Original Article

Advancing Global Palliative Care Over Two Decades: Health System Integration, Access to Essential Medicines, and Pediatrics

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Abstract

Context. Between 2000 and 2020 Open Society Foundations was one of very few funders that supported global palliative care development and advocacy.

Objectives. To describe progress made in three priority areas—the integration of palliative care into public health systems, access to controlled medicines, and pediatric palliative care—during those 20 years.

Methods. Activities and developments between 2000 and 2020 on global integration of palliative care into health systems, access to and availability of controlled medicines, and pediatric palliative care are described and analyzed.

Results. Major progress has been made in each area. Whereas in 2000, integration of palliative care into public healthcare systems was on the agenda in just a few pioneering countries, by 2020 a global consensus had emerged that palliative care should be integral to all health systems including in universal health coverage and countries were increasingly taking steps to integrate it into national health systems. While limited availability of these medicines was barely recognized as a public health or drug control issue in 2000, it had become an important priority in global drug policy debates by 2020 and numerous countries had taken steps to improve access to these medicines. Pediatric palliative care, available mostly in a small number of wealthy countries in the 1990s, has seen rapid growth, especially in low- and middle-income countries, and now has a solid foothold in all world regions.

Conclusion. Despite this progress, significant challenges remain as funding for palliative care advocacy is limited, the overdose crisis in the US has recently had a chilling effect on efforts to improve availability of opioid analgesics, and economic crises related to the COVID-19 pandemic create uncertainty over the future of universal health coverage. J Pain Symptom Manage 2022;64:58–69. © *2022 Published by Elsevier Inc. on behalf of American Academy of Hospice and Palliative Medicine.*

Key Words

Palliative care, advocacy, universal health coverage, controlled medicines, opioid analgesics, health systems, human rights, pediatrics

Key Message

This article describes progress made in the last twenty years in three areas that were global funding priorities for the Open Society Foundations. It describes developments between 2000 and 2020 on global integration of palliative care into health systems, access to and availability of controlled medicines, and pediatric palliative care.

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Accepted for publication: 2 March 2022.

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0885-3924/$ - see front matter
https://doi.org/10.1016/j.jpainsymman.2022.03.001

Introduction

The International Palliative Care Initiative (IPCI) began in 1998, evolving from the Open Society Foundation (OSF)'s U.S.-based Project on Death in America, a nine-year 45 million dollar project to improve the care of the dying in the U.S.[1] As part of the OSF Network Public Health Program (PHP), IPCI built partnerships with national and regional foundations in the Open Society network, most importantly in Africa, Europe, and Eurasia, to support the palliative care field in those regions long term.[2]

IPCI's strategy was based on a recognition of palliative care as a public health and human rights issue and simultaneously pursued a top down approach with international leaders, international nongovernmental organizations and governments, and bottom up approaches with grass roots advocacy organizations and individual hospice programs and key leaders.[2] While the majority of its support for palliative care focused on driving change at the national level,[3] IPCI invested at least $10.86 million over 20 years in efforts to put palliative care on global health, drugs and human rights policy agendas. This paper focuses on three key areas of global work that OSF supported: integration of palliative care into health systems, improved availability of and access to controlled medicines, and the development of pediatric palliative care.

Early strategy documents identified global priorities such as advocacy for inclusion of palliative care into funding strategies of international funders and promotion of regional and international advocacy and information sharing.[3] IPCI supported the development of freely accessible tools that could guide efforts to develop palliative care at the national level and helped build and strengthen global palliative care organizations to provide technical and information support to national champions, and advocate on their behalf at the global level.[2,4] Observing that palliative care providers generally did advocacy on a volunteer basis, on top of their clinical work, OSF invested in the professionalization of advocacy work by financially supporting and training advocates and offering fellowship opportunities.

Integration of Palliative Care into Public Healthcare Systems

From its inception, OSF's palliative care strategy sought to integrate palliative care into health systems, including by strengthening global norms calling for such integration. An early strategy described the overall goal of the palliative care initiative as serving as "a catalyst for the integration of palliative care into national health care plans, programs, and systems of care."[3] A subsequent internal action plan defined palliative care integration as complete when it is "included in national cancer control programs, national AIDS strategies, and national pediatric and geriatric plans."[5] In 2017, given that universal health coverage (UHC) had become a global health priority, OSF's Public Health Program began to emphasize the integration of palliative care into publicly-financed UHC.[6]

Based on these strategic considerations, OSF funded work at the national, regional and global level to facilitate, promote and advocate for palliative care to be part of public health services. This included technical support and advocacy to integrate palliative care into various health policies and programs; inclusion of palliative care medicines in essential medicines lists and packages; development of clinical guidance; integration of palliative care into healthcare worker curricula and continuing education programs; and inclusion of palliative care in health financing frameworks.

The Global Situation Prior to 2000

Building on the work of Cicely Saunders who founded the first "modern" hospice in the United Kingdom in 1967, Dr. Balfour Mount developed the first model for integrating what he coined "palliative care" into health services at the Royal Victoria Hospital in Canada in the 1970s.[7] While other palliative care pioneers replicated and adapted Mount's model in different settings, efforts to integrate palliative care happened primarily at the level of individual hospitals or hospital systems, rather than at a health system level. Indeed, palliative care remained a relatively little-known concept in broader public health circles and was not taught in medical, nursing, or public health schools in much of the world.

Prior to 2000, global health documents rarely, if ever, referenced palliative care. The Alma Ata Declaration on Primary Health Care adopted in 1978, groundbreaking in many ways, referred to "promotive, preventive, curative and rehabilitative" but not palliative care services.[8] The 1987 UN General Assembly resolution on AIDS focused only on prevention and control, even though AIDS was incurable at the time and people with AIDS desperately needed palliative care.[9] The World Health Assembly, the decision-making body of the World Health Organization (WHO) which has met annually since 1948 to discuss key global health challenges, had rarely if ever discussed it[10] and the Millennium Development Goals, adopted in 2000, made no reference to it.[11] The WHO's 1990 cancer control guidance was the exception and first global health policy document that clearly identified palliative care as a priority and as "one of the four key components (pillars) of comprehensive cancer care."[12] Not until the 2001 Declaration of Commitment on HIV/AIDS did a major international agreement pledge to advance palliative care as part of a comprehensive response to the global HIV and AIDS epidemics.

Developments Since 2000

In the early 2000s, along with OSF several other funders began supporting palliative care services, including the US President's Emergency Plan for AIDS Relief;[13] the Global Fund to Fight AIDS, TB and Malaria;[14] the UK government through the Department for International Development;[15] and the Diana Princess of Wales Memorial Fund.[16]

At that time, palliative care advocates began to organize around an agenda that focused on palliative care as a public health issue, as outlined in a 2007 paper,[12] an essential health service and a human right.[17,18] They engaged policy makers around a public health model for palliative care, with a specific focus on improving the policy environment for palliative care and access to controlled medicines.[10] For example, the International Association for Hospice and Palliative Care (IAHPC) successfully presented the evidence for the inclusion of a list of essential medicines for pain and palliative care in the WHO Model List of Essential Medicines;[19] the Worldwide Hospice Palliative Care Alliance (WHPCA) worked with WHO on a palliative care atlas that mapped global need and service development;[20] the Pain and Policy Studies Group, Union for International Cancer Control and Human Rights Watch engaged drug policy makers;[10] and Human Rights Watch solidified the argument, later affirmed by UN human rights experts, that access to palliative care was an integral part of the right to health by demonstrating how people were harmed as a result of arbitrary and neglectful government policies that impeded palliative care.[10] Palliative care advocates working at the national level supported these efforts, bringing their first-hand experiences and credibility to global meetings. In a key example, a presentation by a Panamanian doctor at the World Health Assembly (WHA) resulted in his country's decision to spearhead a World Health Assembly (WHA) resolution on palliative care.[21,22] With the emergence of UHC as a global health priority in the 2000s, palliative care advocates increasingly pressed for inclusion of palliative care into its conceptualization, planning and implementation, with a first success—the inclusion of palliative care into the definition of UHC—following in 2013.[23]

Increased funding for palliative care services, coupled with this advocacy, resulted in a rapidly growing recognition that palliative care should be an integral part of the global health agenda. In contrast to 2000, following the groundbreaking 2014 WHA resolution on palliative care[22] for which OSF grantees actively advocated, WHO guidance now unequivocally describes palliative care as an integral part of comprehensive health services; numerous WHO member states have made clear (rhetorical) commitments to making palliative care available; and robust tools and guidance documents have been developed for countries and national-level advocates to draw on in the implementation of palliative care. In 2021, WHO published palliative care indicators to help countries monitor its implementation of their commitments.[24] A selection of international declarations, action plans and consensus documents presented in Table 1 demonstrate how palliative care has become an integral part of the global health fabric and an "ethical responsibility" of health systems.[22] The fact that current WHO Director General Dr. Tedros Adhanom personally hosted two roundtables with global palliative care advocates in 2021 to discuss the integration of palliative care into UHC and COVID-19 response underscores palliative care's new place in the global health policy arena.[25–27]

Controlled Medicines

Improving access to morphine was a central objective of OSF's support for the palliative care field from the outset, given its critical role in palliative care. IPCI's 2005 global strategy included a "major emphasis on access to opioid analgesic drugs" citing the need for "strong advocacy and policy change to ensure the availability of essential drugs for palliative care. . .provided through government healthcare systems."[29] In 2011, access to pain treatment was selected as a flagship issue for the high-profile OSF Campaign to Stop Torture in Health Care. A 2017 strategy reframed this work as focused on controlled medicines generally, including any medicines that contain controlled substances. It articulated the objective as "challeng[ing] the power of security, drug control. . .interests that currently threaten the realization of palliative care as a public good. [6] This work deliberately complemented OSF's work on mitigating the health consequences of punitive drug laws and promoting harm reduction-based alternatives to the "war on drugs."

In 2002, IPCI supported a first regional workshop in Eastern Europe to evaluate opioid control policies in six countries, develop action plans to address barriers to opioid availability, and provide technical assistance for regulatory change processes, creating a model that was later replicated in regions around the world.[3,30] In the mid-2000s, IPCI began supporting the Pain and Policy Studies Group at the University of Wisconsin to run international pain and policy fellowships programs seeking to "increase [the number of] drug availability experts working in the world."[5] Simultaneously, it supported several organizations to raise awareness about and challenge the limited availability of opioid analgesics—and the unnecessary suffering it caused—at the global level and seek commitments from the international community to change this state of affairs.[28,31,32]

Table 1

Selected Examples of Interventions to Improve Access to Controlled Medicines

Activity	Organization	Year	Reflections
An analysis of national narcotics control laws showed that few laws recognize the dual obligation of governments under the international drug control conventions (Husain SA, Brown MS, Maurer MS. Do national drug control laws ensure the availability of opioids for medical and scientific purposes? Bulletin of the World Health Organization. 92 (2013): 108-116. Available from: https://www.who.int/bulletin/volumes/92/2/13-121558.pdf?ua=1 Accessed July 15, 2021.)	Pain and Policy Studies Group	2013	As national drug control laws are generally prepared by people with a law enforcement background, they often ignore the fact that controlled substances also play a key role in healthcare. This study demonstrated how unbalanced many of these laws were and was used to educate national and international officials on the need for regulatory reform
The Access to Opioid Medications in Europe (ATOME) project researched and sought to address the reasons for inadequate use opioid analgesics and drug treatment medicines in 12 European countries (Larjow E. Access to Opioid Medication in Europe (ATOME): project results and achievements (2015). Available from: http://endoflifestudies.academicblogs.co.uk/access-to-opioid-medication-in-europe-atome-project-results-and-achievements-by-eugenia-larjow/ Accessed July 15, 2021.)	WHO, European Association of Palliative Care, academia	2010-2015	This project focused on drug regulations in specific countries and involved a review of those regulations and a process to work with national officials on regulatory change needed to ensure drug laws did not arbitrarily impede access to controlled medicines.
Opioid Price Watch monitored and reported on dispensing prices of opioids in different countries of the world (International Association for Hospice and Palliative Care (IAHPC). Opioid Price Watch Project. Available from: http://hospicecare.com/opioids/reports/map/ Accessed July 15, 2021.) (De Lima L, Pastrana T, Radbruch L, Wenk R. Cross-Sectional Pilot Study to Monitor the Availability, Dispensed Prices, and Affordability of Opioids Around the Globe. J Pain Symptom Manage 2014 48(4): 649−659. https://doi.org/10.1016/j.jpainsymman.2013.12.237)	IAHPC	Ongoing	Controlled medicines are subject to a variety of requirements regarding production, transportation, import, export, sale and use that do not apply to other medicines—all of which translates in extra. This project monitored the cost of opioid analgesics for patients in different countries, finding, in many countries, in inverse relation between level of economic development and cost: the poorer the country the more expensive the medicines.
Analyses of government human rights obligations to ensure availability of opioid analgesics: Please Don't Make Us Suffer Anymore and the Global State of Pain Treatment[28] (Human Rights Watch. Please, do not make us suffer any more. Access to Pain Treatment as a Human Right. March 2009. Available from: https://www.hrw.org/sites/default/files/reports/health0309webwcover_1.pdf Accessed August 19, 2021.)	Human Rights Watch	2009, 2011	These reports sought to frame access to controlled medicines as a human rights issue and to generate public attention for the suffering their limited available caused for people with palliative care needs. They were used as tools in advocacy for regulatory change with national, regional and international decision makers.
Events at the Commission on Narcotic Drugs to raise awareness about the impact and causes of limited availability of controlled medicines	Various	Annually since 2009	As the Commission on Narcotic Drugs had not previously paid attention to controlled medicines, these events were essential to educate member states and UN officials about the impact of
Four regional workshops focused on Essential Pain Medication Accessibility sponsored by OSF, APCA, NHPCO, & FHSSA	OSF, APCA, NHPCO, & FHSSA	2006-2007	These workshops sought to bring together stakeholders at the national level, including both health providers and drug control officials, to review and address barriers to the availability of controlled medicines related to drug control regulations and practices.
Making Oral Opioids Available in Eastern Europe and Central Asia	OSF, WHPCA, GAPRI	2013	
12 Availability and Rational Use of Opioids workshops covering 24 countries	IAHPC	2010-2018	

(*Continued*)

Table 1
Continued

Activity	Organization	Year	Reflections
International Pain Policy fellowships	Pain and Policy Studies Group	2006, 2008, 2012, 2014	This fellowship program sought to equip dozens of fellows from around the world with knowledge and skills to identify barriers to opioid analgesics use in their countries and engage policy makers on them.
Development of focal points in 12 countries to advocate for improved access to essential palliative care medicines at national, regional, and global levels. (International Association for Hospice and Palliative Care (IAHPC). 2020-2024 Strategic plan. Strategic Objective 1.2. (2020) Available from: https://hospicecare.com/uploads/2019/9/IAHPC%20Strategic%20Plan%202020-2024.pdf Accessed July 15, 2021.)	IAHPC	2020 and ongoing	This project seeks to develop regional focal points on palliative care medicines who can be resources for drug regulatory reforms process in other countries in the region.

The Global Situation Prior to 2000

Although the UN drug control conventions create a dual obligation on member states to a) ensure the adequate availability of controlled substances for medical and scientific use and b) prevent their diversion and non-medical use,[33] in practice many countries focused on the latter, prioritizing drug control and punitive sanctions through criminal justice and policing, priorities that have had profoundly negative effects on the availability and accessibility of medicines that contain controlled substances.[34–36] The focus of drug control laws and regulations in many countries on control − both of licit and illicit substances − severely deters and impacts stocking, prescribing, dispensing and use of opioid analgesics, restricting availability of these medicines for legitimate medical needs. Governments with little understanding of palliative care and the rational use of controlled medicines used diplomatic spaces, such as the UN Commission on Narcotic Drugs, to stymie the development of international norms and commitments to improve access to controlled medicines. As a result, millions of people suffered from inadequately treated pain every year due to the limited availability of opioid analgesics.[37]

While the WHO and International Narcotics Control Board (INCB)—the latter charged with monitoring member states' compliance with the UN drug conventions—periodically raised concern, the pain treatment gap was not an issue on most national or the global health and drug policy agendas. For example, the 1990 and 1998 UN General Assembly Special Sessions on drugs ignored the issue altogether;[38] the UN Commission on Narcotic Drugs, an annual meeting of drug control officials, had never taken steps to address it;[39] and the UN Office on Drugs and Crime focused on illicit use of controlled medicines rather than on their lack of availability. At the national level, drug control authorities were often focused on strengthening drug restrictive laws and criminal justice policies with little consideration for the impact on medical availability of controlled substances.

Developments Since 2000

Starting in the early 2000s, palliative care leaders and civil society organizations, often working in concert with HIV prevention and harm reduction advocates, led efforts to put the issue on national and global agendas and rectify these disparities in access to controlled medicines.

These advocacy activities led to a growing recognition of access to controlled medicines as an important drug control and public health issue that the relevant authorities had to address. At the global level, the political declaration adopted at the 2009 High Level Meeting of the Commission on Narcotic Drugs briefly mentioned access to opioid analgesics.[40] Subsequent

political declarations contained increasingly specific language, culminating in the outcome document of the 2016 UN General Assembly Special Session on the World Drug Problem which included a standalone section on the issue, providing both a detailed analysis of the situation and specific guidance to UN member states.[41] The INCB began preparing periodic supplements to its annual reports describing the situation with controlled medicines and barriers to their availability following a Commission on Narcotic Drugs resolution.[42,43] The UN Office on Drugs and Crime began to engage the topic in 2011 and has since provided technical assistance to several countries on safely improving availability of controlled medicines.[44] Table 2 contains a selection of the most significant resolutions, declarations, and reports by global drug control bodies on controlled medicines.

By 2021, controlled medicines were firmly on the global drug policy agenda; UNODC and INCB had begun systematically collecting and publishing data on access to controlled medicines; and an increasing number of countries had begun to take steps to improve access to controlled medicines—all evidence of fundamentally changed global picture around controlled medicines compared to the early 2000s.

Pediatric Palliative Care

OSF began supporting the development of pediatric palliative care in 1999, funding conferences in Warsaw and Bucharest where faculty provided training on pediatric palliative care and engaged participants in discussions about its integration into national health care plans. In subsequent years, it identified a need for "special advocacy" for children with palliative care needs[29] and supported multiple organizations to do so. It also funded educational programs; supported clinicians to train at centers of excellence, such as the Warsaw Hospice for Children and Hospice Casa Speranti in Romania; provided grants to conferences of the Maruzza Foundation and International Childrens' Palliative Care Network (ICPCN). Together with national foundations, IPCI supported the introduction and development of pediatric palliative care in countries such as Armenia, Georgia, Kazakhstan, Kenya, Kyrgyzstan, Poland, Romania, South Africa, Uganda, Ukraine and Tajikistan. Shaping global norms and standards was a critical part of this effort.

The Global Situation Before 2000

The initial development of pediatric palliative care can be traced back to the early 1970s.[45–47] Prior to 2000, children's hospice and palliative care programs developed mainly in the United Kingdom, Canada, Australia and the United States, although some programs were established in West and Eastern Europe, the Asia-Pacific, Latin America, and Africa, with the latter influenced by the impact of the HIV/AIDS pandemic on children.

Some national and international networks had been established through, among others, Children's Hospice International conferences, the Children's International Project on Palliative/Hospice Services (ChiPPS) under the National Hospice and Palliative Care Network (NHPCO) in the USA in 1998, and workshops at the Warsaw Hospice for Children. The first international guidance on pediatric palliative care emerged in the late 1990s, with WHO publishing Guidelines on Cancer Pain Relief and Palliative Care in Children in 1996 and a definition of palliative care for children in 1998.[47–50] Whilst educational programs were developing, the evidence for pediatric palliative care was minimal.[45]

Developments Since 2000

After 2000, a global movement for pediatric palliative care built on the work of the early pioneers,[46,47] supported by funders such as IPCI; the Diana Princess of Wales Memorial Fund and the True Colours Trust. In 2005, the International Children's Palliative Care Network (ICPCN) was established[51,52] It became an independent organization in 2011 and the global voice for pediatric palliative care with membership in 130 countries, providing e-learning courses that have been taken by over 5,000 individuals from 133 countries;[53] initiating a partnership with UNICEF to estimate the number of children globally who require palliative care;[54] advocating for inclusion of children in the World Health Assembly resolution on palliative care and the Lancet Commission report on access to palliative care and pain control;[55] supporting development through innovative models in low and middle income countries; organizing three international conferences in such countries; and publishing an International Case-Based Manual on Pediatric Palliative Care.[56]

This advocacy has contributed to a rapid increase in recognition of pediatric palliative care as a health priority that is related to but distinct from palliative care adults and the development of a growing body of policy and clinical guidance for states, health systems and workers on the roll out and implementation of pediatric palliative care. At the same time, the availability of pediatric palliative care has rapidly grown around the world, as Figs. 1 and 2 demonstrate, although it is estimated that still only between 5% and 10% of children needing palliative care can access it. Among others, the WHO included pediatric palliative care in the Global Initiative in Childhood Cancer[57] and has published a handbook on integrating palliative care and symptom relief in pediatrics.[58] Significant progress has been made in developing methods to estimate the need for pediatric palliative care and to map service provision.

Table 2
Selected Resolutions, Declaration and Reports of Global Drug Control Bodies on Controlled Medicines

Document	Year	Description and Authors' Commentary
2009 Political Declaration of the High Level Meeting on the World Drug Problem[40]	2009	This was the first time ever that a global drug control strategy adopted by UN member states mentioned availability of controlled medicines. The reference was very brief and did not make specific recommendations to member states but it opened the door for subsequent discussion of the topic.
CND resolution 2010 (United National Office on Drugs and Crime. The Commission on Narcotic Drugs. Promoting adequate availability of internationally controlled licit drugs for medical and scientific purposes while preventing their diversion and abuse. Resolution 53/4. March 2010. Available from: https://www.unodc.org/documents/commissions/CND/Drug_Resolutions/2010-2019/2010/CND_Res-53-4.pdf. Accessed August 5, 2021.)	2010	The Commission on Narcotic Drugs (CND) has met annually since 1946 and has adopted hundreds of resolutions since then. This was the first CND resolution that specifically addressed access to controlled medicines. CND resolutions do not create obligations for member states but provide guidance to the UN Office on Drugs and Crime, other UN agencies and member states on key drug policy issues. This resolution clearly identified access to controlled medicines as an issue that member states considered important.
CND resolution 2011 (United National Office on Drugs and Crime. The Commission on Narcotic Drugs. Promoting adequate availability of internationally controlled narcotic drugs and psychotropic substances for medical and scientific purposes while preventing their diversion and abuse. Resolution 54/6. 2011. Available from: https://www.unodc.org/documents/commissions/CND/Drug_Resolutions/2010-2019/2011/CND_Res-54-6.pdf Accessed August 5, 2021.)	2011	This resolution, which built on the 2010 resolution, called on UN agencies and member states to take a series of steps to improve availability of controlled medicines. While, as noted above, it does not bind states to take specific steps, it was the first time that UN member states recommended specific actions to improve the availability of controlled medicines.
INCB supplement 2010[43]	2011	The International Narcotics Control Board has issued annual reports on illicit drugs and illicit drugs use for decades but these do not cover licit controlled substances. The supplement, the first on controlled medicines in 15 years and a direct response to the 2011 CND resolution, provided a detailed analysis of the availability of controlled substances for medical and scientific purposes, along with recommendations to UN member states on steps to improve access to controlled medicines.
UNODC discussion paper on Ensuring availability of controlled medications for the relief of pain and preventing diversion and abuse[44]	2011	Until this publication, controlled medicines had not been on UNODC's agenda but the 2010 and 2011 CND resolutions inspired it to develop this discussion paper which complemented documents prepared by WHO and INCB to assist member states in moving forward with practical action in this area involving cooperation and coherence at both national and international levels. While none of the recommendations in the document are binding on member states, it demonstrated that palliative care champions had succeeded in firmly putting controlled medicines on the drug policy agenda.
Joint ministerial statement (2014 high-level review by the CND of the implementation by member states of the political declaration and plan of action on international cooperation towards an integrated and balanced strategy to counter the world drug problem United National Office on Drugs and Crime. Joint Ministerial Statement 2014 High-Level Review by the Commission on Narcotic Drugs of the Implementation by Member States of the Political Declaration and Plan of Action on International Cooperation Towards an Integrated and Balanced Strategy to Counter the World Drug Problem. Commission on Narcotic Drugs. Fifty-seventh Session, Vienna, 13-21 March 2014. Available from : https://www.unodc.org/documents/drug-prevention-and-treatment/JOINT_MINISTERIAL_STATEMENT_2014_HIGH_LEVEL_REVIEW_BY_THE_COMMISSION.pdf. Accessed August 5, 2021.)	2014	In 2014, UN member states conducted a mid-term review of the global drug control strategy adopted in 2009 to examine successes, challenges and potential adjustments. The ministerial statement that resulted from this review noted concern about the limited availability of controlled medicines in much of the world and called for international collaboration to improve access to controlled medicines, thus placing a bit more emphasis on the issue than the 2009 strategy itself had done.

(*Continued*)

Table 2
Continued

Document	Year	Description and Authors' Commentary
INCB supplement 2015 (International Narcotics Control Board. Availability of Internationally Controlled Drugs: Ensuring Adequate Access for Medical and Scientific Purposes. (2015). Available from: https://www.incb.org/documents/Publications/AnnualReports/AR2015/English/Supplement-AR15_availability_English.pdf. Accessed August 19, 2021.)	2016	The INCB issued another supplement on controlled medicines, the second in five years, providing another detailed analysis of the availability of controlled substances for medical and scientific purposes. The supplement was prepared to contribute to the discussions of the 2016 UN General Assembly Special Session on the World Drug Problem, which had been called by Colombia, Guatemala and Mexico to critically review the global approach to drugs. For the first time, INCB published its findings in a peer-reviewed journal (Berterame et al, Use of and barriers to access to opioid analgesics: a worldwide, regional, and national study, The Lancet, Vol. 387, Iss. 10028, p. 1644-1656, April 16, 2016. DOI:https://doi.org/10.1016/S0140-6736(16)00161-6)
UNGASS 2016[41]	2016	The 2016 UN General Assembly Special Session on the World Drug Problem, which critically reviewed global drug control approaches, gave much more significant visibility to the issue of controlled medicines that any other high level drug policy document adopted by UN member states before. It included a large standalone section on the issue, providing both a detailed analysis of the situation and specific guidance to UN member states.

In 2020, WHO published new guidelines on chronic pain in children.[59] A wide variety of education programs became available, including e-learning, face-to-face, and virtual modules and competency frameworks.[60,61] A range of models of pediatric palliative care delivery developed globally, as well as mobile-phone health innovations such as the ICPCN Pain App and the MyPal game for reporting patient outcomes.[62] Research on pediatric palliative care grew rapidly with a PubMed search for papers on children's palliative care showing a 700% increase in publications in 2020 as compared to 2000.

Reflections on the Impact of Global Advocacy

Securing high level global political commitment to palliative care—and the development of effective tools to help countries implement it—were important components of the IPCI/PHP's palliative care strategy. In combination with national-level advocacy and technical assistance, they were seen as key drivers of change to improve the availability of palliative care at country level.

As described above, the last twenty years have seen a sea change in the place of (pediatric) palliative care and controlled medicines in the global health and drug policy arena. Palliative care is now firmly on global agendas; national governments have made commitments to improve its availability and that of controlled medicines at the international level; and numerous tools exist to help government in realizing these commitments.

Simultaneous advocacy efforts at the global and national level have, as expected, generated synergies as progress globally has helped accelerate progress at the national level and vice versa. For example, the 2014 WHA palliative care resolution contributed to the inclusion of palliative care in Moldova's universal health coverage package[22] and South Africa's health minister appointing a national steering committee for palliative care to develop a strategic plan for public financing and integration of palliative care into the public healthcare system.[63] Examples of synergies between global palliative care advocacy and national progress were previously documented in India and Kenya.[10]

Yet, the palliative care community has also encountered challenges in translating global commitments into change on the ground as resolutions remain paper documents unless they are implemented. While Australia and Belgium have provided funding to the UN Office on Drugs and Crime and NGOs to improve access to controlled medicines in several countries in Asia and Africa, funding to implement the UNGASS commitments and WHA resolution has been limited. The overdose crisis in the United States has recently

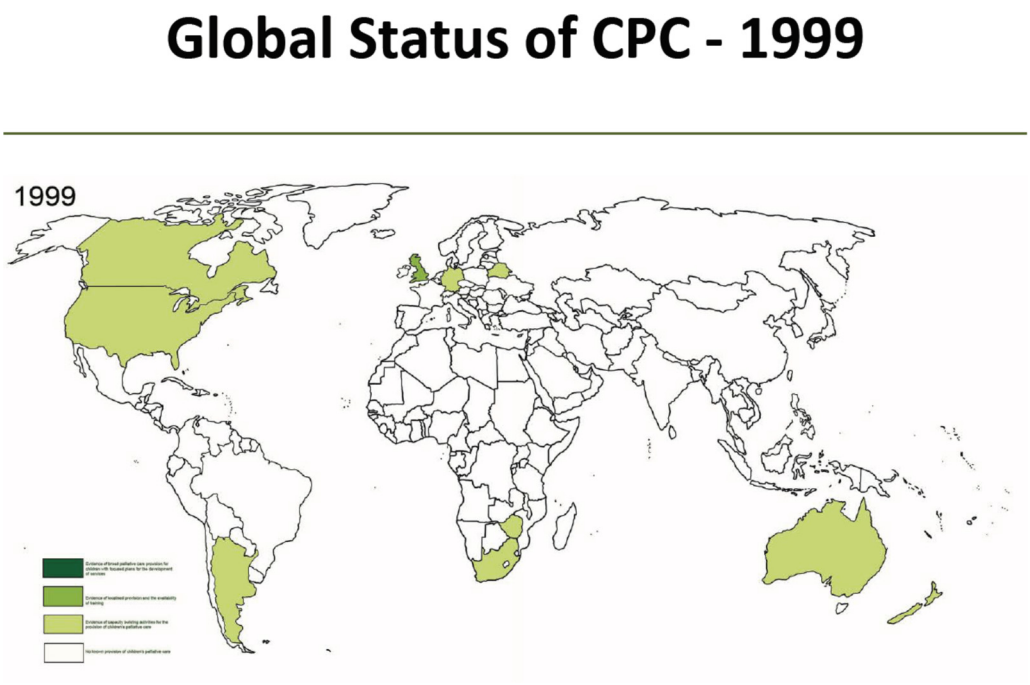


Figure 1. Global status of childrens palliative care in 1999.

created headwinds for efforts to improve access to opioid analgesics for palliative care, despite a widespread consensus that palliative use of opioid analgesics is not part of the problem. The COVID-19 pandemic may create both risks and opportunities for global health priorities, as health security and vaccine access have taken center stage creating uncertainty over the future of universal health coverage and other pre-pandemic priorities—despite the critical role that UHC and palliative care play in a pandemic response. The withdrawal

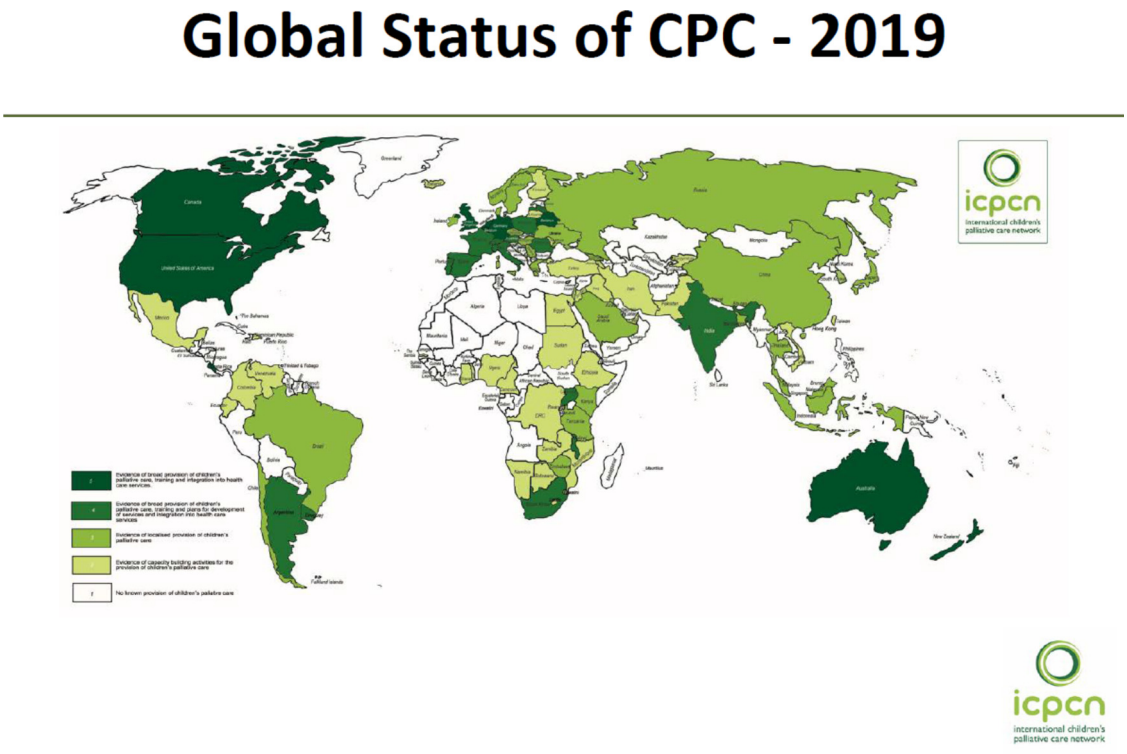


Figure 2. Global status of childrens palliative care in 2019.

of most philanthropic funders with a specific interest in palliative care, including, most recently, OSF, compounds those challenges.

Conclusion

Ensuring access to palliative care is the responsibility of governments under the right to health. It is time for governments to step up and make good on their commitments to roll out palliative care, including for children, and ensure the availability and accessibility of pain medicines. The urgency is all the greater as the need for palliative care worldwide will grow rapidly[64] in the coming decades as a result of global aging and the epidemiological transition from infectious to chronic disease. Over the last twenty years, the palliative care movement has achieved significant progress but government action is required to ensure that health systems around the world are ready for the wave of palliative care need that is about to arrive.

Disclosures and Acknowledgments

DL, JC, SC, LDL, JD, JM, CM and KP declare that they have worked for organizations that received grants from Open Society Foundations to work on the development of palliative care globally. DL and SP were staff of Open Society Foundations to work on the development of palliative care globally. The authors confirm that they do not have any other conflicts of interest to disclose.

The authors are grateful to Mary Callaway and Dr. Kathleen Foley, former director and medical director of Open Society Foundations' International Palliative Care Initiative, and Jonathan Cohen, director of Open Society Foundations' Public Health Program, for their review of and contributions to this manuscript.

The authors thank the staff of OSF's national and regional foundations who have worked so hard to advance palliative care development in their countries over the last 20 years; the staff of the International Palliative Care Initiative, the palliative care subtheme and OSF's Public Health Program more generally; and the leadership of the Public Health Program and OSF whose support made all this work possible.

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