Intervention of Dr. Felicia Knaul, IAHPC Board Member, Chair of the Lancet Commission on Pain and Palliative Care, Roundtable II with Dr. Tedros Ghebreyesus, DG WHO. April 28, 2021

Doctor Tedros: It is wonderful to have this second opportunity to meet and discuss how we can collaborate to ensure that palliative care is not only *said* to be, but *is in fact an essential* an essential part of UHC, and fully integrated into health systems.

In that spirit, I want to respectfully begin by suggesting that WHO itself take an increasingly diagonal approach to making access to palliative care and pain relief universal. I believe that PC must operationally be part of health systems strengthening – as it is now in WHO- ***but also*** embedded in the excellent disease-specific work around NCDs that you have underway. Universal access to palliative care is not an "either-or" – it requires both horizontal and vertical programming.

Cancer is an example. I continue to be awed – and I say this as patient-advocate and President of the Mexican NGO *Tómatelo a Pecho* – of the huge, recent strides at WHO around the cancers most affecting women and children. That said, as a woman who has lived a mastectomy, I share that it is unimaginable without access to opioid pain relief medicine. As a daughter who watched her father die of stomach cancer, it is unthinkable what I would have done to help him had I not had morphine at his bedside to ease his pain. Yet, most patients, especially poor patients and their families, face surgeries and end-of-life without pain relief —— a horror that we have the power and moral responsibility to prevent.

Following on our previous roundtable, I focus on supply chain strengthening, local manufacturing, workforce training, and joint procurement strategies.

We know that action is of the essence given the catastrophic, cumulative damage of the pandemic. The persistent and huge unmet need for palliative care was multiplied by the COVID-19 tsunami of suffering.

What was a severe shortage is now a dire and desperate lack of medications for sedation and for pain and breathlessness. Many countries have been forced to reallocate their meager supplies of these medicines away from palliative care and to COVID. This means that while a year ago, I would have told you that many low-income countries could meet only 5-10% of palliative care needs with existing stocks; today, I must speak of stock outs and the many countries left with **no** medicines for either pain relief or COVID. The 50% poorest of our world continue to hold only 1% of distributed opioid morphine equivalent – this is a statistic that bears witness to a tragedy that is ripe for change. It is also one of the few global health imperatives that is affordable. The Lancet Commission on Global Access to Palliative Care and Pain Relief that I had the honor of chairing, estimated the cost of the morphine required to close the global pain divide - at best international prices – to be as little as $US150 million. That is roughly the annual budget of one, mid-sized hospital in the US.

Yet, funding and financing for medicines is only a part of the challenge.

Strong global and national supply chains for essential controlled medicines are **so** needed both for critical and palliative care. But, existing global supply chains for controlled medicines were never fit for purpose and have been further eroded by the pandemic.

WHO *can* be a beacon for member states to guide the world away from the precipice of a looming pain catastrophe. WHO is showing **how** to collaborate effectively with other UN agencies, and multilateral networks, and of course with civil society – exactly as you are doing now by personally participating in this, our dialogue.

Let me highlight the importance of the Joint INCB/WHO/UNODC Statement on Access to Medicines released in 2020.We request that WHO take the lead in producing an updated and more granular set of recommendations one year on - in August 2021. We pledge our commitment as civil society to working with you to ensure that all countries implement its recommendations.

Critical care and palliative care are mutually supportive; not mutually exclusive. Yet, official COVID responses have taken the mistaken route of defunding palliative care and rendering it a "non-essential service". Palliative care ***is*** an essential part of the COVID response and must be part of any sustainable recovery plan.

The panic and opioidphobia surrounding the North American opioid crisis have been mistakenly and tragically focused on denying pain relief medication to the poor. This prevents many member states from taking the necessary steps to ensure adequate access to medical opioids and invest in the Essential Package recommended by the Lancet Commission. Yet, successful health systems have solved the false dilemma between the pain pandemic and the opioid crisis: They apply the very practical, human rights based, principle of balance to their regulatory policies for essential medicines.

To avoid crises like that afflicting North America in other settings, the Lancet Commission report calls for monitoring the supply and marketing of medical opioids, restricting direct marketing of opioid medications to health care providers by pharmaceutical companies, and implementing basic mandatory training for all health care personnel for safe management and evidence-based prescribing and use of opioid analgesics. These strategies are already operating in many settings but they will flounder without the support of WHO.

We respectfully request *your* intervention to encourage government support and funding for a sustainable, balanced approach to the provision of opioid analgesics. The Triple Billion Dashboard on the WHO Website should include Palliative care Country Case studies, Output scorecards, and impact measurements. *Countries need to know that this can be done, and safely.*
We are here as committed partners. And we reiterate our asks from the previous roundtable. Specifically, to assist member states to:

1) identify manufacturers and encourage them to produce cost-effective generics;
2) work with international financial institutions and development banks to set up regional or global pooled procurement and financing mechanisms and catalyze governments to use them,
3) work closely with the INCB and UNODC to help increase national, regional, and global buffer stocks, and
4) integrate relief efforts with humanitarian agencies to ensure controlled medicines reach populations living in crisis.

Our hearts, thoughts and prayers, and hopefully each of our country´s emergency assistance programs are with India as its health system and pharmaceutical industry collapses under this latest COVID assault. Patients around the world will go without the morphine and other Indian-manufactured opiates required to control extreme and manage COVID-19 breathlessness. We live in an inter-connected world and we must commit to the health of those who live beyond our own borders.

Dr. Tedros, in your pre-WHA dialogue with civil society last week you exposed the tragic global inequity in access to COVID vaccines. You asked all of us to commit to vaccine equity as one of three action pillars *and we do*.

Vaccine inequity mimics the global inequity in access to essential palliative care medicines. They co-exist as part of a view that renders some populations expendable; some lives *worthless* as well as worth less

than others. Civil society - the connective tissue between patients and policymakers - is key to remedying this callous disregard for the suffering of the poor.

Dr. Tedros, allow me to thank you for caring about those how are most in need and for giving voice to the causes of those who suffer and have little voice; and for engaging civil society in this process.