a core human rights obligation that all states must ensure regardless of income level.[2]

Advocacy Education for Our Members

The IAHPC is developing an advanced advocacy webinar series, following publication of the Basic Course. This is intended as a tool for palliative care associations wishing to help their governments implement the language of the various World Health Assembly and UN resolutions mentioning the obligation to provide palliative care. The Basic Course is free to IAHPC members and can be accessed here. If you're not yet a member, please join today, or ask your Institution to join so you and your colleagues can take this basic course and the soon to be released advanced course. Stay tuned for my Policy and Advocacy reports in the monthly IAHPC newsletter and please subscribe (free of charge) if you have not already.

[1] UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment 14, The right to the highest attainable standard of health, E/C.12/2000/4, 11 August 2000, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=9&DocT ypeID=11, para. 34.

[2] Ibid., para. 12.