Introduction

Ensuring the integration of palliative care into healthcare responses to humanitarian crises varies depending on the type of crisis and length of time that aid is required. Humanitarian crises take myriad forms and thus can be extremely variable in length and complexity. The average length of crises with an active inter-agency appeal rose from 4 to 7 years between 2005 and 2017, reflecting the increasing complexity and protracted nature of current crises. There is, therefore, a real need to respond to rapidly emergent or short-term crises while recognizing that the overall trend is increasing numbers and increasingly likely to be protracted.
Providing palliative care requires organizational policies, guidelines, and standards that include palliative care; training, education, and skills; access to essential palliative care equipment and medicines, including opioids; collaboration and integration with local services; and close engagement and support of palliative care specialists.

**The Sphere Standards and the Cluster System**

All acute crises require palliative care expertise to be integrated into the initial or existing healthcare response.

The foundational standards for coordination and collaboration are set out in the *Sphere Handbook*, specifically Core Standard 2, which provides guidance on the actions required to ensure that coordination and collaboration are embedded in an agency’s response. Such standards apply for UN or non-UN agencies, and international as well as regional or local responders. These key actions within this standard include such aspects as participation; sharing of agency mandate; information sharing in the response; policy on and practice in engagement; and being informed about the coordination role of the state and other coordination groups. In addition, the *Sphere Handbook* outlines in Standard 2.6, Care of Non-communicable Diseases, the need to establish a referral system, including to palliative and supportive care. Finally, the 2018 edition of the *Sphere Handbook* incorporates—for the first time—a specific standard on palliative care. This is essential reading for anyone providing or intending to provide palliative care in humanitarian settings, as it lays out key actions that support integration. These include the establishment of guidelines and policies, including for triage; development of care plans; integration at all levels of the health system, focusing on home-based care; training of healthcare workers; and working closely with local systems and networks.

This last key action—working with local systems—is critically important to ensure that patients, caregivers, and families are supported in the community and at home. Such local systems may include national palliative care associations, hospices, faith-based organizations, and local medical and nonmedical staff experienced in palliative care in the country.

One essential mechanism for the coordination of agencies in emergencies is the cluster system was proposed by the IASC (Inter-Agency Standing Committee) of the UN in 2006 to improve humanitarian effectiveness. Clusters comprise humanitarian organizations across the main sectors in emergencies. For palliative care, the relevant cluster is health, and the global cluster lead is the World Health Organization (WHO), often co-chaired with a national government representative.
Localization and the National Disaster Management Office

Coming out of the World Humanitarian Summit in 2016, there was much focus on the issue of localization, to meet the growing global humanitarian challenge. But as the Australian Red Cross has noted, “the dominant approach to localisation within organisations has been to tweak—in a programmatic sense—rather than re-think the systematic approach to local humanitarian action.”

In researching this issue, the Pacific region provided a definition (now adopted by the Organisation for Economic Co-operation and Development [OECD]) of localization as “. . . a process of recognising, respecting and strengthening the independence of leadership and decision making by national actors in humanitarian action, in order to better address the needs of affected populations.” Recommendations arising from this research highlighted key requirements for effective localized action, including leadership by national actors at all levels; building on and strengthening local practices; maximizing national and regional capacity before requesting international support; and being directed by nationally appropriate tools, systems, and processes.

In integrating palliative care to strengthen the formal healthcare system and attain long-term sustainability, these key approaches must be explicitly considered and used. One essential point of engagement in-country will be the National Disaster Management Office (NDMO) or its equivalent. The NDMO is the national coordinating agency for disasters within a country and must be engaged with for any responding individual or organization. The NDMO will be constituted differently by country but has a leading role and must be respected as the sovereign decision-making body regarding deployments to areas of need and the prioritization of activities and affected populations. Any responders must contact the NDMO and ensure that they engage with the cluster approach, if in operation.

Emergency Medical Teams

Emergency medical teams (EMTs) are groups of health professionals providing medical care locally and internationally in humanitarian emergencies. Their work is supported by WHO-established minimum standards and a global registry.

While the WHO classification of EMTs is focused on surgical care, in general terms it has a “sliding scale” of care from EMT type 1 to type 3, with EMT type 3 being most complex and specialized. An EMT type 1 provides outpatient emergency care, EMT type 2 provides inpatient surgical emergency and other general care, and EMT type 3 provides complex inpatient referral surgical care including intensive care.

Palliative care clinicians would likely be deployed in an EMT type 3, but palliative care services can and should be considered for all EMTs.
ensuring the competencies, essential medications, and guidance are integrated at all levels.3

Foundations for Integration of Palliative Care

The existing evidence base regarding integration of palliative care into emergency humanitarian settings is currently limited. There is, however, evidence of effective integration into longer-term humanitarian situations in Jordan,6 Bangladesh,7 Nepal,8 and Uganda.9

There is also evidence of successful palliative care integration in low-resource settings. Malawi, for example, has a national palliative care policy and a national development program for adults and children. There is also enormous palliative care experience and expertise that has been developed through the well-documented response to HIV, AIDS, and tuberculosis in sub-Saharan Africa10 that should be drawn on in responding to humanitarian crises locally and internationally. Based on this expertise the following elements comprise a foundation of palliative care integration:

• Inclusion of palliative care in organizational policy of humanitarian healthcare response teams, locally and internationally
• Routine or “just-in-time” training of humanitarian healthcare workers in all essential components of palliative care provision
• Routine or “just-in-time” training of palliative care specialist teams or individuals regarding working in humanitarian situations3
• Training of community-based palliative care providers in basic palliative care surveillance, counseling, and spiritual and psychosocial support
• Embedding the principles of localization by maximizing the capacity of local health services and giving leading roles to existing care organizations and networks4
• Ensuring that existing or newly established referral pathways for patients requiring specialist care include palliative care11
• Routine surveillance to identify palliative care needs, involving community members11
• An embedded referral system involving both nongovernmental and government organizations
• Access to palliative care medicines, including opioids, incorporated into local systems of pharmaceutical storage, distribution, prescription, and provision11
• Provision of palliative care beds in hospitals and clinics, if feasible
Integrating Palliative Care into Long-Term Humanitarian Emergencies

Many acute emergencies, particularly complex humanitarian emergencies, can become protracted, and agencies must therefore look at ways to integrate palliative care fully within routine care provision for affected populations, akin to development contexts.

Such integration can occur through:

- Building palliative care expertise across primary healthcare staff. This requires training of all providers in the principles and practice of palliative care.
- Inclusion of a palliative care team or specialists within the primary healthcare system. Palliative care expertise can be made available for direct care, in an advisory capacity, or to facilitate referral out of the humanitarian areas, if available.11
- Training, mentoring, and supervision of community members as palliative care assistants and volunteers,9 utilizing technology for training, communication, and expert advice.12
- Provision of independent palliative care teams through an external agency or from within the country8
- Establishment of a palliative care centre linked to a community palliative care team or teams9

Ultimately, integration of palliative care into the local healthcare system is a longer-term objective, in line with the Sustainable Development Goal of universal health coverage.13

References


 Practical Tips on Integrating Palliative Care


