Statements of IAHPC delegates during WHO Civil Society Dialogues April 20-22

I. Session One

Pillar 2: Public health emergencies: preparedness and response

- 17.1 COVID-19 response
- 17.3 WHO's work in health emergencies
- 18 Mental health preparedness for and response to the COVID-19 pandemic

Dr. Tania Pastrana (ALCP – Latin America)

Low- and Middle-income countries *already* suffered from limited access to controlled essential medicines before the pandemic. So, using opioids and **benzodiazepines** for the treatment of COVID patients resulted in stockout for everyone in need. Additionally, due to the pandemic, many cancer patients missed diagnostic and early treatment appointments, increasing the number of patients with advanced disease and in excruciating pain. Colleagues have been ***forced*** to use available medications even if they are **expired**, thus practicing medicine based on what is **available** and not on evidence or international standards. Some reported having to intubate patients being **paralyzed** but aware, because they do not have midazolam to sedate them. Patients are living a situation that can be described as torture. We urge the WHO to support member states in their efforts to ensure that there are enough essential medications needed to relief suffering during the pandemic.

Dr. Eve Namisango (Uganda)

To reduce the spread of Covid-19 African governments are emphasizing the strengthening primary health care in communities to de-congest tertiary level facilities and restriction of movement. To address the shortage of controlled essential medicines prescribers these locales African countries are continuing to embrace task shifting by training other cadres besides the doctors as prescribers. For example, we have the Diploma in Clinical Palliative Care for nurses and Rapid Morphine Prescribers Course for clinical officers at the Institute of Hospice and Palliative Care Uganda, which prepares nurses for this role.

How does this help? We have more nurses than doctors and these can reach out to patients in the communities and most importantly in the rural under severed areas where 90% of our patients dwell. This strategy therefore expands our reach to improve access to controlled essential medicines at community level. We urge WHO to support such novel innovations in low-middle income settings.

II Session Two

Pillar 2: Public health emergencies: preparedness and response

- 17.1 COVID-19 response
- 17.3 WHO's work in health emergencies
- 18. Mental health preparedness for and response to the COVID-19 pandemic

Dr. Ednin Hamzah (Malaysia)
The Covid 19 pandemic has devastated the global community but especially patients and vulnerable groups. Palliative care with its approach to severe health related suffering has been effective to the plight of patients and families affected by life threatening illness. However, only about 12% of those that need palliative care are receiving it. Palliative Care can make a huge difference in dealing with the Covid 19 pandemic. However, this would not be possible without investing in policy changes, access to essential medicines, education and training as well as integrating palliative care into health systems. The Lancet Commission report on alleviating the access abyss in palliative care and pain relief suggests innovative ways to deliver affordable care to these populations. I would urge WHO and member states to consider making palliative care an imperative part of the national response to the pandemic by integration into primary health care and universal health care. We owe it to our loved ones to make this happen.

Dr. Chitra Venkatesh (India) Mental Health Response
According to a recent Indian Psychiatric Society survey, mental illness (common mental disorders) has jumped up to 40.5% since COVID struck India, affecting care of vulnerable populations with chronic illnesses and co morbidities. As a palliative care psychiatrist, I can attest that since onset of pandemic the Kerala state collaborations with charitable and other agencies has focused to effectively reduce the spread of COVID 19 and minimise its psychosocial impact. Existing government, private and voluntary sector strengths were mapped and combined. The palliative care sector participated actively in this network. We are adopting similar strategies for the current crisis we are facing.

Strong community relationships with our patients helped our palliative care organization, which includes mental health, transition to a remote MO, doing only emergency home visits or consultations. Leveraging technology to deliver services strengthened our outreach to patients (using phone, platforms like whatsapp, zoom), allowing us to follow up and identify non-adherence to medications or early signs of psychosocial distress. IAHPC urges governments to follow this. Model and build effective collaborations with palliative care organizations with strong ground networks.

III. Session Three

Pillar 1: One billion more people benefitting from universal health coverage

- 14. Health in the 2030 Agenda for Sustainable Development
- 15. Health workforce
- 16. Committing to implementation of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)

Simone Cernesi (Italy)
Older persons' unaddressed palliative care needs rise given the gap in the physician and nursing workforce both inside and especially outside hospitals. Although nursing homes are the worst setting ever, all the resources go to ICUs, and not enough to nursing homes.
Several studies have shown that many residents of nursing homes have unmet palliative care needs. Integrating palliative care into Primary Care can help health systems move from this

tragic situation. Fewer nursing home patients means more home care, more informal caregivers, and more resource challenges. Let's not create a new vicious circle! This is the right time to re-shape organisational models, beginning with WONCA. Nursing homes can no longer be islands but must be better connected with the health care system. They need regular access of GPs, geriatrician and palliative care in support to support the core team. Only with Universal Health Coverage and integrated multidisciplinary approach we can guarantee the respect of fundamental rights, right of health and right to live well till the end, without FUTILE SUFFERING. I thank you for this opportunity to contribute my experience and perspective as a geriatrician.

Gulnara Kunirova (Kazakhstan)
Kazakhstan needs about 7 thousand trained doctors, nurses, psychologists and social workers, as well as a a cohort of health workers familiar with palliative care basics, to provide genuine UHC for people living with cancer and palliative care needs. The level of material, financial and human resources allocated by the Government for this essential component of UHC is disproportionately lower. Despite its declared intention to ensure the availability of palliative care for both adults and children, the Government provides a low level of support to civil society initiatives aimed at enhancing the human capacity of medical and social organizations and introducing curricula in medical schools. It does not support NGO projects providing practical assistance to patients and their families, which are financed through private donations and outside grants. This is the case throughout much of the world. Private and charitable organizations such as [name of your organizations] can meet a fraction of the need.
I strongly believe that to achieve that goal, countries like Kazakhstan, which are in early stages of integration of palliative care into the health sector and the social security system, require a national program that has to be developed taking into account existing needs, available resources and conditions on the ground.
Question: What can the WHO workforce division do to support member states to train health workers to provide palliative care under UHC?

IV. Session Four

Pillar 3: One billion more people enjoying better health and well-being

- 22.1 Social determinants of health
- 23. WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children

Pillar 1: One billion more people benefitting from universal health coverage

- 13.3. Expanding access to effective treatments for cancer and rare and orphan diseases, including medicines, vaccines, medical devices, diagnostics, assistive products, cell- and gene-based therapies and other health technologies; and improving the transparency of markets for medicines, vaccines, and other health products

Katherine Pettus (IAHPC)

Some High-Income countries are experiencing crises of *non*-medical use of prescription medications, some of which are considered an essential medicines for palliative care on the WHO Model List. These countries are funding many programs on prevention and control of opioid addiction. The vast majority of the world's countries, though, are experiencing a crisis of access to these same medications rational medical use? How can WHO support member states to improve governance frameworks around these medicines? We know that there are national and sub-national health systems in countries of all income levels, where neither access nor non-medical use are public health issues. WHO can help countries development of more robust regulatory frameworks that promote and sustain the principle of balance, which in the case of controlled medicines, ensures public health availability while preventing non-medical use?

Liliana de Lima (IAHPC)
13.3. Expanding access to effective treatments for cancer and rare and orphan diseases, including medicines, vaccines, medical devices, diagnostics, assistive products, cell- and gene-based therapies and other health technologies; and improving the transparency of markets for medicines, vaccines, and other health products. Thank you for the floor. I will address the transparency of markets for internationally controlled essential palliative care medicines.
The IAHPC has been working for several years in its capacity as an NSA in official relations, on the Opioid Price Watch, an interactive global program whose aim is to monitor availability, dispensing prices and affordability of opioids. We found that opioids with complex delivery mechanisms [fentanyl transdermal (TD) patches, sustained-release (SR) morphine, and SR oxycodone] had lower dispensing prices than immediate-release (IR) morphine formulations.
Our WHO focal points and member state colleagues are well aware that affordability is one of many barriers to access to palliative care medicines, which is why we advocate for inexpensive, generic, oral morphine as a staple that must be available in ALL health systems. Morphine is an essential medicine for anesthesia, trauma, surgery, obstetrics, critical and palliative care
Question: What is WHO doing to assist governments to support local manufacturing, strengthen supply chains, and adopt pooled procurement strategies for essential palliative care medicines such as morphine?

V. Session Five

Pillar 1: One billion more people benefitting from universal health coverage
- 15. Health workforce

Pillar 3: One billion more people enjoying better health and well-being
- 22.1 Social determinants of health

Pillar 4: More effective and efficient WHO providing better support to countries
- 11.Proposed programme budget 2022–2023: Sustainable Financing

Dr. Joseph Mwate Chaila (Zambia)
Zambia has an estimated 2021 population of 18.8 million people. To improve health services for the Zambian people, the Ministry developed the National Health Strategic Plan 2017-2021 in which we have articulated 10 legacy goals. Five of these goals speak to cancer and palliative care which are recruitment of health care workers; implementation of the National Health Insurance Scheme; reduction of HIV incidence; training of specialists; and indeed, halting the

incidence of Non-Communicable Diseases (NCDs). Zambia currently does not have a functional Palliative Care Association, but during its time, the Palliative Care Association of Zambia (PCAZ) supported health care workers with basic training in PC and also got scholarship to pursue the training in Kenya and Uganda. Today, that crop of health care workers has continued to advocate for PC services integration and Zambia. We are proud to state that we now have a National Coordinator for PC, the government has created PC position on its payroll, we have developed a training curriculum for PC, and we have since developed the PC strategy awaiting its finalization & launch. With the right amount training, health care workers have the capacity to change the health landscape in their countries.

Ms. Kate Reed-Cox, NP (Australia)
Relieving suffering by ensuring that all persons with life threatening illness have access to essential palliative care services and medicines as part of universal health coverage is not only a human right but an obligation for all member countries and their governments. This ethos is central to the work of Palliative Care Australia and the International Association of Hospice and Palliative Care. PCA has developed the National Palliative Care Standards (5th Ed.) together with an online tool PaCSA which enables services caring for people with palliative care needs to develop a quality improvement action plan to inform strategic development increasing access while building workforce capacity and skills. Additionally, PCA supports numerous government-funded national palliative care projects. Broadly, these projects provide content to support and increase expertise and capability of the workforce in delivering high quality palliative care in a variety of settings across all populations. PCA administers the National Service Directory of palliative care services and works with the Australian Institute of Health and Welfare to build the data set for palliative care to inform policy direction and investment.