

Special Article**Advancing Palliative Care as a Human Right**

Liz Gwyther, MB ChB, FCFP, MSc, Frank Brennan, MBBS, DCH, Dip Obs, FRACP, FACHPM, LLB, and Richard Harding, BSc, MSc, DipSW, PhD

School of Public Health, University of Cape Town, Cape Town, and Hospice and Palliative Care Association of South Africa (L.G.), Cape Town, South Africa; Calvary Hospital and University of New South Wales (F.B.), Sydney, New South Wales, Australia; and Department of Palliative Care, Policy & Rehabilitation (R.H.), King's College London School of Medicine, London, United Kingdom

Abstract

The international palliative care community has articulated a simple but challenging proposition that palliative care is an international human right. International human rights covenants and the discipline of palliative care have, as common themes, the inherent dignity of the individual and the principles of universality and nondiscrimination. However, when we consider the evidence for the effectiveness of palliative care, the lack of palliative care provision for those who may benefit from it is of grave concern. Three disciplines (palliative care, public health, and human rights) are now interacting with a growing resonance. The maturing of palliative care as a clinical specialty and academic discipline has coincided with the development of a public health approach to global and community-wide health problems. The care of the dying is a public health issue. Given that death is both inevitable and universal, the care of people with life-limiting illness stands equal to all other public health issues. The International Covenant on Economic, Social and Cultural Rights (ICESCR) includes the right to health care and General Comment 14 (paragraph 34) CESCR stipulates that “States are under the obligation to respect the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, ... to preventive, curative and palliative health services.” However, these rights are seen to be aspirational—rights to be achieved progressively over time by each signatory nation to the maximum capacity of their available resources. Although a government may use insufficient resources as a justification for inadequacies of its response to palliative care and pain management, General Comment 14 set out “core obligations” and “obligations of comparable priority” in the provision of health care and placed the burden on governments to justify “that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, [these] obligations.” This article describes recent advocacy activities and explores practical strategies for the palliative care community to use within a human rights framework to advance palliative care development worldwide. *J Pain Symptom Manage* 2009;■:■—■. © 2009 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.

Key Words

Palliative care, human rights, equity, public health, strategy

Background

Worldwide, palliative care workers are concerned that the expansion and support for palliative care services for patients and family

Address correspondence to: Liz Gwyther, MB ChB, FCFP, MSc, P.O. Box 38785, Pinelands 7430, Western Cape, South Africa. E-mail: liz@hpca.co.za

Accepted for publication: March 30, 2009.

members facing the diagnosis of life-threatening illness are not receiving the attention and commitment from health policy makers that it require.¹ There is a sense of urgency to alert governments, health professionals, and communities to the need for palliative care and to its efficacy.² This has led to a growing call for palliative care to be recognized as a human right and obligations that flow from that right to be fulfilled—access to palliative care services for all those patients and their family members that would benefit from this care. The rationale for palliative care to be recognized as a human right has been clearly described. Brennan³ considered the foundation of a right to palliative care with regard to the ICESCR, the obligation of signatory nations, and the difficulties in promoting a human right to palliative care.

It is the consideration of these difficulties that has led to this article. Palliative care workers may view the fact of palliative care as a human right as self-evident, but we need to develop an understanding of human rights instruments and a strategy on how to use these to action access to palliative care locally and internationally. How can this concept be advanced in a practical way? What steps have already been employed?

Current Situation

Whereas many developed countries have established palliative care services, most of these services are voluntary, nongovernmental services and do not receive the attention or funding support of government.³ Most countries do not have palliative care policies or integrated palliative care services. Clark and Wright of the International Observatory on End-of-Life Care have mapped palliative care provision worldwide⁴ (see Fig. 1) and have categorized palliative care provision on four levels: no activity yet identified, capacity building activity, localized provision, and approaching integration. They recognize the broadness of these categories and comment, for example, that Pakistan (in the localized provision category) has one hospital-based palliative care service for the whole country, serving a population of 158 million.⁵ South Africa (approaching integration) has well-established, nongovernmental organization (NGO) services, although not yet country-wide, and a few hospital-based services integrating palliative care into the

formal health care sector. Within the African region, generally, coverage is generally confined to centers of excellence,⁶ although palliative care initiatives to advocate for opioid availability have had some success.⁷

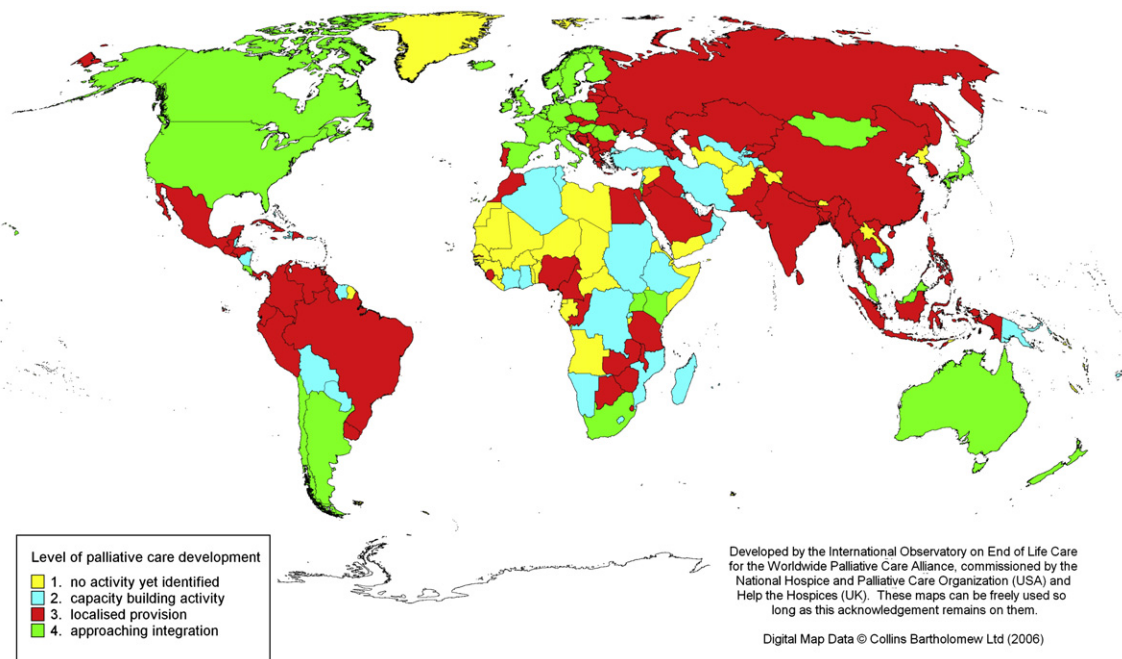
Radbruch et al. notes that even in countries with an adequate standard of care and well-developed health care services, access to palliative care is greater in urban areas and for particular patient groups such as cancer patients.⁸ Access to comprehensive home-based palliative care in the United States is limited to patients with a life expectancy of less than six months, an artifact of the health insurance reimbursement system; hospital-based palliative care services are growing in number but may or may not be linked to service delivery in the home or to care provided by home hospice programs during the period before death. Clinicians who perceive palliative care to be terminal care only with withdrawal of active treatment—as opposed to active management of the disease process, control of distressing symptoms, psychosocial and spiritual support—deny their patients the comprehensive care they require when facing the diagnosis of life-threatening illness. Thus, many human immunodeficiency virus (HIV) patients do not receive palliative care, as their clinicians believe that with antiretroviral treatment, palliative care will no longer be necessary. This, despite the fact that patients on antiretroviral treatment still suffer from distressing symptoms^{9,10} and may still die (2.9 million HIV patients died in 2005¹¹).

Scope of the Problem

The World Health Organization (WHO) estimated that in 2002, 57 million people died, 7 million of whom died of malignant neoplasm.¹² Franks et al. estimated that, in the United Kingdom, 25% of people with advanced cancer will require inpatient palliative care and 65% will require home-based palliative care.¹³ Add to this 2.9 million people who died of AIDS-related illness during 2005,⁶ many in developing countries with resource constraints in delivering health care in general, and the scope of the problem starts to unfold. The statistics provide a concept of the magnitude of the problem but do not describe the suffering experienced

177
178
179
180
181
182
183
184
185
186
187
188
189
190
191
192
193
194
195
196
197
198
199
200
201
202
203
204
205
206
207
208
209
210
211
212
213
214
215
216
217
218
219
220
221
222
223
224
225
226
227
228
229

web 4C/FPO

Fig. 1. World map: level of palliative care development.⁴

nor the length or severity of the illness before death. Moreover, throughout the world, there are growing numbers of individuals who suffer and die from end-stage cardiac, respiratory, renal, and hepatic conditions and life-limiting neurological conditions. These people are likely to experience problems that also would benefit from palliative care.²

Human Rights Covenants

Both palliative care and human rights are based on principles of the dignity of the individual and the principles of universality and non-discrimination. To palliative care personnel, this creates a self-evident premise that palliative care is a human right. However, we need to look closely at the history of human rights development and the human rights covenants that have been established to pursue this claim.

The International Bill of Rights comprises the UN Declaration of Human Rights, the International Covenant on Civil and Political Rights, and the ICESCR. Article 25.1 of the Universal Declaration of Human Rights states, "Everyone has the right to a standard of living adequate for the health of himself and his family, including food, clothing, housing and medical care and

necessary social services."¹⁴ The ICESCR Article 12.1 asserts that "the State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."¹⁵

The ICESCR is seen as aspirational in that, in resource-constrained settings, these rights may not be immediately attainable but State Parties that are signatories of the ICESCR commit to progressive realization of the right to health over a period of time and to reporting on the steps taken to reach this goal. It is also recognized that the right to health includes a number of socioeconomic factors "such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment."¹ This raises the question of how to prioritize a population's socioeconomic needs in working toward the realization of the rights articulated in the ICESCR. General Comment No. 14 issued by the committee that oversees the ICESCR asserts that "in particular, States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services¹⁶"; General Comment No 14

230
231
232
233
234
235
236
237
238
239
240
241
242
243
244
245
246
247
248
249
250
251
252
253
254
255
256
257
258
259
260
261
262
263
264
265
266
267
268
269
270
271
272
273
274
275
276
277
278
279
280
281
282

283 further describes (in the section on older persons) “attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity.”

284 Thus, palliative care is already articulated as
285 a human right within the International Bill of
286 Rights. Some countries have taken this further
287 and included palliative care in official docu-
288 ments. In 2000, a Standing Committee of the
289 Canadian Senate proclaimed that end-of-life
290 care was a right of every citizen.¹⁷ In 2003,
291 the European Committee of Ministers adopted
292 a recommendation which stated, in part, “pal-
293 liative care is...an inalienable element of a citi-
294 zen’s right to health care.”¹⁸ The South
295 African Department of Health’s Patients’
296 Rights Charter¹⁹ describes access to health
297 care: “Everyone has the right of access to
298 health care services that include: iii. provision
299 for special needs in the case of...patients in
300 pain, persons living with HIV or AIDS patients;
301 v. palliative care that is affordable and effective
302 in cases of incurable or terminal illness.”

303 *Statements From the International 304 Palliative Care Community*

305 The international palliative care community
306 has made a number of key statements, including
307 the Cape Town Declaration (2002),²⁰ the Korea
308 Declaration (2005),¹ and the Budapest Com-
309 mitments (2007).²¹ The consensus is a call to
310 governments for

- 311 1. the creation and implementation of palli-
312 ative care policies
- 313 2. equity of access to services, without
314 discrimination
- 315 3. availability and affordability of critical
316 medications, including opioids
- 317 4. the provision of palliative care at all levels
318 of care
- 319 5. the integration of palliative care education
320 at all levels of the learning continuum from
321 informal caregivers to health professionals.

322 *Strategies to Implement Palliative Care 323 Into Health Care Systems*

324 A key partner in palliative care development
325 worldwide is the WHO. There are a number of

326 important clinical and policy guide books that
327 assist health care workers in managing pain
328 and other distressing symptoms, and policy
329 makers in implementing cancer control and
330 palliative care programs. WHO recommends
331 a public health strategy to assist governments
332 in integrating palliative care into the country’s
333 health care system. The main elements of this
334 strategy are 1) policy development; 2) drug
335 availability; 3) education of policy makers
336 and health care workers and improving com-
337 munity awareness regarding the service of pal-
338 liative care; and 4) implementation of
339 palliative care at primary, secondary, and
340 tertiary care levels.²²

341 This strategy is mirrored in the initiative de-
342 veloped by the European Association of Pallia-
343 tive Care, the International Association for
344 Hospice and Palliative Care (IAHPC), and the
345 Worldwide Palliative Care Alliance (WPCA),
346 namely the Budapest Commitments.¹³ The fo-
347 cus of this initiative is to help individuals and na-
348 tional palliative care organizations to develop
349 effective strategies to meet the needs of patients
350 requiring palliative care. The proposed areas of
351 work are drug availability, policy development,
352 palliative care education, quality of care, and
353 palliative care research. None of the basic initia-
354 tives of palliative care education, policy develop-
355 ment, and legislation to ensure availability of
356 essential palliative care drugs are costly, and all
357 governments could subscribe to these activities.
358 The growth of palliative care that is culturally
359 appropriate, affordable, and effective in re-
360 source-poor settings demonstrates the feasibil-
361 ity of palliative care provision. This growth
362 goes some way to allaying fears that invoking
363 a legislative catalyst for provision would prove
364 too expensive and ultimately unsustainable.

365 *Addressing Barriers to Palliative Care 366 Development*

367 Although it appears to be a straightforward ex-
368 ercise to ensure accessibility of palliative care to
369 all patients requiring this service, there are still
370 a number of significant barriers to implement-
371 ing the essential elements of the right to pallia-
372 tive care: availability, accessibility, acceptability,
373 and quality. These barriers include lack of polit-
374 ical support and awareness; social and cultural is-
375 sues; “opiophobia” and “opioignorance”

389 (inadequate teaching of doctors and nurses in
390 pain management); entrenched attitudes within
391 the medical profession; and low prioritization of
392 palliative care among policy makers, health ad-
393 ministrators, and health care educators. It is to
394 address these barriers that the international pal-
395 liative care community has identified a need to
396 work within a human rights framework, in addi-
397 tion to current initiatives, to advance the devel-
398 opment of palliative care.

401 ***Human Rights Mechanisms to Advance*** 402 ***Access to Palliative Care*** 403

404 There are a number of human rights mech-
405 anisms that can be used by the palliative care
406 community to advance access to palliative
407 care. These include

- 408 1. entering into correspondence with the
409 Special Rapporteur to the UN Human
410 Rights Commission on the Right to Health
411
- 412 2. outlining specific national and interna-
413 tional palliative care issues
- 414 3. questioning signatory nations to ICESCR
415 on their compliance with the “core obli-
416 gations” relating to palliative care
- 417 4. making a statement endorsing palliative
418 care as a significant element of health care,
419 describing the core obligations expected of
420 nations and endorsing the work of the WHO
- 421 5. there is also an opportunity to use the re-
422 course of complaint to the UN Human
423 Rights Commission.

424 At national level, several strategies are avail-
425 able. It may be that government and health
426 officials are not aware of the obligations placed
427 on them through the signing of the human
428 rights covenants or the contents of the coven-
429 ants. Discussion of these documents with
430 health care policy makers would alert them the
431 need to develop palliative care policies. Palliative
432 care organizations could assist their govern-
433 ments to comply with their obligations to pro-
434 vide health care within the context of palliative
435 care, including policy development, opioid law
436 reform, and providing palliative care education.
437 The Wisconsin Pain and Policy Study Group has
438 been active in various parts of the world—East-
439 ern Europe, India, and sub-Saharan Africa—to
440 assist palliative care organizations in influencing
441 governments with regard to opioid legislation.

442 Effective pain management is an essential
443 component of palliative care and is empha-
444 sized in the WHO definition of palliative
445 care.²³ Pain management is a strong and emo-
446 tive aspect of palliative care that policy makers,
447 health care workers, and community members
448 are able to understand, often better than the
449 complexities of components of comprehensive
450 palliative care, and can be used as the first step
451 in promoting access to palliative care. In 2004,
452 the International Narcotics Control Board
453 published the per capita use of morphine for
454 medical purposes for all countries for the pre-
455 vious year.²⁴ Six nations accounted for 79% of
456 all analgesic morphine consumption. Coun-
457 tries comprising 80% of the world’s population
458 used 6% of the world’s consumption of mor-
459 phine for medical purposes. This represents
460 an appalling discrepancy in achieving equity
461 of access to pain-relieving medications and is
462 a strong advocacy focus.

463 ***From Theory to Practice*** 464

465 The last year has seen significant activity in
466 employing an approach based on human
467 rights to advance both pain management and
468 palliative care.
469

- 470 1. Conference presentations^{25,26} and work-
471 shops²⁷ have assisted in creating aware-
472 ness of human rights documents and
473 mechanisms among palliative care profes-
474 sionals with practical advice on how to
475 engage government in discussion to rec-
476 ognize the need to integrate palliative
477 care into health care systems.
478
- 479 2. Following sustained advocacy by the
480 IAHPIC and the WPCA, two United Na-
481 tions Special Rapporteurs on Human
482 Rights issues have made clear and explicit
483 statements to the international commu-
484 nity linking pain management and pallia-
485 tive care to human rights. In a statement
486 made to the UN Human Rights Council
487 in 2008, the Special Rapporteur on the
488 Right to Health placed palliative care
489 firmly within the obligations that derive
490 from the international right to health:
491

492 Many other right-to-health issues need urgent
493 attention, such as palliative care.... Every year
494

495 millions suffer horrific, avoidable pain.... Palliative care needs greater attention.²⁸

496
497 Similarly, in a joint statement, the UN Special
498 Rapporteur on the Right to Health and the Special
499 Rapporteur on Torture, after reviewing the
500 inadequacies of pain management and palliative
501 care around the world, stated that:

502
503 The failure to ensure access to controlled
504 medicines for the relief of pain and suffering
505 threatens fundamental rights to health
506 and to protection against cruel inhuman
507 and degrading treatment. International human
508 rights law requires that governments
509 must provide essential medicines—which include,
510 among others, opioid analgesics—as part of their
511 minimum core obligations under the right to health.
512 ...Lack of access to essential medicines, including
513 for pain relief, is a global human rights issue
514 and must be addressed forcefully....²⁹

515
516
517 3. Regional Advocacy Workshops for palliative
518 care and accessibility of essential pain medication.
519 The Wisconsin Pain and Policy Study Group has
520 been active in various parts of the world—Eastern
521 Europe, India, and sub-Saharan Africa—to assist
522 palliative care organizations in influencing
523 governments with regard to opioid legislation.³⁰

524
525
526 4. Submission to the UN Human Rights Council
527 on HIV/AIDS. In October 2008, a joint submission
528 was made by the IAHP, the WPCA, and the International
529 Association for the Study of Pain (IASP) to the
530 UN Human Rights Council. In summary, it outlined
531 the human rights implications of pain management
532 and palliative care for patients with HIV/AIDS
533 and their families. It reminded the council that
534 the UN Joint Programme on HIV/AIDS (UNAIDS)
535 and the Declaration of Commitment on HIV/AIDS
536 by the UN General Assembly both indicated the
537 commitment of the United Nations to promoting a
538 human rights perspective on the care and management
539 of HIV/AIDS. It stated that palliative care, generally,
540 and pain management, in particular, for patients
541 with HIV/AIDS, is undertreated, poorly resourced,
542 and subject to multiple barriers. It stated that
543 most nations have signed one or

548 more UN human rights instruments that
549 contain the right to health care.

550 5. Collaboration between Human Rights
551 Watch and the international palliative care
552 community to highlight the need for opioid use
553 for medical purposes with the Narcotic Drugs
554 Committee at the United Nation. The committee
555 overseeing the ICESCR is preparing a general
556 comment on the issue of discrimination. A
557 submission has been made to the committee by
558 the IAHP, the WPCA, and the IASP describing
559 discrimination in the provision of, and access to,
560 both pain management and palliative care. The
561 submission argued that draconian domestic opioid
562 laws, policies, and practices that restrict opioid
563 availability, accessibility, and affordability
564 constitute a significant discrimination against
565 patients in pain and the dying. Other examples
566 of de facto discrimination in the provision of
567 pain management and palliative care are laws,
568 policies, and practices that fail to provide
569 adequate health care services in rural and remote
570 areas or fail to provide adequate health care
571 services for children, patients with HIV/AIDS,
572 indigenous persons, persons with disabilities,
573 prisoners, women, refugees, and stateless
574 persons.

575
576
577 6. World Hospice Palliative Care Day. The
578 2008 theme for this day was Palliative Care as
579 a Human Right. Concurrent with World Day,
580 the IAHP and the WPCA promulgated the Joint
581 Declaration and Statement of Commitment on
582 Palliative Care and Pain Treatment as Human
583 Rights (2008).³¹

584
585
586 7. In October 2008, the African Palliative
587 Care Association hosted a meeting in Nairobi
588 for heads of African medical and nursing
589 schools to encourage the integration of palliative
590 care into medical and nursing training and to
591 develop plans on how to accomplish this.

592
593 8. The IASP has designated the year October
594 2008 to October 2009 as the Global Year
595 Against Cancer Pain.³²

596
597 It is particularly encouraging to note the
598 statements by the special rapporteurs. These
599 statements are a major breakthrough. They
600 not only represent the most explicit linkage of

human rights with pain management and palliative care made to date by representatives of the United Nations, but they also provide clinicians and advocates a clear recommendations to present to the health ministries of individual countries. Clinicians and advocates may argue for the integration of palliative care into health care systems on the basis of evidence and a medical and moral imperative. These arguments are more powerful when supported by clear statements of national obligations articulated by senior members of the UN system.

Shadow Reports on Individual Countries

All nations that are signatory to the International Covenants that contain the right to health care are expected to report to committees overseeing those covenants on the progress of their compliance with that obligation. NGOs may submit shadow reports on that country's performance. It is planned that the coalition of the IAHP, the WPCA, and the IASP will commence submitting shadow reports on the status of palliative care and pain management of individual nations.

It is important to build on the advocacy and policy initiatives of palliative care workers worldwide to ensure that patients and their families facing the problems associated with life-threatening illness are afforded the care they require in whatever country and setting they live. We recommend contact with national, regional, and international palliative care associations to share learning and to strategize mechanisms to influence policy.

Conclusions

The growing consensus between the disciplines of palliative care, public health, and human rights provides an opportunity to collaborate in advancing the access to palliative care for patients and family members facing the diagnosis of life-threatening illness. It strengthens our mandate to act as advocates for this group of people who because of their illness or grief have not had the capacity to demand the services they need. As Chochinov stated in his eloquent address to the Canadian

Senate Standing Committee on Social Affairs, Science and Technology: "Unfortunately, in end-of-life care, we do not have a vocal constituency: The dead are no longer here to speak, the dying often cannot speak, and the bereaved are often too overcome by their loss to speak."¹⁷

Recent initiatives have emphasized that with clear strategy and effective action we can achieve policy change and promote integration of palliative care into public health programs. The development of expertise in using human rights mechanisms improves palliative care professionals' effectiveness in discussions with health policy makers.

The human rights approach to advancing palliative care development serves to coalesce a broad medical, moral, and legal imperative—that the care of patients with life-threatening illness is a fundamental responsibility of governments, societies, and health professionals.

Acknowledgments

The authors acknowledge the support provided by the Open Society Institute in funding the project that led to this article.

References

1. National Hospice and Palliative Care Associations. The Korea declaration. Report of the second global summit of National Hospice and Palliative Care Associations, Seoul, Korea, 2005. Available from http://www.eolc-observatory.net/global/pdf/NHPCA_2.pdf.
2. Higginson IJ. Evidence based palliative care. There is some evidence—and there needs to be more. *BMJ* 1999;319(7208):462–463.
3. Brennan F. Palliative care as an international human right. *J Pain Symptom Manage* 2007;33(5):494–499.
4. Clark D, Wright M. The International Observatory on End of Life Care: a global view of palliative care development. *J Pain Symptom Manage* 2007;33(5):542–546.
5. World Health Organization. Core health indicators: Pakistan. Available from http://www.who.int/whosis/database/core/core_select_process.cfm%3Fcountry%3Dpak%26indicators%3Dselected%26language%3Den. Accessed November 11, 2007.
6. Harding R, Higginson IJ. Palliative care in Sub-Saharan Africa: an appraisal of reported activities, evidence and opportunities. *Lancet* 2005;365:1971–1977.

Q3

Q4

Q2

707 7. Logie D, Harding R. An evaluation of a mor-
708 phine public health programme for cancer and
709 AIDS pain relief in Sub-Saharan Africa. *BMC Public*
710 *Health* 2005;5:82.

711 8. Radbruch L, Foley K, De Lima L, Prail D,
712 Furst CJ. The Budapest Commitments: setting the
713 goals—a joint initiative by the European Association
714 for Palliative Care, the International Association for
715 Hospice and Palliative Care and Help the Hospices.
716 *Palliat Med* 2007;21:269–271.

717 9. Sherr L, Harding R, Norwood S, et al. Successive
718 switching of antiretroviral therapy is associated with
719 high psychological and physical burden. *Int J STD*
720 *AIDS* 2007;18:700–704.

721 10. Harding R, Molloy T, Easterbrook PE, Frame K,
722 Higginson IJ. Is antiretroviral therapy associated
723 with symptom prevalence and burden? *Int J STD*
724 *AIDS* 2006;17:400–405.

725 11. UNAIDS. AIDS epidemic update. Global summary
726 of the AIDS epidemic. Geneva, Switzerland: UNAIDS, 2006.

727 12. World Health Organization. WHO mortality data-
728 base: tables. Available from <http://www.who.int/healthinfo/morttables/en/index.html>. Accessed No-
729 vember 11, 2007.

Q5

730 13. Franks PJ, Salisbury C, Bosanquet N, et al. The
731 level of need for palliative care: a systematic review
732 of the literature. *Palliat Med* 2000;14:93–104.

733 14. United Nations. The universal declaration of
734 human rights. 1948. Available from <http://www.un.org/Overview/rights.html>.

735 15. International covenant on economic, social and
736 cultural rights, article 12. Geneva, Switzerland: Of-
737 fice of the High Commissioner for Human Rights,
738 1966. Available from http://www.unhchr.ch/html/menu3/b/a_cescr.htm.

739 16. Committee on Economic, Social and Cultural
740 Rights. General comment no.14. Twenty-second ses-
741 sion. Geneva, April 25–May 12, 2000. Available
742 from <http://www.unhchr.ch/html/menu2/6/cescr.htm>.

743 17. Standing Committee on Social Affairs, Sci-
744 ence and Technology. Quality end-of-life care:
745 The rights of every Canadian. Final report of the
746 subcommittee to update of life and death. Ot-
747 tawa, ON: Senate of Canada, 2000. Available
748 from <http://www.parl.gc.ca/36/2/parlbus/commbus/senate/Com-e/upda-e/rep-e/repfinjun00-e.htm>. Accessed October 13, 2007.

749 18. Council of Europe. Recommendation rec
750 (2003)24 of the committee of ministers to member
751 states on the organisation of palliative care and ex-
752 planatory memorandum. Available from [http://www.coe.int/T/E/Social_Cohesion/Health/Recommendations/Rec\(2003\)24.asp](http://www.coe.int/T/E/Social_Cohesion/Health/Recommendations/Rec(2003)24.asp)

753 19. Department of Health, South Africa. The pa-
754 tients' rights charter. Available from <http://www.doh.gov.za/docs/legislation/patientsright/chartere.html>. Accessed May 14, 2007.

755 20. Mpanga-Sebuyira L, Mwangi-Powell F, Pereira J,
756 Spence C. The Cape Town Palliative Care Declara-
757 tion: home-grown solutions for sub-Saharan Africa.
758 *J Palliat Med* 2003;6:341–343.

759 21. European Association for Palliative Care. The
760 Budapest Commitments. Available from <http://www.eapcnet.org/congresses/Budapest2007/Budapest2007Commitments.htm>. Accessed November 11, 2007.

761 22. Stjernsward J, Foley KM, Ferris FD. The public
762 health strategy for palliative care. *J Pain Symptom*
763 *Manage* 2007;33(5):486–493.

764 23. Sepulveda C, Marlin A, Yoshida T, Ullrich A. Pal-
765 liative care: the World Health Organization's global
766 perspective. *J Pain Symptom Manage* 2002;24:91–96.

767 24. International Narcotics Control Board. Report of
768 the International Narcotics Control Board for 2004.
769 Vienna, Austria: International Narcotics Control
770 Board, 2004.

771 25. Gwyther L. Palliative care as a human right. Paper
772 presented at: 2nd African Palliative Care Association
773 Conference; 2007; Nairobi, Kenya.

774 26. Gwyther L, Brennan F. Advancing palliative care
775 as a human right. Paper presented at: 17th Congress
776 on Palliative Care; 2008; Montreal, QC.

777 27. Open Society Institute. Equal partners: health
778 and human rights. Cape Town, South Africa, June
779 3–8, 2007. Available from <http://www.soros.org/initiatives/health/focus/law/events/partners20070603>. Accessed January 13, 2009.

780 28. UN Human Rights Council. Statement by Paul
781 Hunt, special rapporteur on the right of everyone
782 to the highest attainable standard of physical and
783 mental health. 2009. Available from http://www.hospicecare.com/resources/pain_pallcare_hr/list.html.

784 29. Special rapporteurs on the question of torture
785 and the right of everyone to the highest attainable
786 standard of physical and mental health. Letter to
787 Mr. D. Best, vice-chairperson of the commission
788 on narcotic drugs, December 10, 2008.

789 30. African Palliative Care Association. APCA advoca-
790 cy workshop for palliative care in Africa: A focus
791 on essential pain medication. Windhoek, Namibia,
792 February 2008.

793 31. International Association for Hospice and Palli-
794 ative Care and the Worldwide Palliative Care Alli-
795 ance. Joint declaration and statement of
796 commitment on palliative care and pain treatment
797 as human rights. Available from http://www.hospicecare.com/resources/pain_pallcare_hr/docs/jdsc.pdf. Accessed November 14, 2008.

798 32. International Association for the Study of Pain.
799 Global year against cancer pain. October 2008–
800 October 2009. Available from <http://www.iasp-pain.org>. Accessed January 6, 2009.

Q6

Q7