Ref. No 37-21 25th August, 2021

Minister of Healthcare
Republic of Kazakhstan
Mr. Alexey Tsoy

Copy:
WHO Representative, Head of
WHO Country Office in Kazakhstan
Dr. Caroline Clarinval

WHO Regional Director for Europe
Dr. Hans Henri P. Kluge

Re.: WHO Regional Committee for Europe 71st session (RC71), 13th–15th September, 2021

Dear Alexey Vladimirovich,

My name is Gulnara Kunirova and I'm the President of the Kazakhstan Association for Palliative Care (KAPC) – an NGO, established in 2013 with the aim to protect the interests of patients of all ages with severe incurable illnesses, their families and professionals, providing palliative care. KAPC Vision is that every citizen of Kazakhstan, facing the life limiting disease and at the end of life can exercise his right to dignified living without pain and suffering. Our Mission is to consolidate efforts to establish a sustainable system of palliative care in the Republic of Kazakhstan.

Being a WHO member, Kazakhstan has accepted obligations to relieve suffering and integrate palliative care into the national healthcare system, as a result of ratifying a number of international documents in the field of healthcare and observance of human rights. These documents include, in particular, the UN Declaration on the Prevention and Control of Non-communicable Diseases, Political declaration on HIV/AIDS and Political Declaration of the High-level Meeting on Universal Health Coverage (UHC); Report of the World Health Organization (WHO) on UHC; World Health Assembly (WHA) resolution on palliative care; Outcome document of the Special Session of the United Nations General Assembly (UNGASS) on the world problem of narcotic drugs; WHA Resolution on Cancer and WHO Global Action Plan on Dementia; WHO Astana Declaration; as well as Reports of the International Narcotics Control Board (INCB) regarding availability of internationally controlled drugs.

Even before the pandemic, palliative care in Kazakhstan could hardly be considered accessible and systematically developing, but COVID-19 led to more restrictions for patients and their families in need of palliative care. A number of hospices, palliative and nursing units were re-profiled into units for patients with COVID; physicians and nurses providing palliative care were most often dispatched for emergency care to COVID patients; patients in need of palliative interventions were denied hospitalization and home care; there was a critical shortage of essential medicines for treatment of pain and other severe symptoms.

From the very first days of pandemic, due to the lack of personal protection equipment, personnel of palliative care units got into a high-risk zone of coronavirus contamination.

The fact that patients with COVID-19 need palliative care is also underestimated. Palliative care professionals are able to relieve dyspnea, fever, shortness of breath, panic attacks, depression, delirium and other symptoms common to COVID-19. They are trained to manage end-of-life complications. Patients with severe forms of COVID-19, as well as their families, experience emotions that palliative care professionals, trained to provide psychological support to families, and, if necessary, to create conditions for paying last respects to dying relatives.

With this letter, I would like to inform you that I am registered for RC71 as a delegate of the International Association for Hospice and Palliative Care (IAHPC), a non-state actor in official relations with the World Health Organization and in consultative status for ECOSOC.

Please, consider our comments on RC71 Agenda items 3 and 5 below[1]:

Agenda Item 3. COVID-19 lessons learned: getting ready for the next pandemic
REPORT: EUR/RC71/6 Response to the COVID-19 pandemic: lessons learned to date from the WHO European Region

KAPC is disappointed that the Report on lessons learned to date (RC71/6)[2] does not include palliative care, which should be included both in the resolution and the new action plan to be developed. Our patients and families have learned the hard way that palliative care should be integrated into the national pandemic response at the community level.

Palliative care should have been included in the report in the following sentences:

1) Paragraph 11, at the top of page 5
"Leaving no one behind" should apply from prevention, through testing, treatment, follow-up care and, where relevant, rehabilitation, ***and palliative care*** and requires universal access to comprehensive health care."

2) Paragraph 19 (b) on health workforce, on page 10
- Enhanced surge capacity within a trained health and social care workforce that is ready to expand capacities to provide life-saving interventions and emergency, ***palliative***, and urgent care services while ensuring continued access to safe and quality essential health services for all ("dual-service provision"), using innovative and flexible delivery of services.

3) Top of page 11 paragraph on supply chains for medications should include ***essential palliative care medicines***.

[1] EUR/RC71/1 Provisional Agenda
https://apps.who.int/iris/bitstream/handle/10665/342440/71wd01e-ProvAgenda-210740.pdf?sequence=1&isAllowed=y

[2] REPORT: EUR/RC71/6 https://apps.who.int/iris/bitstream/handle/10665/343157/71wd06e-PR-Response-LessonsLearned-210693.pdf?sequence=1&isAllowed=y

Agenda Item 5. Reinventing primary health care in the post-COVID-19 era.
REPORT EUR/RC71/9 Realizing the potential of primary health care: lessons learned from the COVID-19 pandemic and implications for future directions in the WHO European Region[3].

The 2018 Astana Declaration, which updated the 1978 Alma Ata Declaration, includes palliative care in the list of essential primary health care services. Our Association is disappointed that "palliative care" is missing from the RC71 report on Reinventing Primary Health Care and emphasizes that there are many places where, to reflect Astana commitments, "palliative care" should have been included with little problem to the spectrum of services already listed.

1) Bullet point at the top of page 5 (table)
"• Strengthen capacity for emergency responses, including such areas as surveillance, contact tracing, first response, case management, rehabilitation, ***palliative care***, and follow-up"

2) Paragraph 12, on page 7
«Such services may include supporting surveillance efforts, engaging in testing and contact tracing, managing mild and moderate cases on the basis of adequate clinical guidelines and training, providing rehabilitation ***and palliative care*** services, protecting the vulnerable through regular contact and tailored service delivery mechanisms, and providing surge health workforce capacity in other areas of the health system.»

3) Bullet point at the bottom of page 9
"• Create stronger financial incentives for services to be provided in PHC settings and financially reward the delivery of health promotion, prevention, early detection, team-based disease and condition management, ***palliative care*** and rehabilitation services for PHC-amenable conditions, while simultaneously reducing incentives to access such services at the specialist and/or hospital levels."

4) Paragraph 14 on Page 8
"Integration between PHC and public health services can facilitate health promotion, prevention, early detection, treatment, ***and palliative care*** service provision where appropriate to at-risk populations."

With regard to the draft **Resolution[4]** to be approved by the RC, we request that the following language be added:

1) Page 3, paragraph (3)(g):
«(iii) incentivizing delivery of health promotion, prevention, early detection and condition management, ***including palliative care***;

[3] REPORT EUR/RC71/9 https://apps.who.int/iris/bitstream/handle/10665/343168/71wd09e-PR-PHC-LessonsLearned-210744.pdf?sequence=1&isAllowed=y

[4] EUR/RC71/CONF./6 https://apps.who.int/iris/bitstream/handle/10665/343334/71cd06e-DraftResolution-PHC-210848.pdf

The one document that DOES include palliative care is EUR/RC71/17(D) Midterm progress report on the Action Plan to Improve Public Health Preparedness and Response in the WHO European Region, 2018–2023[5], which mentions palliative care on page 8:

"22. In 2019, WHO developed a toolkit for assessing and strengthening people-centered emergency care systems, which encompassed a full package of services: pre-hospital services, emergency medical services, intensive care units and hospital-based services, and out-of- hospital services **including palliative** and rehabilitation care."

Dear Alexey Vladimirovich, we are hopeful that the abovementioned recommendations will find your full consideration and support. On our part as a dedicated professional organization, we are ready to provide support and cooperate with the Ministry of Healthcare on issues of integration of palliative care into the National healthcare system, as well as its inclusion into the National COVID-19 pandemic response plan.

We look forward to your response.

Sincerely,

Gulnara Kunirova
KAPC President,
IAHPC Board of Directors Member

[5] EUR/RC71/17(D) https://apps.who.int/iris/bitstream/handle/10665/343209/71wd17e-D-PR-PreparadnessResponse-210795.pdf?sequence=1&isAllowed=y