

# Integrating palliative care and symptom relief into the response to humanitarian emergencies and crises

A WHO guide



World Health  
Organization

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## Abbreviations and acronyms

<b>CHC</b>	community health centre
<b>CHS</b>	Core Humanitarian Standard on Quality and Accountability
<b>CHW</b>	community health worker
<b>EMT</b>	emergency medical team
<b>EP Hum</b>	Essential Package of Palliative Care for Humanitarian Emergencies and Crises
<b>ERC</b>	United Nations Emergency Relief Coordinator
<b>HICs</b>	high-income countries
<b>IASC</b>	United Nations Inter-Agency Standing Committee (for humanitarian action)
<b>ICRC</b>	International Committee of the Red Cross
<b>IDP</b>	internally displaced person
<b>IFRC</b>	International Federation of Red Cross and Red Crescent Societies
<b>INCB</b>	International Narcotics Control Board
<b>IOM</b>	United Nations International Organization for Migration
<b>ISDR</b>	International Strategy for Disaster Reduction
<b>LMICs</b>	low- and middle-income countries
<b>MHPSS</b>	mental health and psychosocial support
<b>MoH</b>	Ministry of Health
<b>MSF</b>	Médecins Sans Frontières (Doctors without Borders)
<b>NCDs</b>	noncommunicable diseases
<b>NDMO</b>	National Disaster Management Organization
<b>NGO</b>	nongovernmental organization
<b>OCHA (or UNOCHA)</b>	United Nations Office for the Coordination of Humanitarian Affairs
<b>PFA</b>	psychological first aid
<b>PTSD</b>	post-traumatic stress disorder
<b>SARS</b>	Severe Acute Respiratory Syndrome
<b>SSRI</b>	selective serotonin reuptake inhibitor
<b>UN</b>	United Nations
<b>UNDP</b>	United Nations Development Programme
<b>UNHCR</b>	United Nations High Commissioner for Refugees
<b>UNICEF</b>	United Nations Children's Fund
<b>UNOCHA (or OCHA)</b>	United Nations Office for the Coordination of Humanitarian Affairs
<b>WHO</b>	World Health Organization



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# Foreword

Humanitarian emergencies and crises (Humanitarian emergencies and crises) are large-scale events that may result in the breakdown of health care systems and society, forced displacement, death, and physical, psychological, social and spiritual suffering on a massive scale. Current responses to Humanitarian emergencies and crises rightfully focus on saving lives, but for both ethical and medical reasons, the prevention and relief of pain, as well as other physical and psychological symptoms, social and spiritual distress, also are imperative. Therefore, palliative care, should be integrated into responses to Humanitarian emergencies and crises.

The principles of humanitarianism and impartiality require that all patients receive care and should never be abandoned for any reason, even if they are dying. Thus, there is significant overlap in the principles and mission of palliative care and humanitarianism: relief of suffering; respect for the dignity of all people; support for basic needs; and accompaniment during the most difficult of times.

This manual is part of a series of WHO publications on palliative care. Their objective is not to provide clinical guidelines but rather practical guidance on integrating palliative care and symptom relief into health care systems. The current publication is intended to assist anyone involved with planning, implementing or managing responses to Humanitarian emergencies and crises, as well as palliative care leaders and practitioners interested in participating in responses to Humanitarian emergencies and crises.

With this guide, WHO reiterates its commitment to answering the needs and expectations of all people, especially the most vulnerable.





# Introduction

The United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) reports that, in 2015, nearly 125 million people needed humanitarian assistance worldwide (1). Yet responses to humanitarian emergencies and crises rarely provide palliative care, the discipline devoted to preventing and relieving suffering rather than to specific diseases, organs or technical skills. This guide, the fourth in a series of World Health Organization (WHO) guidance documents on palliative care, describes the medical and moral necessity of integrating palliative care and pain relief into responses to humanitarian emergencies and crises of all types. It offers an expanded conception of palliative care based on the needs of people affected by humanitarian emergencies and crises and proposes an Essential Package of Palliative Care for Humanitarian Emergencies and Crises (EP Hum).







## 1

# What is humanitarianism?

Humanitarianism can be defined simply as the benevolent response to the suffering and needs of others. It is action to prevent and alleviate human suffering wherever it may be found, to protect life and health, and to ensure respect for the human being. Motivated typically by charity, solidarity or a sense that one should not remain passive while others are in need, humanitarianism encompasses responses to suffering caused by disaster, conflict, a health emergency or protracted poverty. It often entails providing health care and social supports such as protection, food, water, shelter, sanitation and education.

Aghast by the unattended suffering of thousands of wounded after the Battle of Solferino in Italy in 1859, the Swiss businessman Henry Dunant conceived the idea for what became the International Committee of the Red Cross (ICRC). It met for the first time in 1863 in Geneva, and in 1864 it organized a conference during which the first Geneva Convention was signed. The Geneva Conventions of 1864, 1906, 1929 and 1949, and their Additional Protocols, are the foundation of international humanitarian law (Annex 5). They specifically protect people who are not taking part in the hostilities (civilians, health workers and aid workers) and those who are no longer participating in the hostilities, such as wounded, sick and shipwrecked soldiers and prisoners of war.

In 1965, the 20th International Conference of the Red Cross proclaimed seven fundamental principles as the basis for the Red Cross (4). The first four principles also help to define humanitarianism:

1. **Humanity:** preventing and alleviating human suffering wherever it may be found, protecting life and health, ensuring respect for the human being, promoting mutual understanding, friendship, cooperation and lasting peace among all peoples.
2. **Impartiality:** making no discrimination as to nationality, race, religious beliefs, class, gender or political opinions; endeavouring only to relieve suffering, giving priority to the most urgent cases of distress.
3. **Neutrality:** taking no sides in hostilities or engaging at any time in controversies of a political, racial, religious or ideological nature.
4. **Independence:** maintaining autonomy so as to be able at all times to act in accordance with the principles of humanity, impartiality, and neutrality.

Humanitarianism implies recognition that suffering is universal and requires a response, that suffering cannot be met with indifference. Humanitarianism entails respect for human dignity, helping and protecting others regardless of who they are or what they have done. It entails protecting life and health not only by responding to disaster and disease, but also by preventing them (4).

A collective of aid organizations, under the Sphere Project, has proposed the Humanitarian Charter to guide minimum standards in humanitarian response (5). The Humanitarian Charter is consistent with and further elaborates on the humanitarian principles as outlined below.

- All human beings are born free and equal in dignity and rights.
- All people affected by disaster or conflict have a right to receive protection and assistance to ensure the basic conditions for life with dignity.
- Action should be taken to prevent or alleviate human suffering arising out of disaster or conflict, and nothing should override this principle (the humanitarian imperative).
- All people affected by disaster or conflict – women and men, boys and girls – have the rights to

protection and assistance reflected in the provisions of international humanitarian law, human rights and refugee law that can be summarized as:

- the right to life with dignity, including an adequate standard of living; freedom from torture or cruel, inhuman or degrading treatment or punishment; physical well-being; and respect for one's values and beliefs;
- the right to receive humanitarian assistance, including adequate food, water, clothing, shelter and the requirements for good health and well-being; and
- the right to protection and security.

While the imperative of the humanitarian health care response tends to focus on saving lives, not all members of affected populations will survive, and many who survive do endure severe suffering. The nature of the events and types of injuries experienced during humanitarian crises will sometimes lead to death no matter what efforts or resources are available. In many cases, people will die due to the injuries sustained during the event itself. In other cases, people will have been reaching the ends of their lives before the event, for example, due to unrelated chronic illness such as advanced cancer. In all cases, there are likely to be some deaths. The principles of humanitarianism preclude the selective exclusion from care of people who cannot be restored to health. The principles of humanity and impartiality demand that all patients receive care and should never be abandoned for any reason, even if they are dying (6,7).

Humanitarian responses can achieve the best results by assisting affected countries communities to implement and strengthen their own health care services. This includes helping with creation and strengthening of international emergency medical teams (EMTs). In addition, members of affected communities can provide insight for international emergency medical teams on the most culturally appropriate care and modes of medical decision-making. It is especially important for international EMT members to seek local guidance in designing and providing services such as mental health care, breaking bad news and decision-making about life-sustaining treatment or end-of-life care.









## 2

## What are humanitarian emergencies and crises?

Humanitarian emergencies and crises, or HECs are large-scale events that affect populations or societies causing a variety of difficult and distressing consequences that may include massive loss of life, disruption of livelihoods, breakdown of society, forced displacement, and other severe political, economic, social, psychological and spiritual effects.

Such events can exceed a society's ability to care for its own people, severely distort its developmental trajectory and cause a host of acute and long-term ill-effects ranging from acute injury and illness to chronic and multigenerational physical, mental health and psychosocial consequences (9). Complex humanitarian emergencies have been defined as "multifaceted humanitarian crises in countries, regions, or societies where there is a total or considerable breakdown of authority resulting from internal or external conflict and which requires a multisectoral, international response that goes beyond the mandate or capacity of any single agency" (10, 11). Humanitarian emergencies and crises are rarely caused by a single factor such as an earthquake and are usually the result of mixed natural, human-made, environmental, political and economic causes and vulnerabilities.

The first response to a Humanitarian emergencies and crises is usually by the people and communities most closely affected or by grassroot or national organizations that, when properly resourced and mandated, are largely effective (12). However, many Humanitarian emergencies and crises are too large or too severe for those affected to handle by themselves and require international emergency relief. The type of response depends on the need and may include, for example, acute life-saving interventions such as surgery for crush wounds after earthquakes; creation, organization and management of wide-ranging health services; or developing water and sanitation infrastructure for large displaced populations. This requires professional humanitarian services (13).

UNOCHA reports that, in 2015, 103 million people were affected by natural hazards, 65.3 million people were forcibly displaced by conflict and violence and 795 million people were undernourished. Of these, nearly 125 million people needed humanitarian assistance worldwide (1).

### Types of humanitarian emergencies

#### Conflict

War and violence have always been the major concern of modern humanitarian action and have catalysed the humanitarian movement, from the Battle of Solferino in 1859 that was the impetus for the first Geneva Convention and the creation of ICRC to the Biafra War in the 1960s out of which Médecins Sans Frontières (MSF) was born.

Conflicts have evolved over time from inter-state wars (wars between countries and regular armies) and intra-state (civil) wars to the current, more complex wars that often are protracted proxy wars in low-income settings between surrogates of larger, wealthier powers and in which new technologies such as remote-controlled airborne drones are used. As a result of these new types of warfare, humanitarian responses must prepare nowadays for the following four conditions (14):

1. The locus of war no longer coincides with state borders – in areas of fragmented authority, in fact, borders are often meaningless.
2. Instead of states and their militaries being the main agents, non-state actors are playing an increased role.

3. Economies of war are no longer financed principally from government tax revenues but increasingly from illicit activities, aid and plunder.
4. Instead of uniformed combatants being the main victims, civilians are increasingly paying the lion's share of the costs.

Humanitarian medical actors must nowadays be prepared to respond to mass civilian suffering due both to bombs and bullets and to weak or destroyed health care systems. Thus, humanitarian medical action cannot focus only on direct, acute and localized effects of conflict. The geographical area of need is often large and the range of health problems may be broad. They may include epidemic infectious diseases resulting from poor sanitation, advanced chronic illnesses among people who have lost access to health care and severe chronic sequelae of psychological trauma (15). In the Syrian Arab Republic, for example, a poliomyelitis outbreak occurred in 2013 after a long absence from the country, and a measles outbreak occurred in areas considered safe from the fighting but that received massive numbers of internally displaced persons (IDPs). In Yemen, where the services for chronic noncommunicable diseases (NCDs) became scarce after war broke out in 2015, people with severe acute or chronic kidney failure lost access to haemodialysis. And in 2016, a cholera epidemic began in Yemen that became massive due to the widespread destruction of water and sanitation infrastructure and health services.

Finally, humanitarian medical actors themselves are increasingly being targeted despite the Geneva Conventions that forbid attacks on health care workers (16).

### Forced displacement

The displacement of people has reached unprecedented levels as a result of conflicts, natural disasters, including droughts and famines, environmental degradation, political oppression and poverty. The 2015 Global Trends report by the United Nations High Commissioner for Refugees (UNHCR) shows 65.3 million displaced persons globally, of which 21.3 million are refugees and 40.8 million are internally displaced (17). While much of the humanitarian action and resources are focused on refugees who cross international borders, IDPs, who typically flee conflict but remain within the borders of their own country, are more numerous and may be more negatively affected by the health consequences of conflicts. Strong evidence from the Centre for Research on the Epidemiology of Disasters shows that crude mortality rate for IDPs is nearly twice that of refugees. Similar trends are shown in malnutrition and health service coverage (18).

It is difficult to provide adequate and consistent health care to displaced persons, especially refugees who cross borders, who do not stay in camps and who have chronic conditions such as HIV/AIDS, tuberculosis or NCDs such as cancer, diabetes and heart and lung diseases.

### Natural disasters

Natural disasters are caused by geophysical hazards (e.g. earthquakes, tsunamis and volcanic eruptions) or meteorological hazards (e.g. floods, storms, hurricanes and heatwaves). However, while the hazards causing the disasters are natural phenomena, the intensity and danger of meteorological events have been increased by human activity and environmental degradation. Further, the consequences of natural disasters on life, health and well-being vary greatly depending on the vulnerability of the population they affect.

A useful formula to understand the risk of natural disasters on populations can be illustrated by the formula: **Risk = Hazard x Vulnerability**.

Vulnerabilities such as poverty and malnutrition may affect whole communities or specific groups in a community such as women in single-headed households, the elderly, children or people with mental or physical disabilities. Vulnerability is illustrated by the 2010 Haiti earthquake that measured 7.0 on the Richter scale and killed hundreds of thousands of people (19). By contrast, many stronger earthquakes in wealthy countries with strong health care systems and disaster preparedness programmes are much

less deadly. For example, the Tohoku earthquake in Japan in 2011 was 1000 times stronger than the Haiti earthquake but caused the death of under 16 000 people (20).

While the frequency of geophysical disasters has remained stable over the past decades, that of meteorological disasters (climate and weather related) more than doubled in the past 40 years and were responsible for the majority of disaster deaths in most years (21). Additionally, natural disasters caused nearly double the number of new displacements in 2015, more than 19 million new displacements mostly in Asia, as opposed to conflicts and violence which resulted in 8.6 million new displacements.

Natural disasters compromise or incapacitate the health services in many ways. They physically destroy health facilities and overwhelm the remaining ones with patients whose injuries and acute illnesses result directly from the disasters. When a health system is overloaded with injured, acutely ill or malnourished patients, then illness prevention, patients with chronic illnesses and pregnant women typically become deprioritized or completely neglected. The result is increased suffering and mortality in these populations.

## Disaster risk reduction

Disaster risk reduction “aims to reduce the damage caused by natural hazards such as earthquakes, floods, droughts and cyclones, through an ethic of prevention” (22). The International Strategy for Disaster Reduction (ISDR), mandated by United Nations General Assembly resolution (56/195) in 1999, is based on the recognition that much of the devastation of major natural hazards could be prevented through preparedness, surveillance and early warning (23). In 2015, the United Nations General Assembly endorsed the Sendai Framework for Disaster Risk Reduction 2015–2030, a 15-year, voluntary, non-binding agreement that recognizes that, although the state has the primary role to reduce disaster risk, the responsibility should be shared with other stakeholders including local government, the private sector and other stakeholders. It aims for “substantial reduction of disaster risk and losses in lives, livelihoods and health and in the economic, physical, social, cultural and environmental assets of persons, businesses, communities and countries” (24).

## Epidemics and disease outbreaks

In the 2005 United Nations International Health Regulations (IHR), a serious epidemic or disease outbreak is called a “public health emergency of international concern” (25). This is defined as “an extraordinary or unexpected event which is determined: (i) to constitute a public health risk to other states through the international spread of disease; and (ii) to potentially require a coordinated international response” (25).

The Ebola outbreak in West Africa that lasted from 2014 to 2016 is an extreme example of a public health emergency of international concern (25). The Ebola outbreak devastated Guinea, Liberia and Sierra Leone, had a case fatality rate of over 70%, had an even higher case fatality rate among children and pregnant women, and claimed the lives of over 11 000 people (26). It demonstrated how a disease that spreads rapidly across international borders can cause multiple dilemmas for humanitarian responders. These included the safety of health workers, the lack of a cure, the lack of effective prevention other than containment, the inability to provide effective care for people with other illnesses during the outbreak, the obligation to relieve suffering of multiple types (physical, psychological, social and spiritual), the need to care for the dying and bereaved, the need to bury the dead in a way that is both safe and respectful, and the need to provide effective health promotion amid tense social and political turmoil caused by the disease.

Other diseases that can cause large-scale loss of life and health include influenza, yellow fever, measles, meningitis, cholera and hepatitis E. While the transmission, causes and management of these diseases vary, they have in common the burden they put on patients and health service providers and the diversion of resources from other health and social needs.

## Responding to humanitarian emergencies

According to United Nations General Assembly resolution 46/182 of 19 December 1991 on “Strengthening of the coordination of humanitarian emergency assistance of the United Nations”, the government of each member state has the duty to respond humanitarian emergencies and crises within its borders (103). However, international EMTs should assist with strengthening and filling gaps in local health system or with creating effective national EMTs, as needed. Both international and national EMTs should focus not only treatment of acute injuries and illnesses and symptom relief, but also, on providing continuity of care for people with chronic conditions and assuring the comfort and dignity of patients not expected to survive. Regardless of the type of humanitarian emergency or crisis, there is wide agreement that response should be governed by the Humanitarian Charter of the Sphere Project (5) and the humanitarian principles of the Red Cross (4). The ethics principles of the ICRC and of MSF also provide useful guidance (27, 129).







## 3

## What is palliative care?

WHO defines palliative care as the prevention and relief of suffering of adult and paediatric patients and their families facing the problems associated with life-threatening illness (28). These problems include physical, psychological, social and spiritual suffering of patients, and psychological, social and spiritual suffering of family members. Palliative care entails early identification and impeccable assessment and treatment of these problems. It enhances quality of life, promotes dignity and comfort, and may also positively influence the course of illness. It is applicable early in the course of illness in conjunction with other therapies that are intended to prolong life and provides accompaniment for the patient and family throughout the course of illness. After the patient's death, it also accompanies bereaved family members. Palliative care is not simply an alternative to disease-modifying treatment of questionable value at the end of life; rather, it should be integrated with and complement prevention, early diagnosis and treatment of serious or life-limiting health problems at all levels of any health system and thereby improve continuity of care and strengthen health systems. Palliative care also seeks to mitigate the pathogenic effects of poverty on patients and families and to protect them from suffering financial hardship due to illness or disability. It encourages active involvement by communities and community members. Crucially, integration of palliative care into public health care systems is essential for achievement of universal health coverage (29).

The specific types, scale and severity of suffering may vary by geopolitical location, by economic situation, by culture and, in the setting of a humanitarian emergency or crisis, by the type of emergency or crisis. Typically, people who live in low- and middle-income countries (LMICs) are more vulnerable to unnecessary suffering because they have less access to disease prevention, diagnosis and treatment and to social supports than people in high-income countries (HICs) (5). As a result, the need for palliative care is greater in LMICs than in HICs, and the required palliative care services may differ (30). Further, suffering typically associated with chronic life-threatening illness also may occur acutely or in association with non-life-threatening conditions. In settings where prevention and relief of acute or non-life-threatening suffering is inadequate or unavailable, clinicians trained in palliative care should intervene by training colleagues in symptom control, by providing direct symptom relief, or both. For example, in countries where pain medicine does not yet exist as a specialty, the prevention and relief of pain from trauma or burns or surgery typically are inadequate, especially during and soon after disasters and conflict when health services of all kinds may become scarce or unavailable. Clinicians trained in palliative care should help to fill this therapeutic void. Many countries also lack rehabilitation medicine specialists and programmes to care for people with non-life-threatening but serious disabilities such as paraplegia or quadriplegia or those due to brain injuries or congenital anomalies. Palliative care can help to fill this void as well. Planning and implementing palliative care services should be based on assessment of the types and extent of inadequately prevented or relieved physical, psychological, social or spiritual suffering of adults and children. Only in this way can palliative care services be people-centred: tailored to local need and to the needs of individual patients and families (31).

People affected by different types of emergencies or crises, such as earthquakes, major storms, haemorrhagic fever epidemics or political violence, may suffer in different ways and require care of different kinds. Yet several principles apply to palliative care in any humanitarian emergency or crisis.

1. The most fundamental goal not only of palliative care, but also of medicine itself, including medicine practised in humanitarian emergencies and crises, is to relieve human suffering. Saving lives is a crucial way to achieve this goal but not the only way.
2. Humanitarian responses to emergencies and crises should include palliative care and symptom control. Responses that do not include palliative care are medically deficient and ethically indefensible.
3. In humanitarian emergencies and crises, the statements that palliative care "regards dying as a normal process" and never intends to "postpone death", as in the 2002 WHO definition, require additional

clarification. In this setting, any clinician, including those trained in palliative care, should make every effort to save the life of any patient who may be savable. The only exception should be patients with a pre-existing chronic life-threatening condition who had decided and left clear instructions to forego life-sustaining treatment.

4. Palliative care never intentionally hastens death, but provides whatever treatment is necessary to achieve an adequate level of comfort for the patient in the context of the patient's values. In keeping with the ethical principle of double effect (Chapter 7), there may be rare cases of severe, refractory symptoms in a patient with a terminal illness or mortal injury when the intention of assuring comfort may result in unintentional but foreseeable hastening of death (32).
5. Palliative care and life-saving treatment should not be regarded as distinct. Palliative care and symptom control should be integrated as much as possible with life-saving treatment for patients with acute life-threatening conditions or triaged red (Tables 1 and 2).
6. Palliative care should commence immediately, as needed, for patients with non-life-threatening conditions (triaged yellow) whose injury- or disease-specific treatment may be delayed.
7. Palliative care must be provided for all patients deemed expectant (triaged blue) and should commence immediately (130).

**Table 1. Standard triage categorization in humanitarian emergencies and crises**

This categorization makes no mention of palliative care or symptom relief and suggests that category 4 or expectant patients require even less attention than those with minor health conditions. A medically and ethically more sound categorization is described in Table 2.

Category	Colour code	Description
1. Immediate	Red	Survival possible with immediate treatment.
2. Delayed	Yellow	Not in immediate danger of death, but treatment needed soon. Would be treated immediately under normal circumstances.
3. Minimal	Green	Will need medical care at some point after patients with more critical conditions have been treated.
4. Expectant	Expectant	Survival not possible given the care that is available.

**Table 2. Recommended triage categories in humanitarian emergencies and crises**

Category	Colour code	Description
1a. Immediate	Red	Survival possible with immediate treatment. Palliative care should be integrated with life-sustaining treatment as much as possible.
2a. Expectant	Blue	Survival not possible given the care that is available Palliative care is require
	Yellow	Not in immediate danger of death, but treatment needed soon. Palliative care and/or symptom relief may nevertheless be needed immediately.
3. Minimal	Green	Will need medical care at some point, after patients with more critical conditions have been treated. Symptom relief may be needed.

Source: Adapted from Hayward-Karlsson et al. 2005 (33), and WHO/ICRC 2017 (130).



Thus, in Humanitarian emergencies and crises, prevention and relief of suffering should be made accessible for anyone suffering physically, psychologically, socially or spiritually and not only for those with life-threatening conditions. But there is a particular ethical imperative to providing palliative care and symptom control for expectant patients (triaged blue). This imperative is based on the medical and ethical principles of beneficence and non-abandonment. Failure to benefit these highly vulnerable patients by treating aggressively and immediately any physical and psychological suffering constitutes abandonment and is thus ethically unacceptable. The ethical imperative to save lives need not and should not conflict with the ethical imperative to comfort the dying. This document provides guidance on how to provide this care in the situation/event of Humanitarian emergencies and crises.

In many Humanitarian emergencies and crises, the most common and severe type of suffering is pain. There are multiple medical reasons for treating pain aggressively in any patient, including trauma and postoperative patients. Patients with serious traumatic injuries who received morphine “during early resuscitation and trauma care” may be less likely to develop post-traumatic stress disorder (PTSD) than those who do not receive morphine (34). On occasion, such as when the blood pressure of a critically ill or injured patient in severe pain is dangerously low and cannot be increased safely with vasopressor medicines, it may be necessary to give a lower than adequate dose of opioid to treat the pain. In this situation, saving the patient’s life may have a higher priority than achieving adequate analgesia until greater haemodynamic stability can be achieved. However, in other situations, failure to treat pain aggressively puts patients at unnecessary risk of morbidity and mortality. Inadequate postoperative pain control has been found to have “a wide range of undesirable physiologic and immunologic effects and to be associated with poor surgical outcomes” (35). These undesirable effects and poor outcomes include:

- cardiovascular side-effects, including hypertension, tachycardia, arrhythmias, myocardial infarction, congestive heart failure, haemorrhage and stroke;
- deep vein thrombosis and pulmonary embolism;
- atelectasis and pneumonia;
- hyper-catabolic state and tissue wasting;
- compromised immune function and increased risk of infection;
- hyperalgesia, central sensitization and development of chronic pain (especially common after limb amputations); and
- anxiety, depression, impaired sleep and demoralization.

For these reasons, failure to treat pain as aggressively as possible in patients triaged either red or yellow constitutes substandard care and is both medically and ethically unacceptable.

To provide palliative care and symptom control in Humanitarian emergencies and crises – whether by an EMT or local clinicians in the community – a package of safe, effective, inexpensive palliative medicines and equipment is required, and response team members require at least basic training (Chapter 6 and Annex 6). In most cases, the surgeons, anaesthesiologists, nurse anaesthetists, nurses, infectious disease specialists and others who typically staff medical humanitarian response teams – and local doctors, nurses and community health workers (CHWs) – can be trained to provide adequate palliative care for most patients and family members, including expectant patients. However, in some situations, the presence of a palliative care specialist physician or nurse practitioner with training in disaster medicine may be beneficial to provide or supervise palliative care for a large number of patients in need of palliative care or for patients with complex symptoms and to help the affected country or community to integrate sustainable palliative care services into its health care system. To treat serious long-term psychological sequelae of traumatic events on a large scale and to build local capacity for mental health care the involvement of mental health specialists would be beneficial (2).







# 4 Palliative care for people affected by various Humanitarian emergencies and crises

## Part 1. Natural hazards resulting in sudden onset disasters: earthquakes, major storms, tsunamis, floods

Sudden onset disasters due to natural hazards commonly cause suffering and death on a large scale. Thus, alongside life-saving interventions, palliative care should be an integral part of humanitarian responses. For both medical and ethical reasons, symptom control and relief of suffering are crucial not only for patients who will die in the first hours or days following a disaster. Often, patients triaged to immediate life-saving intervention also need symptom control and psychosocial support (Table 3 and Chapter 3). In addition, many patients live for days or weeks with injuries or illnesses that are non-survivable in a disaster context or develop non-survivable complications. These patients, too, need symptom control and psychosocial support. Surgical and life-sustaining resources often are inadequate to the need in sudden onset disasters, at least initially. Thus, both local health care providers and disaster response teams may be unable to provide critical care for critically ill patients when there are not enough supplies to treat everyone and when it is not always known when more supplies will arrive (35). However, the minimum or essential package of palliative care medicines and equipment needed for effective symptom control (described in Chapter 5) is extremely small and inexpensive. In addition, WHO has published model guidelines to enable transport of controlled medicines such as morphine across international borders for emergency medical care (37). Thus, EMTs always should be equipped to provide palliative care, and humanitarian organizations should help assure that local health care providers have adequate palliative care training and supplies.

### Earthquake

An example of patients who may die weeks after a natural hazard is patients with crush injuries due to collapse of buildings. Many rescued victims of earthquakes subsequently die of complications such as local or systemic infection or renal or cardiac failure. The United States Centers for Disease Control and Prevention (CDC) found that thousands of patients with crush injuries developed acute renal failure after the 7.0 magnitude earthquake in 2010 in Haiti (38). Once acute renal failure develops, patients need dialysis, often not available in resource-constrained settings. In Haiti, haemodialysis was available only to a tiny fraction of the people whose lives could have been saved by it.

### Tsunami

Tsunamis can devastate social and medical infrastructure, cause enormous loss of life and create health problems distinct from those caused by conflicts and other natural hazards. Following the 2004 Indian Ocean tsunami that devastated Aceh Province, Indonesia, common health problems included aspiration pneumonia and traumatic injuries complicated by infection and sometimes by tetanus and gangrene (39,40). In the month following the tsunami, 106 cases of clinically diagnosed tetanus were reported with a case fatality ratio of 18.9% (41). Respiratory and soft-tissue infections often were caused by rare or drug-resistant pathogens (40). In this type of disaster, integrated critical care and palliative care is needed for patients with respiratory failure or tetanus.

In any type of disaster due to natural hazards, palliative care also is needed by people with pre-existing illness, disability or frailty who have lost access to health care, many of whom are at home. Others will have been living in chronic care facilities (42,43). Palliative care entails accompaniment and non-abandonment of patients, assuring that no patient is left without care. This principle applies even during emergency evacuations in the setting, for example, of major storms or floods (6,42). Whenever possible, efforts should be made to provide palliative care not only in hospitals and clinics, but also to assist local clinicians or organizations to provide home care.

**Table 3. Types of suffering of people affected by sudden onset disasters, war, political conflict, or ethnic violence, and recommended steps to integrate palliative care into the humanitarian response**

Type of suffering	Recommended palliative care responses to suffering (3)
<b>Physical suffering</b>	
Symptoms due to acute injury or illness (Table 5)	<ul style="list-style-type: none"> <li>Put in place policies clarifying that humanitarian medical assistance aims both to save lives and to relieve suffering</li> <li>Develop protocols for a minimum standard of symptom assessment and treatment, and for care of expectant patients, by international and national EMTs and local healthcare providers</li> <li>Train and equip EMTs and local health care providers with minimum standards of care for expectant patients</li> <li>Include the essential package of palliative care medicines and equipment for Humanitarian emergencies and crises in all emergency health kits; ensure that oral and injectable morphine are included in all kits and are both secured and accessible in adequate quantities by EMTs and local health care providers</li> <li>Include in all Type 1 EMTs include at least one physician and nurse with at least basic palliative care training (Chapter 5 and Annex 6)</li> <li>Include in all Type 2 and 3 EMTs include at least one physician with at least intermediate palliative care training and that all anaesthetists and anaesthesia technicians have at least basic palliative care training</li> </ul>
Symptoms due to injury-related complications and sub-acute or chronic illnesses	
<b>Psychological suffering</b>	
Acute psychological effects (including acute anxiety, acute depressed mood, acute grief)	<ul style="list-style-type: none"> <li>Train EMT staff members and local health care providers in PFA</li> <li>Train and equip EMTs and local health care providers with protocols for psychological symptom assessment and treatment</li> <li>Include the essential package of palliative care medicines and equipment for Humanitarian emergencies and crises in all emergency health kits; include oral fluoxetine, injectable diazepam, and oral and injectable haloperidol in all kits so that they are accessible in adequate quantities by EMTs and local health care providers (43)</li> </ul>
Chronic psychological effects (including PTSD, chronic anxiety disorders, chronic depression, complicated grief, survivor's guilt)	<ul style="list-style-type: none"> <li>Train and equip all EMTs in palliative care as above</li> <li>Seek partnerships with local community and spiritual leaders for advice on cultural values and beliefs relevant to mental illness and to inform the local community about the EMT's activities</li> <li>Recruit local mental health care providers who can provide culturally and linguistically appropriate care and advise foreign team members on cultural values and beliefs relevant to mental illness</li> <li>Offer training to local volunteers to provide basic mental health interventions as appropriate</li> <li>Organize support groups for patients and survivors who may wish to share experiences and challenges</li> <li>Include mental health care providers in humanitarian response teams that are likely to encounter many patients with mental health consequences</li> </ul>



**Social suffering**

Loss of access to shelter, clothing, food, sanitation, protection from violence

- Assure access to shelter, clothing appropriate to climate and culture, food, sanitation
- Seek to arrange protection from physical or psychological abuse
- Organize support groups for patients and survivors who may wish to share experiences and challenges

Extreme vulnerability (including frail older people, unaccompanied children, people with mental or physical disabilities, people living in extreme poverty)

**Spiritual suffering**

Loss of sense of meaning of life

- Seek partnerships with local spiritual counsellors willing to visit patients and family members on request

Loss of faith/anger towards God

Sources: Adapted from IASC 2007 (2); Smith and Aloudat 2017 (7); Knaul et al. 2017 (29); Krakauer 2018 (30).

## Part 2. Palliative care for people affected by epidemics of life-threatening infections

In epidemics of life-threatening infections, as in other Humanitarian emergencies and crises, the suffering of victims and efforts to relieve it often are neglected in the haste to save lives. Yet palliative care in these situations is just as critical. Intensive relief of symptoms such as vomiting and diarrhoea may not only provide comfort, but also improve survival as well as foster the patient–clinician relationship and even improve infection control. During infectious diseases outbreaks actions taken by public health authorities to limit spread of disease such as isolation and quarantine can exacerbate psychological suffering. Planners and implementers of humanitarian responses to epidemics of life-threatening infections should be cognizant of both the benefits and burdens of public health interventions. Analysis of the 2014–2015 Ebola epidemic and the 2002 Severe Acute Respiratory Syndrome (SARS) coronavirus epidemic, among others, reveals the physical, psychological, social and spiritual suffering engendered by epidemics of life-threatening infections, the medical and moral importance of relieving this suffering, and specific palliative care strategies for these types of health crises.

Physical suffering during infectious disease outbreaks can be caused either by the disease or the treatment (Table 4). The 2014–2015 West African epidemic of Ebola virus disease, for which there was no definitive treatment, affected 28 646 people and claimed 11 323 lives (45). The clinical symptoms of Ebola include nausea, vomiting, diarrhoea, body aches and in late stages bleeding, respiratory distress and encephalopathy (46). Assessment and relief of these symptoms were inadequate in part because the responders lacked training in palliative care, but also because of the high patient to provider ratio and because the necessary personal protective equipment and brevity of bedside encounters limited the ability of providers to thoroughly evaluate and connect with patients and to provide emotional support (47–49). In addition, Ebola treatment units typically had little or no morphine available for relief of pain or terminal dyspnea (50). Yet integration of palliative care into care for patients with Ebola virus disease has multiple benefits. Aggressive control of nausea, vomiting and diarrhoea not only relieves unnecessary suffering, but also can protect against volume depletion and electrolyte derangements and hence may improve survival. It also can reduce contamination of enclosed, shared spaces within Ebola treatment units with virus laden body fluids, hence lessening the risk of transmission to health care workers. In some epidemics of life-threatening infections, such as multidrug-resistant tuberculosis, adverse reactions to treatment commonly cause significant suffering and make adherence to treatment difficult (51). Thus, pain and symptom control is crucial for a variety of reasons.

Psychological and social suffering during epidemic life-threatening infections also can be caused both by the disease and the response (Table 4) (2). Quarantine of people exposed to the disease and isolation of those with active infection, necessary from a public health perspective, exacerbates the psychological distress of having a life-threatening and stigmatized illness (52). Evaluation of patients and staff by a palliative team at a hospital in Singapore during the 2002 SARS epidemic revealed that physical isolation led to loss of self-esteem, a sense of powerlessness and stigmatization of patients as well as family caregivers (53). During the West Africa Ebola epidemic, confirmed and suspected Ebola patients, all of whom were placed in isolation units and thus separated from loved ones, reported feeling fear, sadness and dehumanization. Many also were grieving the actual or assumed death of family members (54). Among both adult and child patients, these feelings were compounded by the fact that health care workers were required for their own safety to use fully enclosed personal protective equipment and to maintain distance from the patient during care (55). Since people with both confirmed and suspected Ebola virus infection were admitted to Ebola treatment units, some inpatients feared any contact with other patients. This further increased their isolation. Within communities, fear of contracting the disease disrupted social interactions, and there was a communal sense of loss due to deaths (56).

Many Ebola survivors, those whose disease was in remission, continued to suffer physically or psychosocially. Post-Ebola Virus Disease Syndrome commonly consisted of chronic pain, vision loss, cognitive deficits or depression. Psychosocial suffering resulted from extreme stigmatization when survivors tried to reintegrate their communities. Many survivors also experienced survivor's guilt or guilt from transmitting the disease, and the latter were often blamed by members of their community for virus transmission (56). Although psychosocial and spiritual support were integrated in many Ebola treatment unit programmes in West Africa, their resources were overwhelmed by the large number of patients (56–58). Palliative care training for humanitarian responders, including local health care providers, should include assessment and treatment of common psychological symptoms such as adjustment disorder, anxiety and depressed mood as per United Nations and WHO guidelines (2,44). EMTs should collaborate with health care workers who speak local languages and have local cultural understanding to enable appropriate assessment and treatment of psychosocial distress. Successful mental health and psychosocial support (MHPSS) programmes during the West African Ebola outbreak also engaged community and religious leaders to help educate the public to avoid stigmatizing and to help survivors reintegrate (59).

Health care workers themselves frequently need psychosocial support in the situation of epidemics (2). Caring for many suffering and dying patients is extremely stressful in itself. It is more stressful when health care workers are risking their own lives by providing care. Both during the SARS epidemic and the Ebola epidemic in West Africa, many health care workers were also members of communities and even families ravaged by the disease. A significant portion of Ebola responders reported symptoms of post-traumatic stress due to the large loss of life in Ebola treatment units, while dealing with guilt associated with their own survival (60). They also faced stigma from their communities due to their association with the disease. Hence, mental health services should address the palliative care needs of patients, family members and providers.

Spiritual suffering, while not well studied, was likely also prevalent during the Ebola epidemic in West Africa. Spirituality can help victims of any health crisis to cope (61). Yet important bereavement and burial rituals were not possible due to the associated infection risk (54). Further, traumatic events of any kind can lead to crises of faith. Thus, local religious leaders should be invited to participate in palliative care and to provide spiritual counselling if requested by patients after receiving proper infection control training and equipment.



**Table 4. Types of suffering of people affected by epidemics of life-threatening infections and recommended steps to integrate palliative care into humanitarian responses**

Type of suffering	Recommended palliative care responses
<b>Physical suffering</b>	
Direct disease effects	<ul style="list-style-type: none"> <li>Put in place policies clarifying that humanitarian medical assistance aims both to save lives and to relieve suffering</li> <li>Train and equip EMTs and local health care providers to reach a minimum standard of symptom assessment and treatment</li> <li>Develop protocols for a minimum standard of symptom assessment and treatment, and for care of expectant patients, by international and national EMTs and local healthcare providers</li> </ul>
Side-effects of treatment	<ul style="list-style-type: none"> <li>Train EMTs and local health care providers to anticipate adverse effects of treatment and to apply preventative measures as appropriate</li> <li>Include the essential package of palliative care medicines and equipment in emergency health kits; ensure that oral and injectable morphine are included on essential medicine lists and are secured and accessible in adequate quantities by EMTs and local health care providers</li> <li>Include in all Type 1 EMTs include at least one physician and nurse with at least basic palliative care training (Chapter 6 and Annex 6).</li> <li>Include in all Type 2 and 3 EMTs include at least one physician with a minimum of intermediate palliative care training and that all critical care specialists, anaesthetists and anaesthesia technicians have a minimum of basic palliative care training</li> </ul>
<b>Psychological suffering</b>	
Acute and chronic effects of the illness or of stigmatization (including anxiety, depressed mood, delirium)	<ul style="list-style-type: none"> <li>Train EMT staff members and local health care providers in PFA</li> <li>Train and equip EMTs and local health care providers with protocols for psychological symptom assessment and treatment</li> <li>Include the essential package of palliative care medicines and equipment in emergency health kits; Include fluoxetine, oral and injectable diazepam and oral and injectable haloperidol are included on essential medicine lists so that they are accessible in adequate quantities by EMTs and local health care providers (43)</li> <li>Train and equip all EMTs in palliative care as above</li> <li>Seek partnerships with local community and spiritual leaders for advice on cultural values and beliefs relevant to mental illness and to inform the local community about the EMT's activities</li> </ul>
Side-effects of treatment	<ul style="list-style-type: none"> <li>Recruit local mental healthcare providers who can provide culturally and linguistically appropriate care and advise foreign team members on cultural values and beliefs relevant to mental illness</li> </ul>
Grief (including normal and complicated grief)	<ul style="list-style-type: none"> <li>Offer training local volunteers to provide basic mental health interventions such as PFA, as appropriate</li> <li>Organize support groups for patients and survivors who may wish to share experiences and challenges</li> <li>Include mental health care specialists (or clinicians with advanced mental health training) in humanitarian response teams that are likely to encounter many patients with severe mental health problems</li> <li>Train EMTs and local health care providers to anticipate adverse effects of treatment and consider preventative treatment</li> <li>Provide any mental health staff members with infection control training and equipment necessary for safety and to enable them to visit infected patients</li> <li>Provide regular information to patients about their condition and prognosis at the appropriate education/literacy level</li> <li>Organize isolation wards in such a way as to allow patients to communicate with family members/friends at a distance (e.g. lowered barriers placed at appropriate distance to maintain infection control principles) or through technological means (i.e. mobile phones)</li> <li>Organize voluntary psychosocial support groups for patients, survivors and bereaved family members</li> </ul>
Survivor's guilt	<ul style="list-style-type: none"> <li>Reduce patients' time in isolation wards to the minimum necessary for infection control</li> </ul>

<b>Social suffering</b>	
Extreme poverty	<ul style="list-style-type: none"> <li>▪ Assure access to shelter, clothing appropriate to climate, food, sanitation and protection from physical or psychological abuse</li> <li>▪ Based on established criteria for extreme poverty, provide for safe and culturally appropriate funeral/burial</li> <li>▪ Conduct community education about the infectious disease to reduce fear and stigma</li> <li>▪ Organize voluntary psychosocial support groups for patients, survivors and bereaved family members</li> <li>▪ Organize a community reintegration programme for survivors with community/religious leaders</li> <li>▪ Establish a working relationship with organizations that care for orphans to facilitate prompt referrals</li> </ul>
Social stigma (patients, family members, survivors)	
Social isolation	
Extreme vulnerability (including frail older people, unaccompanied children, people with mental or physical disabilities)	
<b>Spiritual suffering</b>	
Loss of sense of meaning of life	<ul style="list-style-type: none"> <li>▪ Seek partnerships with local spiritual counsellors willing to visit patients and family members on request</li> <li>▪ For patients in isolation, provide each spiritual counsellor with infection control training and equipment necessary for safety</li> </ul>
Loss of faith/anger towards God	

Sources: Adapted from IASC 2007 (2); Smith and Aloudat 2017 (7); Knaul et al. 2017 (29); Krakauer 2018 (30).

### Part 3. Palliative care for people affected by war, political conflict or ethnic violence

*... cette oeuvre de charité, laquelle consisterait à apporter ... des secours et des soins sur un champ de bataille au moment même d'un conflit ... . [this work of charity that consists of bringing aid and care to the battlefield during the actual conflict ... translation from French] Henry Dunant 1862 (62)*

Note: This section (Part 3) is adapted from Matzo et al. 2009 (63).

Under the dire circumstances of mass casualties due to war, political conflict or ethnic violence, relief of suffering – palliative care – should be a priority second only to saving lives (64). Palliative care for people affected by war, political conflict or ethnic violence should consist of aggressive relief of pain and other physical symptoms as well as relief of any psychosocial and spiritual suffering of patients who may die, of the bereaved and of those who have experienced or witnessed violence. Unusually aggressive means of symptom management are, at times, appropriate at the end of life (for patients triaged black) in the same way that extraordinary means of saving lives are often appropriate for patients triaged red (Table 2). There should be no intention to hasten the death of expectant patients but rather only to assure comfort by any available and ethically acceptable means (Chapter 7). Humanitarian response planners, implementers and managers should plan for care for all people categorized as likely to die. This includes those who may die as a result of injuries or acute illnesses as well as those in the community or institutional settings already living with limited prognoses. War, political conflict or ethnic violence may overwhelm or eliminate some or all available health care resources and therefore put those with pre-existing, serious acute or advanced chronic illnesses at risk for unrelieved suffering and death. Integration of palliative care services

into emergency medical responses would help to assure the most ethical, humane and appropriate care for these patients.

At a minimum, disaster response palliative care services should include relief of severe physical symptoms such as pain and dyspnea and psychological symptoms such as anxiety and depression. Where possible, services should seek to address other symptoms, bring closure to the life and comfort to the loved ones, and ensure that the dying are as comfortable and meaningful as possible. Mass casualty events due to war, political conflict or ethnic violence commonly have a devastating psychological impact on affected people and strain the resilience of responders (Chapter 6, Part 6). Humanitarian responders with basic training in MSPSS (which should be included in palliative care training) can be helpful in planning and implementing focused, non-specialized psychological support, such as psychological first aid (PFA) and treatment of uncomplicated adjustment disorder and mood disorders, for affected persons and for responders. Psychiatrists and psychologists can be helpful in planning and implementing specialized mental health care for affected persons and responders (2). Spiritual counsellors with experience in palliative care or disaster response also can be helpful in planning and implementing psychological and spiritual support (Table 4).

### **Textbox 1. Palliative care in post-genocide Rwanda**

In the aftermath of the 1994 genocide against the Tutsis in Rwanda, survivors showed high rates of mental health and psychosocial problems due to the extreme violence to which they had been exposed. Entire family systems, as well as the general social fabric that formerly provided support, were destroyed due to losses of family members and growing mistrust and fear following the genocide. A great majority of the survivors were female, and female-headed households proved to be especially vulnerable, suffering from the effects of economic deprivation, which included a lack of food, housing and money for the education of their children. Survivors had often experienced numerous traumatic events such as being attacked with a weapon, serious injury, rape, sexual abuse, being captured or kidnapped, witnessing a killing or massacre or seeing dead and mutilated bodies. Rwandan genocide survivors and their families continue to suffer from high rates of PTSD and depressive and anxiety symptoms. A high level of PTSD has also been found in people – overwhelmingly male – who were imprisoned for perpetrating genocide. In addition, descendants of genocide survivors are at risk for mental health problems. Thus, psychological suffering due to the genocide affects the population at large (65). There remains an enormous need for mental health care 24 years after the genocide, and meeting this need is complicated by a lack of mental health care providers and by the stigma still associated with mental illness.

Psychological suffering during or after the genocide can influence the experience of serious illness in a variety of ways. Untreated or inadequately treated anxiety or depressive disorders, PTSD or complicated grief can compromise treatment adherence. When patients report pain, it may be difficult to discern sometimes whether the pain is primarily psychosocial or due to a physical lesion. Even pain due to obvious lesions such as a malignancy may become worse during the annual genocide commemoration in April. Treatment of a serious illness, whether curative or palliative, also may be affected by a patient's belief in a connection between past events and the current illness. For example, a cancer may be understood as connected to the guilt of surviving or the guilt of having been a perpetrator. Yet either a serious illness or the symptoms it generates may also serve as a connection for the patient to those lost in the genocide. Thus, optimum disease modifying or palliative care may depend on eliciting the patient's explanatory model of the illness. But this, too, may be difficult: survivors may fear speaking openly about the genocide lest the perpetrators return, and perpetrators may fear lest survivors seek revenge. Both should be given the opportunity to talk about traumatic events, but without pressure, and the wish not to talk should be respected (2).









## 5

# Essential Package of Palliative Care for Humanitarian Emergencies and Crises

## Background

The Essential Package of Palliative Care for Humanitarian Emergencies and Crises is intended to guide humanitarian response policy-makers, planners, implementers and managers in equipping and preparing responders to prevent and relieve the most common and severe types of suffering associated with Humanitarian emergencies and crises. The EP Hum is based on the essential package of palliative care described by Krakauer et al. (30) and Knaul et al. (29) and adapted for Humanitarian emergencies and crises based on guidance documents on humanitarian response, on review of the literature and on the expert opinions of the members of the WHO working group on palliative care in humanitarian responses to Humanitarian emergencies and crises (3,5,66). It also is designed in accord with the Core Humanitarian Standard on Quality and Accountability (CHS), a voluntary code used by humanitarian organizations to optimize coordination and quality in humanitarian responses to Humanitarian emergencies and crises (Chapter 6, Part 3, Panel 1) (67). CHS harmonizes existing humanitarian standards, including the Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in disaster relief, the Sphere Handbook Core Standards and the Humanitarian Charter, the 2010 Standard of the Humanitarian Accountability Project (HAP) International, the People in Aid Code of Good Practice, and the Groupe URD (Urgence, Réhabilitation, Développement) Quality COMPAS. CHS requires commitment:

- to people-centred humanitarian assistance: assistance that is timely, coordinated, competent, ethical, appropriate and relevant to the needs people affected by Humanitarian emergencies and crises;
- to promote resilience among people affected by Humanitarian emergencies and crises; and
- to empower people affected by Humanitarian emergencies and crises to participate in decisions that affect them (Panel 1).

## Types and prevalence of suffering in Humanitarian emergencies and crises

Data on the types and prevalence of suffering caused directly by Humanitarian emergencies and crises are limited (Table 5). Pain appears to be the most common physical symptom. Many distressing symptoms and conditions are acute, but some are mainly chronic, and some, such as pain and anxiety, can be both acute and chronic. Many victims of humanitarian emergencies suffer from multiple symptoms of varying chronicity, and they may have multiple types of pain at multiple locations (Table 6). Ebola infection, for example, typically causes multifaceted physical and psychosocial distress. Further, any HEC can cause indirectly virtually any symptom by precipitated major organ failure, exacerbating pre-existing conditions or increasing infections risk. For example, people affected by any HEC may develop nausea, vomiting, diarrhoea, fever and fatigue as a result of dysentery after losing access to clean water, and people with heart failure who lose access to treatment because of any HEC may develop dyspnea, cough, oedema and fatigue. The chronically ill – along with older persons and young children – may be at particular risk of suffering and death in humanitarian emergencies (68–71).

**Table 5. Common symptoms and forms of distress caused directly by humanitarian emergencies**

	<b>Ebola epidemic</b>	<b>Earthquake</b>	<b>Genocide/war</b>	<b>Influenza pandemic<sup>a</sup></b>
<b>Pain</b>	X	X	X	
Dyspnea	X	X		X
Nausea/vomiting	X			
Diarrhoea	X			
Fever	X			X
Fatigue/weakness	X			
Delirium	X			
Cough	X			X
Dizziness	X			
Conjunctivitis	X			
Oedema	X			
Acute stress reactions	X	X	X	X
PTSD	ND	X	X	
<b>Other anxiety disorders</b>	X	X	X	
Depressive symptoms	ND	X	X	
<b>Stigmatized/social isolation</b>	X			X
Complicated grief	ND	X	X	X

ND = no data

<sup>a</sup> Hypothetical

Sources: Leong et al. 2004 (52); Rieder and Elbert 2013 (64); MacNeil et al. 2010 (72); Schieffelin et al. 2014 (73); Dallatomasina et al. 2015 (74); Mollica et al. 2004 (75); Angeletti et al. 2012 (76); Downar and Seccareccia 2010 (77); Roy et al. 2005 (78); Reider and Elbert 2013 (79); Wu et al. 2014 (80); Kristensen et al. 2012 (81); Li et al. 2015 (82); Caffo and Belaise 2003 (83); Catani et al. 2008 (84); West and von Saint André-von Arnim 2014 (85); Teodorescu et al. 2015 (86).

**Table 6. Location of pain (acute or chronic) by cause**

	<b>Headache</b>	<b>Neck/back pain</b>	<b>Chest pain</b>	<b>Abdominal pain</b>	<b>Limb pain</b>
Ebola infection	X			X	
Laceration	X	X			X
Fracture	X	X	X		X
Internal head injury	X				
Internal organ injury			X	X	
Neck/back injury		X			
Psychological stress	X	X	X	X	X

Sources: Doocy et al. 2009 (39); Tanaka et al. 1999 (68); MacNeil et al. 2010 (72); Schieffelin et al. 2014 (73); Dallatomasina et al. 2015 (74); Roy et al. 2005 (78); Teodorescu et al. 2015 (86).



Psychological suffering is closely linked to physical, social and spiritual suffering. Injury and physical symptoms such as pain increase psychological stress as do loss of loved ones, homes, livelihoods, material belongings, communities and social support networks. Inability to connect to religious leaders and supporters, and to properly perform religious rituals such as burials or prayer, also can cause psychological suffering. Other extreme psychological stressors include:

- being a witness to horrific events or atrocities, as often happens during wars and conflict;
- being a victim of physical assault or gender-based violence;
- famine or malnutrition; and
- stigmatization due to an infection such as HIV or Ebola.

All of these stressors increase the risk of mental health problems.

Most people exposed to stressors experience emotional, cognitive, physical and behavioural reactions such as feelings of anxiety, hyperventilation (e.g. rapid breathing, shortness of breath), sense of heightened current threat, re-experiencing symptoms, problems sleeping and sadness as well as medically unexplained physical complaints (e.g. palpitations, dizziness, headaches, generalized aches and pains). Dissociative symptoms relating to the body (e.g. medically unexplained paralysis, inability to speak or see, or pseudo-seizures) can also occur (44). Among children, regressive behaviours (such as bedwetting), fear and separation anxiety, social isolation risk taking (in adolescents) or aggression are common. These symptoms may be indicative of a mental disorder, but are more often normal reactions to stress and transient (44).

The majority of people are able to cope and recover from stressors, especially in a supportive environment (44). However, those who already had difficulties in functioning before the emergency, who have experienced cumulative stressors and who have limited social support are at increased risk of developing mental health problems. Some mental health problems are considered directly related to the exposure to psychological stressors. These include acute stress symptoms described above, PTSD and prolonged grief disorder. Stressors can also increase the risk for developing other mental health problems, including depressive disorder, psychosis, child and adolescent behavioural disorders, alcohol use disorder, drug use disorder, self-harm/suicide and other significant emotional or medically unexplained complaints (86). More information on mental health problems in Humanitarian emergencies and crises can be found in the WHO mhGAP Humanitarian intervention guide: clinical management of mental, neurological and substance use conditions in humanitarian emergencies (44).

## Contents of the EP Hum

The EP Hum consists of a set of safe, effective, inexpensive, off-patent and widely available medicines, simple and inexpensive equipment and basic social supports, which together can prevent and relieve suffering of all types – physical, psychological, social, and spiritual (Table 7). It also includes the human resources needed to apply them appropriately, effectively and safely, and to provide psychological and spiritual support.

**Table 7. Essential package of palliative care for humanitarian emergencies and crises:: interventions, medicines, equipment, human resources, social supports**

Interventions	Inputs			
	Social supports	Medicines <sup>a</sup>	Equipment	Human resources <sup>b</sup>
Prevention and relief of pain or other physical suffering, <sup>d</sup> acute or chronic, related to humanitarian emergencies or crises		Amitriptyline, oral Bisacodyl (senna), oral Dexamethasone, oral and injectable Diazepam, oral and injectable Diphenhydramine (chlorpheniramine, cyclizine, or dimenhydrinate), oral and injectable Fluconazole, oral Fluoxetine, oral Furosemide, oral and injectable Haloperidol, oral and injectable Hyoscine butylbromide, oral and injectable Ibuprofen (naproxen, diclofenac, or meloxicam), oral Lactulose (sorbitol or polyethylene glycol), oral Loperamide, oral Metaclopramide, oral and injectable Metronidazole, oral, to be crushed for topical use Morphine, oral immediate release and injectable Naloxone, injectable Omeprazole, oral Ondansetron, oral and injectable <sup>f</sup> Oxygen Paracetamol, oral Petroleum jelly	Pressure-reducing mattresses Nasogastric drainage and feeding tubes Urinary catheters Opioid lock boxes Flashlights with rechargeable batteries (if no access to electricity) Adult diapers or cotton and plastic	Doctors (with basic palliative care training) Nurses (with basic palliative care training) CHWs (if available)
Prevention and relief of psychological suffering, <sup>e</sup> acute or chronic, related to humanitarian emergencies or crises		Amitriptyline, oral Dexamethasone, oral and injectable Diazepam, oral and injectable Diphenhydramine (chlorpheniramine, cyclizine or dimenhydrinate), oral and injectable Fluoxetine, oral Haloperidol, oral and injectable Lactulose (sorbitol or polyethylene glycol), oral	Adult diapers or cotton and plastic	Doctors (with basic palliative care training) Nurses (with basic palliative care training) Social workers or psychologists CHWs (if available)

Prevention and relief of social suffering, acute or chronic, related to humanitarian emergencies or crises	Income and in-kind support <sup>c</sup>			Social workers  CHWs (if available)
Prevention and relief of spiritual suffering related to humanitarian emergencies or crises				Local spiritual counsellors

<sup>a</sup> Based on WHO Model List of Essential Medicines 2015 (88). Acceptable alternative medicines are in parentheses: ( )

<sup>b</sup> Doctors may be local or foreign and may be surgeons, anaesthesiologists, intensivists, infectious disease specialists, paediatricians, general practitioners, palliative care specialists, or others. Nurses may include nurse-anaesthetists.

<sup>c</sup> Only for patients living in extreme poverty and for one caregiver per patient. Includes cash transfers to cover housing, children’s school tuition, transportation to health care facilities or funeral costs; food packages; and other in-kind support (blankets, sleeping mats, shoes, soap, toothbrushes, toothpaste).

<sup>d</sup> Other physical suffering includes breathlessness, weakness, nausea, vomiting, diarrhoea, constipation, pruritus, bleeding, wounds and fever.

<sup>e</sup> Psychological suffering includes anxiety, depressed mood, confusion or delirium, dementia and complicated grief.

<sup>f</sup> Only at hospitals that provide cancer chemotherapy or radiotherapy.

Sources: Knaul et al. 2017 (29); Krakauer et al. 2018 (30).

The EP Hum outlined in Table 7 and described further below is the minimum package that should be accessible by anyone affected by a health emergency or crisis. It is designed to address the palliative care needs of both adults and children, including neonates. The medicines and equipment should be included in all emergency health kits used in response to Humanitarian emergencies and crises.

## Medicines

The list of medicines in the EP Hum is based on the WHO model lists of essential medicines for palliative care for adults and children and adapted for this document. Medicines were selected based on the following criteria:

- necessary to prevent or relieve the specific symptoms or types of suffering most commonly associated with Humanitarian emergencies and crises (Table 7);
- safe prescription or administration requires a level of professional competency achievable by doctors, clinical officers, assistant doctors or nurse anaesthetists with basic training in palliative care; and
- offer the best balance in their class of accessibility on the world market, clinical effectiveness, safety, ease of use and minimal cost.

### **Morphine and other opioids**

Morphine, in oral fast-acting and injectable preparations, is the most clinically important of the essential palliative care medicines (89). It should be accessible in the proper form and dose by any patient with any of the following symptoms:

- acute pain, moderate or severe;
- chronic moderate or severe pain associated with malignancy;
- chronic moderate or severe pain associated with a terminal prognosis; and
- terminal dyspnea.

Opioids typically are not considered first-line treatment for chronic pain outside of cancer, palliative and end-of-life care, except under special circumstances and with strict monitoring (90).

Morphine, in both injectable and oral fast-acting formulations, must be accessible at any hospital and from any type of EMT. All doctors who ever care for patients with moderate or severe pain of the types described, or for patients with terminal dyspnea, should be adequately trained and legally empowered to prescribe oral and injectable morphine for inpatients and outpatients in any dose necessary to provide adequate relief as determined by the patients. Doctors inexperienced at prescribing morphine can be trained adequately with the curriculum in basic palliative care training described in this document or similar curricula (Annex 6). Any physician with at least basic training in pain control or palliative care should be enabled to prescribe an adequate supply of morphine so that obtaining refills is feasible for patients or families without requiring unreasonably frequent, expensive or arduous travel. Whenever clinically possible, oral morphine rather than the injectable form should be prescribed. All doctors should be trained to assess and treat opioid side-effects and to avoid injudicious use of morphine for mild pain or chronic non-malignant pain.

***Balance: maximizing access to opioids for medical use/minimizing risk of diversion and illicit use***

Although ensuring access to morphine for any adult or child in need is imperative, it also is necessary to take reasonable precautions to prevent diversion and non-medical use. Model guidelines for this purpose are available (91). All hospitals, health centres, EMTs and pharmacies should store morphine in a sturdy, locked and well-anchored box or cupboard at all times, keep records of the remaining supply and record the amount dispensed for a patient and the amount wasted or returned by a patient's family. All personnel at these sites who handle controlled medicines such as opioids should be trained in safe storage and recordkeeping. Doctors should be trained to assess for and minimize risk of opioid dependence and opioid diversion for non-medical uses. In keeping with the principle of balancing maximum accessibility of opioids for medical uses with minimum risk of opioid diversion, additional precautions might be necessary in areas with high rates of crime or violence. For example, it might not be possible to make morphine safely accessible at the community level in areas with high crime rates. In these places, accessibility must be ensured at higher levels in ways that do not unduly increase the travel burden for patients and their families. Where home or clinic supplies of morphine are frequently stolen, or patients and their families are put at risk by carrying or storing morphine, patients needing morphine might require admission to a hospital.

***Other medicines***

Among the other essential palliative medicines are oral and injectable haloperidol and oral fluoxetine, a selective serotonin reuptake inhibitor (SSRI). Although these medicines are considered psychiatric or psychotropic medicines, they have multiple essential uses in palliative care and are safe and easy to prescribe. For example, haloperidol is the first-line medicine in many cases for relief of nausea, vomiting, agitation, delirium and anxiety. Fluoxetine is the first-line pharmacotherapy for depressed mood or persistent anxiety, both of which are common among people affected by Humanitarian emergencies and crises. Any doctor who provides care outside the operating room should be prepared and permitted to prescribe these medicines as part of focused, non-specialized psychological support – not solely psychiatrists or neurologists. Petroleum jelly is essential for dressing non-healable wounds. Wet-to-dry dressings typically

cause pain or bleeding when changed and can be avoided by applying petroleum jelly to dressings. Metronidazole powder, made by crushing metronidazole pills, is essential to reduce or eliminate the odor of any wound infected with anaerobic bacteria. The powder can be sprinkled on the wound or mixed with petroleum jelly or hydrogel dressings.

## Equipment

Equipment in the EP Hum meets the following criteria:

- necessary for relief of at least one type of physical or psychological suffering;
- inexpensive;
- simple to use with basic training; and
- small enough to ship and store easily.

The equipment includes nasogastric tubes (for vomiting refractory to medicines and for administration of medicines or fluids); urinary catheters (to manage bladder dysfunction or outlet obstruction); foam, water or air pressure-reducing mattresses (to prevent and relieve pressure ulcers and pain); locked safeboxes for opioids (to be secured to a wall or immovable object); flashlights with rechargeable batteries (when no adequate light source is available for nocturnal home care); and adult diapers or cotton and plastic bags to make adult diapers (to reduce risk of skin ulceration and infection and caregiver risk and burden). In countries where plastic bags are prohibited as part of laudable environmental protection initiatives, specialized medical use should be permitted at least during health emergencies or crises. The EP Hum does not include materials needed for palliative care that should be standard equipment for any health centre, hospital or EMT such as gauze and tape for dressing wounds, nonsterile examination gloves, syringes and angiocatheters.

## Human resources and training

The necessary human resources depend primarily on the level and type of the health service delivery site and on the competency in palliative care of staff members rather than their professional designations. In most circumstances, it is not necessary for specialist palliative care physicians to deploy with EMTs. However, they are needed to train EMTs. Any medical doctor, clinical officer, assistant doctor or nurse anaesthetist trained in basic palliative care using a curriculum such as that included in this document should be capable of preventing or relieving most pain and other physical suffering (Annex 6). They should be able to competently prescribe opioids such as morphine to treat pain for inpatients and outpatients. They also should be able to diagnose and provide pharmacotherapy as needed (as part of focused, non-specialized psychological support) for uncomplicated anxiety disorders, depression or delirium. Palliative care courses for responders should include training in diagnosis, treatment (psychosocial and pharmacological interventions) and referral of persons with mental, neurological and substance use disorders in line with the WHO mhGAP Humanitarian intervention guide: clinical management of mental, neurological and substance use conditions in humanitarian emergencies (44), the WHO Psychological first aid: guide for field workers (92) and IASC Guidelines for Mental Health and Psychosocial Support in Emergency Settings (2). Training and supervision can be provided by psychiatrists who also can offer consultation for complex and severe cases. Not only doctors, nurses, psychologists and social workers, but also CHWs can be trained to provide simple, culturally appropriate psychotherapy for depression (93–96). Members of EMTs should receive basic palliative care training prior to deployment. During protracted health crises, basic training in palliative care should be offered to local clinicians as a means of improving access to palliative and mental health care and of strengthening local health care capacity.

In Humanitarian emergencies and crises, clinicians often may encounter physical or psychological suffering for which they feel incapable of providing adequate treatment. Examples may include pain refractory to high-dose morphine, severe depression refractory to treatment with maximum dose tricyclic antidepressant or SSRI, or other severe and complex mental disorders. However, if referral for appropriate specialist care is not possible, then a clinician with palliative care training should use whatever resources are available, including telemedicine, to provide the best possible care under the circumstances rather than refuse to treat.

In many Humanitarian emergencies and crises, CHWs can have a crucial role in palliative care and symptom control by visiting patients frequently at home or in refugee camps. With as little as three to six hours of training, CHWs not only can provide important emotional support, but also recognize uncontrolled symptoms, identify unfulfilled basic needs for food, shelter or clothing, or improper use of medications, and report their findings to a nurse-supervisor at a local clinic or EMT. In this way, they can accompany patients in need of palliative care and help to assure their comfort by serving as the eyes and ears of their clinicians. Based on reports by CHWs, it may be possible to arrange an appropriate response to an uncontrolled symptom such as a change in prescription or a home visit by a nurse that does not require the patient to return to the clinic, hospital or EMT. Visits by CHWs also can help to reduce the often heavy emotional, physical and financial burden of family caregivers. Capable family caregivers should be trained, equipped and encouraged by clinicians to provide basic nursing care such as wound and mouth care and medicine administration. But care should be taken to assess for unmet social needs of family caregivers who typically are women and who often also have work and child-care responsibilities, frequently live in poverty and may also have been affected by the HEC.

Clinicians caring for people affected by Humanitarian emergencies and crises should routinely ask patients with serious, complex or life-limiting health problems if they desire spiritual counselling. Every effort should be made to facilitate access to spiritual counselling by local volunteers that is appropriate to the beliefs and needs of the patient and family.

## Social supports

Social supports for patients and family caregivers living in extreme poverty, an essential part of palliative care, are needed to assure that their most basic needs are met such as food, housing and transport to medical care, and to promote dignity. These supports should include, as appropriate, basic food packages, housing or cash payments for housing, transportation vouchers for visits to clinics or hospitals for the patient and a caregiver, and in-kind support blankets, sleeping mats, shoes, soap, toothbrushes and toothpaste (30). These social supports help to assure that patients can access and benefit from medical care and should be accessible by any patient, not only those in need of palliative care or symptom control. In Humanitarian emergencies and crises, shelter, food, water and sanitation are crucial to protect and improve people's mental health and psychosocial well-being (2).

One additional social support that should be accessible for families living in extreme poverty is locally adequate funeral costs (30). Culturally and medically appropriate burial or disposal of bodies can be a major financial burden for families in low-income settings, and inability to provide a funeral can become a chronic emotional burden. When patients die, it is therefore important to discuss preferences with family members and generate solutions to ensure that their wishes can be met to the extent possible. These may include viewing the body, handling the body, specific burial ceremonies or religious practices, involving wider circles of family and key community members and faith leaders, marking the grave and finding meaningful ways to remember the dead. In the setting of Humanitarian emergencies and crises, these wishes may be difficult or impossible to fulfil due to the need for infection control in infectious disease outbreaks, security considerations, displacement and fragmentation of affected communities or limited resources. However, it is important to discuss concerns and obstacles with affected families and communities and to try to generate creative solutions together (2,97).

## Augmenting the EP Hum

The EP Hum includes only the most basic medicines, equipment, social supports and human resources. It should be accessible by all people affected by Humanitarian emergencies and crises, but it should not be considered sufficient to meet all palliative care or symptom control needs. Depending on the type and budget of humanitarian response organizations and the type of health emergency or crisis, the EP Hum may be augmented in various ways. For example, in mass casualty situations, there is a great need for means to prevent and relieve postoperative pain, pain from serious wounds and pain from wound care such as surgical debridement and dressing changes.

### Medicines and other treatments:

- paediatric (liquid) formulations of paracetamol, ibuprofen, morphine and diazepam;
- topical lidocaine or other topical anaesthetic ointment: for preventing pain from procedures in children;
- fentanyl, injectable: for preventing pain from brief procedures or dressing changes and for intravenous analgesia in patients with renal failure;
- fentanyl transdermal patches: for patients with moderate or severe cancer pain or pain near the end of life who are unable to take oral medicines or who have renal failure;
- slow-acting oral morphine: for patients with moderate or severe cancer pain or pain near the end of life who can take oral medicines;
- ketamine, injectable: for preventing pain from brief procedures or dressing changes;
- midazolam, injectable: for conscious sedation prior to painful procedures and for palliative sedation for intractable distress of a dying patient;
- phenobarbital, oral and injectable: for treating seizures; and
- access to palliative cancer treatments (radiotherapy, chemotherapy): for patients with incurable cancers.

### Equipment:

- wheelchairs, walkers, and canes: to improve mobility and reduce burden for family caregivers.

### Human resources:

- palliative care specialist physician or nurse practitioner with basic training in humanitarian response to health emergencies and crises:
  - for Humanitarian emergencies and crises with many patients in need of palliative care or symptom control or in areas where local providers lack training in palliative care; and
  - for Humanitarian emergencies and crises that generate particularly complex symptom control problems, a palliative care specialist physician is preferable;
- mental health specialist with basic training in humanitarian response to health emergencies and crises: for protracted Humanitarian emergencies and crises, or extremely traumatic Humanitarian emergencies and crises such as war or genocide, that result in a high prevalence of severe mental health sequelae;
- child psychologist/psychiatrist or child life specialist with basic training in humanitarian response to health emergencies and crises: for Humanitarian emergencies and crises with many affected children, to help affected children cope with injury, illness, disability, psychological trauma, loss of family members or orphanhood;



- physical medicine and rehabilitation specialist physician and/or physical therapist with basic training in humanitarian response to health emergencies and crises: for chronic Humanitarian emergencies and crises with many patients with physical disabilities; and
- specialized palliative care team: for the largest Humanitarian emergencies and crises with the large numbers of patients in need of palliative care or symptom control, and to help build sustainable local palliative care capacity.

## Interventions for specific patient populations

### Expectant or dying patients (triaged blue)

When a decision is made that a patient is expectant (triaged blue), it is ethically imperative that the patient not be abandoned but rather receive comfort-oriented treatment. Preventing and relieving the suffering of the dying is an essential task of all humanitarian responses to Humanitarian emergencies and crises. Failure to provide this service is medically and ethically indefensible and should not be delayed or considered optional (7,63).

Expectant patients should be placed in as quiet and private a location as possible and provision made for family members to be present. The prognostic understanding of the patient or family should be gently explored and corrected as needed and as culturally appropriate. Advice from local collaborators should be sought on how best to convey bad news and to explain that care to maximize comfort is the best that medicine can offer under the circumstances. It should be made clear that there is never an intention to hasten death but rather to provide whatever treatment is necessary to achieve an adequate level of comfort for the patient in the context of the patient's values. Aggressive efforts must be made to relieve pain and other symptoms. Comfort-oriented care sometimes requires an intensity and ingenuity that rivals critical care. In addition, all patients and family members should have access to PFA, defined by WHO as a "humane, supportive response to a fellow human being who is suffering and who may need support. It entails basic, non-intrusive pragmatic care with a focus on listening but not forcing talk, assessing needs and concerns, ensuring that basic needs are met, encouraging social support from significant others and protecting from further harm" (87). They also should have access to focused non-specialized psychological care by personnel with basic training on mental health care. In the aftermath of especially large and traumatic events, specialized psychiatric supervision and care may be needed (2). Patients capable of preparing a simple legacy for their children or other family members, such as a letter or memory box, should be given this opportunity. Local volunteer spiritual supporters should be sought to provide culturally appropriate spiritual support if requested by the patient or family. If possible, bereavement support also should be offered (98). This may consist of bereavement support groups led by adequately trained personnel. Some interventions can be provided safely and effectively by CHWs with basic training (96).

### Patients with advanced chronic illnesses

In some Humanitarian emergencies and crises, many patients in need of palliative care may be those with advanced chronic illness who have lost access to their usual health care. For patients who still may benefit from disease-modifying treatment, every effort should be made to obtain this treatment through the local or regional health care system. When no further disease-modifying treatment is available or desired by the patient, the sole goal of care may be comfort and maximizing the quality of life.

As for expectant patients, these patients should be placed in as quiet and private a location as possible and provision made for family members to be present. The prognostic understanding of the patient or family should be gently explored and corrected as needed and as culturally appropriate. Advice from local collaborators should be sought on how best to convey bad news and to explain that care to maximize comfort is the best that medicine can offer under the circumstances. It should be made clear that there is never an intention to hasten death but rather to provide whatever treatment is necessary to achieve an

adequate level of comfort for the patient in the context of the patient's values. Aggressive efforts must be made to relieve pain and other symptoms. Patients capable of preparing a legacy for their children or other family members, such as letters or memory box, should be given this opportunity. Local volunteer spiritual supporters should be sought to provide culturally appropriate spiritual support if requested by the patient or family.

### **Patients with psychological suffering**

While mental health complaints in Humanitarian emergencies and crises are diverse in nature and severity, EMT staff members can ameliorate most with basic training in palliative care or that includes assessment and treatment of common, uncomplicated psychiatric disorders (Annex 6 Sample curriculum) (2,44).

First, grief and acute stress are usually transient psychological reactions to adversity and loss. These require a basic, supportive psychosocial response: PFA (2). Yet when these reactions interfere with daily functioning – as is the case when people develop associated symptoms of insomnia, enuresis or hyperventilation – then general health care providers (e.g. non-specialized physicians, clinical officers and nurses) need to know how to manage this.

Second, common mental disorders, such as mild depression, mild PTSD or prolonged grief disorder may be triggered by extreme stressors (e.g. trauma and loss). These disorders may become chronic and undermine the functioning of individuals and communities, which is essential for their survival and socioeconomic recovery. Health care providers need to know how to manage these problems and how to distinguish mental disorders from widespread emotional distress that is common in emergency settings (99).

Third, pre-existing chronic psychoses, bipolar disorder, intellectual disability and epilepsy can cause significant vulnerability in the chaos of an emergency. People with these conditions are at particular risk of neglect, abandonment, abuse, interruption of maintenance medication and lack of access to health services. Moreover, triggered by the stress of adversity, people with a history of severe mental disorder may experience a relapse or exacerbation of existing symptoms (100).

Finally, acute health risks and social problems due to alcohol and drug use can be magnified in humanitarian settings (101); health care providers need to be able to manage harmful use of alcohol and drugs as well as life-threatening withdrawal (2).

Any doctor who provides care outside the operating room should be prepared and permitted to provide non-specialized psychological care that includes PFA and prescription of psychotropic medicines for priority, uncomplicated mental health conditions. Comprehensive WHO guidelines on training non-specialized providers (e.g. doctors, nurses) in the assessment, management and referral of priority mental health conditions are available and should be included in palliative care training curricula (Annex 6 Sample curriculum) (44). Persons with symptoms of acute stress should be offered basic psychosocial support as PFA. Single session psychological debriefing – asking people to recount traumatic experiences – is not recommended since this practice has been found ineffective or even harmful (2, 102).

For bereaved adults and children who do not have a mental disorder, it is not recommended to provide structured psychological interventions such as psychotherapy, grief counselling or discussing grief-related feelings because there is evidence suggesting that such interventions have no effect on grief-related symptoms among adults, children and adolescents (87). Instead, it is recommended to follow general principles of care such as communication, mobilizing and providing social support and attention to overall well-being (44), to offer PFA and encourage and facilitate participation in culturally appropriate mourning practices (87).

Recommended interventions for depression that can be provided by trained and supervised community workers include problem-solving counselling (e.g. Problem Management Plus PM+), interpersonal therapy

and behavioural activation (44). Cognitive behavioural therapy should be offered if trained and supervised therapists are available. Recommended interventions for PTSD include PM+ by trained and supervised lay workers. If trained and supervised therapists are available, then cognitive behavioural therapy with a trauma focus or eye movement desensitization and reprocessing (EMDR) should be considered (44).

Distressed family members of friends of severely ill or injured patients sometimes may act inappropriately. They may become agitated, aggressive or threatening. Any clinician who feels threatened by a patient or family member should leave the area and seek assistance from security personnel. If the situation is not threatening, it is important to stay calm and patient, take the person(s) to a quiet space if possible, listen to and reflect concerns, provide needed explanations and jointly explore potential solutions to the problem.





## 6

# Implementing palliative care in Humanitarian emergencies and crises: practical considerations

## Part 1. Key humanitarian agencies and roles

In case of a disaster, the government of the affected state has primary responsibility for the coordination and management of the response operations. This is recognized, for example, under United Nations General Assembly resolution 46/182 of 19 December 1991, whereby the affected state – the government and its officials – retain the primary role in the initiation, organization, coordination and implementation of humanitarian assistance within its territory (103). When the scale of an emergency exceeds the capacity of a state to respond, it may invite international organizations to provide support. International humanitarian assistance should complement any existing coordination systems or working groups established through the National Disaster Management Office (NDMO) or authority or equivalent body within that sovereign state.

IASC was established in June 1992 in response to resolution 46/182 to serve as the primary mechanism for inter-agency coordination relating to humanitarian assistance in response to complex and major emergencies under the leadership of the United Nations Emergency Relief Coordinator (ERC). The members of IASC are the heads or designated representatives of the United Nations operational agencies: United Nations Development Programme (UNDP); United Nations Children’s Fund (UNICEF); UNHCR; World Food Programme (WFP); United Nations Food and Agriculture Organization (FAO); WHO; United Nations Human Settlements Programme (UN-HABITAT); UNOCHA; and International Organization for Migration (IOM). In addition, there are standing invitations to ICRC, the International Federation of Red Cross and Red Crescent Societies (IFRC), the United Nations Office of the High Commissioner for Refugees (OHCHR), the United Nations Population Fund (UNFPA), the Special Rapporteur on the Human Rights of IDPs, and the World Bank. The Humanitarian Reform process was initiated by the ERC, together with IASC, in 2006 to improve the effectiveness of humanitarian response through greater predictability, accountability, responsibility and partnership. As part of these efforts to strengthen coordination in emergencies, the cluster approach was proposed and adopted. Clusters are groups of humanitarian organizations, both United Nations and non-United Nations, in each of the main sectors of humanitarian action (health, logistics, nutrition, protection, shelter, education, water and sanitation/hygiene, early recovery, food security, camp organization/management, emergency telecommunications). They are designated by IASC and have clear responsibilities for coordination. Agencies that are not part of the cluster system, such as ICRC, coordinate with it in most situations.

Each of the sectors or areas of activity has a designated Global Cluster Lead, bringing surge capacity, technical expertise, stockpiles, technical tools and best practices, including in monitoring and evaluation. The Global Cluster Lead for Health is WHO. Other examples include protection led globally by UNHCR and education led globally by UNICEF. The Cluster Lead Agency is the agency or organization at the country level, designated by the Resident Coordinator and/or Humanitarian Coordinator. At the country level, each cluster will have a lead individual – the Cluster Coordinator – responsible for coordination and facilitation of cluster work. The cluster coordination for health frequently involves co-chairing by a WHO and a national government representative.

The Humanitarian Coordinator is the highest representative of the international humanitarian response and must ensure coordination and effectiveness of response efforts. The Humanitarian Coordinator establishes and leads the Humanitarian Country Team – a strategic and operational decision-making and oversight body. It has representatives from the United Nations, IOM, international NGOs and the Red Cross/Red Crescent Movement. The Humanitarian Country Team is responsible for agreeing on common strategic



issues, including which clusters to establish and which organizations are to lead them. Agencies that are also designated Cluster Leads should represent the clusters as well as their respective organizations.

### ***How can palliative care teams and clinicians respond to the need?***

#### **Joining humanitarian response teams**

A palliative care clinician or team may find one of many possible ways of helping to provide assistance in humanitarian emergencies.

- Volunteering with a local governmental organization, or an international or local NGO, to assist in case of a domestic humanitarian emergencies and crises. A palliative care clinician already may be working in a country that is suddenly affected by a humanitarian emergencies and crises. However well intentioned, ad hoc volunteering and deployment are likely to result in uncoordinated or substandard care by poorly prepared clinicians. Therefore, palliative care clinicians or teams interested in participating in responses to Humanitarian emergencies and crises should contact their NDMO and familiarize themselves with the cluster approach. They should be prepared to deploy when requested by the NDMO or health cluster decisions and to abide by the sovereign role that the state has in deciding what assistance is required including where and when it is provided.
- Joining an EMT

EMTs are groups of health professionals (doctors, nurses, paramedics, etc.) that provide medical care both domestically and internationally for people affected by Humanitarian emergencies and crises. Individual professionals may come from governments, NGOs, academic institutions, the military, and international humanitarian organizations such as the Red Cross/Red Crescent organization. WHO and its partners have established minimum standards with which EMTs are expected to comply. EMTs must be adequately trained and prepared to provide appropriate care, and they must be self-sufficient so as not to place an additional burden on the national system of the affected state.

Historically, EMTs were prepared primarily to provide surgical and trauma care. The Ebola outbreak in West Africa and resultant need mainly for medical intensive care led to an expansion of EMT roles. However, the WHO classification of EMTs still emphasizes surgical care:

- EMT Type 1 provides outpatient emergency care, including emergency care of injuries and other significant health care needs.
- EMT Type 2 provides inpatient surgical emergency care including acute care, general and obstetric surgery for trauma and other major conditions.
- EMT Type 3 provides complex inpatient referral surgical care including intensive care capacity. There are also additional specialized care teams within inpatient settings of hospitals, where palliative care clinicians would likely be embedded.

Additional specialized care teams provide other specialized care within EMT Types 2 or 3 or in a local hospital.

Global EMT Registry: WHO has developed an EMT registry to verify that EMTs meet minimum standards and to facilitate coordinated deployment of EMTs (3).

Type 1 EMTs should have at least one physician and one nurse with at least basic training in palliative care, defined as 35–70 hours (Table 8). Type 2 and 3 EMTs that likely will care for critically injured or ill patients and dying patients should have at least one physician with at least intermediate level training in palliative care, defined as from two weeks (70 hours) to six weeks. In addition, all anaesthetists and anaesthesia technicians should have basic training in palliative care. Palliative care specialist physicians or nurse

practitioners who join EMTs should be prepared to address the palliative care needs of people affected by various Humanitarian emergencies and crises, including mass casualty events, infectious disease outbreaks and famine. These may entail risks for which the clinician should prepare as well as possible in advance, thus they should have basic training in response to Humanitarian emergencies and crises. The Sphere Project has made available a training resource in English, Spanish, Arabic and French that can be used for this purpose (Annex 7 Sample curriculum) (104).

**Table 8. Types of palliative care training**

Level	Typical duration	Trainees	Comments
Specialist	1–3 years	Doctors Nurse practitioners	Needed only for Type 2 and 3 EMTs at Humanitarian emergencies and crises likely to produce many patients with particularly complex symptom control problems
Intermediate	2–6 weeks	Doctors, clinical officers, assistant doctors, anaesthetists or nurse practitioners who frequently care for people with serious or life-threatening health problems	Recommended for all EMTs to have at least one clinician with intermediate-level training At a minimum, Type 2 and 3 EMTs should have at least one physician with intermediate-level training
Basic	1–2 weeks (35–70 hours)	Doctors Clinical officers Assistant doctors Anaesthetists Nurse practitioners Nurses	Recommended for all clinical staff members of all EMTs At a minimum, Type 1 EMTs should have at least one physician and one nurse with basic training
Rudimentary	3–8 hours	CHWs	

## Part 2. International conventions require that access to essential controlled medicines be assured

The primary objective of the international drug control conventions is to ensure adequate availability of narcotic drugs and psychotropic substances for medical and scientific purposes while ensuring that they are not diverted for illicit purposes (105). The United Nations Single Convention on Narcotic Drugs of 1961, as amended, and the United Nations Convention on Psychotropic Substances of 1971 established a system of controls to serve a dual purpose: to ensure the availability of controlled substances for medical and scientific purposes while preventing the illicit production of, trafficking in and abuse of such substances (106,107).

According to the United Nations Single Convention on Narcotic Drugs of 1961, certain essential opioid analgesic medicines are “indispensable for the relief of pain and suffering”, and their availability must be ensured so they are adequately provided (106). Inadequate access to opioid analgesia is inconsistent with Article 25 of the Universal Declaration of Human Rights, including the right to medical care, which encompasses palliative care. United Nations reports have stressed for more than two decades the need to eliminate disparities in access. The major barriers to opioid medicine use reported by countries to the International Narcotics Control Board (INCB) included:

- lack of prescriber training;
- fear of producing addiction or dependence on opioid analgesics;

- financial constraints, problems sourcing or importing opioid medicines, and unnecessarily burdensome regulatory frameworks;
- fear of diversion; and
- clinicians' fear of prosecution for prescribing.

These concerns can and should be addressed by EMTs and by national governments. EMT staff members should be trained in opioid analgesia and in supply chain security. Any restrictions on opioid prescribing in accordance with WHO or other internationally recognized standards in Humanitarian emergencies and crises should be eliminated. Guidance on sourcing or importing opioid medicines for Humanitarian emergencies and crises is provided below.

The Convention on Psychotropic Substances of 1971 calls for efforts to prevent the abuse of psychotropic substances and their diversion to illicit uses, but it also recognizes that the use of psychotropic substances for medical and scientific purposes is indispensable and that their availability for such purposes should be ensured and facilitated and not unduly restricted. Several narcotic drugs and psychotropic substances under control are listed in the WHO Model List of Essential Medicines (88), and they are therefore considered essential to satisfying the priority health care needs of the population. Just as opioid analgesics such as morphine are essential for the treatment of pain, psychotropic substances such as benzodiazepines, antidepressants and antipsychotics are indispensable for the treatment of anxiety disorders and various neurological and mental conditions.

Article 21 of the Single Convention on Narcotic Drugs of 1961 provides specific limitations to manufacture and importation of controlled substances. However, the article states that exception can be made "in exceptional cases where the export, in the opinion of the Government of the exporting country, is essential for the treatment of the sick" (106). The commentary on the Single Convention further states that "As long as a Party makes use of this authority in good faith, its opinion about the need of the drugs for the treatment of the sick cannot be questioned" (105). To this end, simplified control measures are in place for the provision of internationally controlled medicines for emergency medical care. Emergencies are defined as any acute situation (e.g. earthquakes, floods, hurricanes, epidemics, conflicts, displacement of populations) in which the health conditions of a group of individuals are seriously threatened unless immediate and appropriate action is taken, and which demands an extraordinary response and exceptional measures.

Simplified control procedures lift the import authorizations requirements, provided that the import and delivery are handled by established international, governmental organizations and/or NGOs engaged in the provision of humanitarian assistance in health matters recognized by the authorities of both the recipient country and the exporting countries. Those simplified procedures are available to all states in the WHO Model guidelines for the international provision of controlled medicines for emergency medical care (Annex 4).

Competent national authorities may allow the export of internationally controlled substances to affected countries even in the absence of import authorizations or estimated requirements. Emergency deliveries need not be included in the estimates of the receiving country, and exporting governments may wish to use parts of their special stocks of narcotic drugs and psychotropic substances for that purpose. The INCB has the capacity to assist in these processes to facilitate export and import of controlled medicines in emergency situations (Annex 4) (105, 108).

## Part 3. Rules for humanitarian response teams: the CHS

*Note: This section is adapted from:*

CHS Alliance. *Core Humanitarian Standard on Quality and Accountability 2014 (66)*. <https://corehumanitarianstandard.org/the-standard>

The Core Humanitarian Standard on Quality and Accountability (CHS) sets out nine commitments that organizations and individuals involved in humanitarian response can use to maximize the quality and effectiveness of the assistance they provide (Panel 1). It also promotes accountability to communities and people affected by crisis. When they know the commitments of humanitarian organizations, then people affected by crisis are able to hold those organizations accountable.

CHS describes the essential elements of principled, accountable and high-quality humanitarian action. Humanitarian organizations may use it as a voluntary code with which to align their own internal procedures. It can also be used as a basis for verification of performance.

### Panel 1: Core Humanitarian Standard – The Nine Commitments and Quality Criteria

1. Communities and people affected by crisis receive assistance appropriate and relevant to their needs.  
**Quality Criterion:** Humanitarian response is appropriate and relevant.
2. Communities and people affected by crisis have access to the humanitarian assistance they need at the right time.  
**Quality Criterion:** Humanitarian response is effective and timely.
3. Communities and people affected by crisis are not negatively affected and are more prepared, resilient and less at-risk as a result of humanitarian action.  
**Quality Criterion:** Humanitarian response strengthens local capacities and avoids negative effects.
4. Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them.  
**Quality Criterion:** Humanitarian response is based on communication, participation and feedback.
5. Communities and people affected by crisis have access to safe and responsive mechanisms to handle complaints.  
**Quality Criterion:** Complaints are welcomed and addressed.
6. Communities and people affected by crisis receive coordinated, complementary assistance.  
**Quality Criterion:** Humanitarian response is coordinated and complementary.
7. Communities and people affected by crisis can expect delivery of improved assistance as organisations learn from experience and reflection.  
**Quality Criterion:** Humanitarian actors continuously learn and improve.
8. Communities and people affected by crisis receive the assistance they require from competent and well-managed staff and volunteers.  
**Quality Criterion:** Staff are supported to do their job effectively, and are treated fairly and equitably.
9. Communities and people affected by crisis can expect that the organisations assisting them are managing resources effectively, efficiently and ethically.  
**Quality Criterion:** Resources are managed and used responsibly for their intended purpose.

## Part 4. Role of anaesthetists in providing palliative care

In Humanitarian emergencies and crises, anaesthetists and anaesthesia technicians routinely prevent and relieve pain with opioids and care for critically ill or injured patients using basic medicines commonly used in palliative care. Thus, on EMTs staffed mainly to address surgical problems, they often are the staff members' best prepared to provide palliative care, alleviate suffering and promote the dignity of patients and their families. To optimize this preparation, they should undergo basic palliative care training that includes not only symptom control, but also (Annex 6 Sample curriculum):

- exploring a patient's values, illness understanding and fears;
- cultural sensitivity;
- breaking bad news;
- shared decision-making about goals of care;
- optimum use of life-sustaining treatment;
- assuring comfort during withdrawal of life-sustaining treatment; and
- psychosocial support for patients and family members.

In Humanitarian emergencies and crises, anaesthetists must be prepared to provide palliative care especially for two patient populations:

- patients with advanced chronic illnesses who have lost access to health care and either:
  - have symptoms at baseline; or
  - have advanced disease with no options available for disease-modifying treatment; and
- patients with moderately or severely symptomatic or life-threatening injuries.

Even in mass casualty events, where health care needs are overwhelming the resources and patients are triaged according to their likelihood of survival, the majority of patients in need of palliative care will not be expectant or actively dying. Rather, anaesthetists must integrate palliative care with life-sustaining and reparative treatment (Table 2).

Typically, it is assumed that the preeminent goal of triage in mass casualty events is to maximize the number of lives saved. As a result, patients triaged as expectant may receive little attention or be neglected completely because their treatment may be seen as diverting resources from salvageable patients. However, life-saving versus palliative care is a false dichotomy (7). For both medical and ethical reasons, life-saving and palliative care must be integrated. According to the OCHA United Nations Disaster Assessment and Coordination Field Handbook, "... international humanitarian assistance ... aims to save lives and alleviate suffering" (109). Further, the first of the four basic principles for humanitarian action is that "human suffering must be addressed wherever it is found". Thus, there is an ethical responsibility to maximize comfort and minimize physical and psychological suffering for all people affected by a mass casualty event, including those triaged as expectant. In addition, it has been shown that pain and symptom relief can reduce morbidity and mortality, for example:

- use of morphine during early trauma care after serious injury may reduce risk of PTSD (34); and
- control of postoperative pain can reduce risk of pneumonia, deep-vein thrombosis, cardiac events (35).

For Humanitarian emergencies and crises where anaesthesia providers (anaesthetists and/or anaesthesia technicians) are needed, they should take the lead in planning palliative care services and the integration of palliative and life-saving care. Planning should include the following:

- transparent, explicit triage criteria should be established (Table 2);
- a list of essential palliative care medicines should be created and their accessibility ensured (Chapter 5);
- all anaesthetists, anaesthesia technicians and ward nurses should have at least basic palliative care training (Annex 6);
- adult and paediatric pain relief protocols should be available and followed in order to optimize comfort and safety and minimize the potential errors; and
- if the necessary resources and trained anaesthesia personnel are available to provide regional (upper and lower limb) nerve blocks, then they may be considered as an alternative or supplement to systemic analgesia, for example, for traumatic lower limb amputation, femoral and sciatic nerve blocks may be appropriate.

## Part 5. Collaborations

Collaboration between individual team members and EMTs is critical for effective responses to Humanitarian emergencies and crises. In the setting of Humanitarian emergencies and crises, collaboration should entail:

- working closely with others for a shared outcome; and
- being adaptable and willing to compromise to achieve common goals.

### ***Local public health and disaster management systems***

Over 400 NGOs responded in the first days and weeks following the 2004 Indian Ocean tsunami. While many of them did excellent work, others worked without authorization or oversight, failed to collaborate and became a burden on the host country.

Systems for certification and coordination of responding teams have improved since then. Ideally, EMTs should deploy in response to a request for assistance from the host country made to the United Nations Resident Coordinator or Humanitarian Coordinator. In some cases, however, it is unclear what the coordinating authority is. In others, there is limited capacity for the host country to manage a large influx of responders. It is incumbent on responders, therefore, to understand from whom they should seek authorization and direction. Most countries will have an NDMO or equivalent agency. Inter-ministerial coordinating or advisory mechanisms may also support this body.

EMTs may consist partly or entirely of government personnel, either civilian or military, or they may be local or international NGOs. The NDMO should coordinate the activities of EMTs of all types.

It is essential for international EMTs to understand and engage with the local public health system. The Sphere Handbook Core Standard 2: coordination and collaboration sets out important ways to ensure coordination with the local health system (5). Key actions include:

- participating in sectoral coordination mechanisms from the outset;
- learning about the responsibilities, objectives and coordination role of the state and any other coordination groups;



- providing coordination groups with information about your agency's mandate, objectives, capabilities and programme;
- sharing assessment information with the relevant coordination groups in a timely manner and accessible format;
- using programme information from other humanitarian agencies to inform analysis, selection of geographical area and response plans;
- regularly updating coordination groups on progress, reporting any major delays, agency shortages or spare capacity;
- collaborating with other humanitarian agencies to strengthen advocacy on critical shared humanitarian concerns; and
- establishing clear policies and practice regarding the agency's engagement with non-humanitarian actors.

### ***Health system strengthening***

According to WHO, a health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities (110). Much of the suffering and death resulting from some Humanitarian emergencies and crises is due to the weakness of the local health system. In some cases, humanitarian responses further weaken health systems by setting up parallel structures, logistic mechanisms and governance. While coexisting systems may be necessary in some situations, at least temporarily, such as when a sudden onset disaster overwhelms a health care system, a disaster response should have as one of its goals to strengthen the local health care system and prepare it to cope better with future challenges.

WHO has defined several features of strong health care systems that can serve as aims for humanitarian interventions. Strong health care systems consist of (110):

- services that deliver effective, safe, quality personal and non-personal health interventions to those that need them, when and where needed, with minimum waste of resources;
- a workforce that has sufficient staff, fairly distributed, and who are competent, responsive and productive;
- a health information system that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health system performance and health status;
- a service delivery system that ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness;
- a financing system that raises adequate funds for health, protected from financial catastrophe and providing incentives for providers and users to be efficient; and
- leadership and governance that involves ensuring strategic policy frameworks, effective oversight, coalition-building, regulation and accountability.

In humanitarian responses, EMTs can contribute to achieving these aims not only through good modelling, but also through active technical assistance and training. Such support might include:

- embedded human resources acting in a mentorship role;
- provision of expert technical and administrative input;

- provision of technologies and materials to build better systems;
- guidelines and procedures to provide ongoing direction; and
- a commitment to ongoing engagement.

Responding agencies may be well positioned to return at intervals following a disaster or emergency and work to build on the system improvements that were initiated during a response. This not only builds a relationship that might provide support in future challenges, but also helps to ensure that the investments made during a crisis are not lost. International humanitarian action should be driven by subsidiarity: supporting rather than replacing local systems. This requires building capability at local and national levels.

### **International organizations**

Intergovernmental organizations are composed primarily of sovereign (or member) states. Those most relevant to humanitarian assistance include many United Nations agencies:

- United Nations High Commissioner for Refugees (UNHCR)
- International Organization for Migration (IOM)
- World Bank
- World Health Organization (WHO)
- United Nations Development Programme (UNDP)
- United Nations Children’s Fund (UNICEF).

In addition, the International Committee of the Red Cross (ICRC) is a humanitarian institution based in Switzerland. It is not an international nongovernmental organization or intergovernmental organization but rather a private entity, named under international humanitarian law as a controlling authority.

## **Part 6. Promoting resilience of self and team members**

Humanitarian aid workers, including health care professionals, witness extreme and large-scale suffering among people affected by Humanitarian emergencies and crises. Aid workers tend to be driven by a deep sense of personal responsibility to their work and a dedication to community service (111). They tend to have shared feelings of altruism as their overriding motivational values. Exposure to suffering and death on a large scale can cause feelings of helplessness and distress among workers. Other factors that contribute to distress include a sense of isolation, the physical harshness of certain environments and security concerns. In addition, many feel they were inadequately prepared for the suffering that they witnessed. Many personnel find returning to their normal life hard and reintegrating into daily life to be difficult (111).

Burnout is common among humanitarian aid workers (112). Common factors that increase the risk of burnout include overworking, overwhelming emotional exposure, hardship in the field, lack of self-care, poor personnel management and underlying or pre-existing emotional conditions. Additional sources of burnout include poor programme management, not seeing tangible changes in humanitarian situations, imbalance in personal life and lack of social support from family and home community (111). The consequences of prolonged and unalleviated stress include physical changes such as fatigue, emotional changes including mood swings and guilt or shame, and spiritual changes such as loss of hope (113,114).

The development of resilience is important to support the individual aid worker and the whole team to prevent burnout and unhealthy and destructive coping mechanisms and to improve their sense of well-being. Resilience is the ability of a person to withstand or recover quickly from difficult situations and to

learn from the situation and enhance one's personality (115). It entails an ability to maintain meaning, purpose and feelings of self-efficacy and self-worth in the face of tremendous suffering (116). Key qualities of resilient personnel include flexibility, maturity, adaptability and past experience in emergency situations (noting the cumulative risk of stress) (117).

### ***General interventions for the development of individual resiliency***

Five factors enhance the development of resilience among health care practitioners (118):

- building positive professional relationships through networks and mentoring;
- maintaining positivity through laughter, optimism and positive emotions;
- developing the emotional insight to understand one's own risk and protective factors;
- achieving work–life balance and embracing spirituality to give one's life meaning and coherence; and
- becoming more reflective.

### ***General self-care***

Burnout prevention entails good personnel and field management and enabling staff members to take time away from the field. Attention to work–life balance, a good social support, mental health education and post-field counselling also reduce burnout. Forms of personal stress management include journaling, social media and exercise. Identifying the positive meaning of work helps reduce distress. Supervision by a designated mentor is important as extreme emotions can be activated and there can be a sense of helplessness by what is witnessed in the field (119).

### ***General team care***

Social connections are important coping mechanisms for dealing with stress and intense personal experiences in the field. Connecting with fellow aid workers, talking with friends and family, self-reflection and being open with others were the most common recommendations by returning humanitarian aid workers (111).

### ***Interventions***

Pre-deployment preparation (2) which should include the following.

- training in self-care, including stress management techniques, team building and conflict resolution strategies;
- mandatory briefing on:
  - local cultural, social, political and historical context (to help prevent cognitive dissonance about local norms); and
  - the organization's expectations of team members;
- medical check-up, including vaccinations;
- training on the basic humanitarian principles of impartiality, humanity, neutrality and independence (120);
- identifying one or more friends or family members with whom you will be in frequent contact during and about the deployment (121);

- packing items of personal significance that can give comfort during times of stress such as a meaningful or sacred book, a picture or piece of art with healing significance, and pictures of friends and family;
- packing a device for communication such as a smart phone, satellite phone and/or personal computer; and
- identifying a mentor either at the main office or in the field whom you can contact for work-related concerns.

### ***During deployment***

The development of strong relationships between aid professionals and national staff can be key sources of psychological, practical and professional support (120). Having an opportunity to discuss experiences and debrief and discuss ethical dilemmas as they occur is critical (Chapter 7). Specific recommendations to improve well-being include:

- daily team meetings to review daily events and supply new information about the situation;
- allowing time for daily exercise or meditation;
- making sure that each team member is getting enough sleep;
- daily check-in with family or friends at home, if possible;
- assigning each team member a buddy whose responsibility is to make sure their partner is hydrated, taking breaks and maintaining appropriate safety and security measures; additionally, the buddy can alert the team leader if their partner appears to be in emotional danger;
- team leader should be available daily for onsite supervision to debrief difficult situations and to provide conflict resolution as needed; and
- ideally the team should include someone trained in crisis intervention.

### ***Post-deployment***

- mandatory in-person debriefing to discuss emotional reactions to the deployment; a second debriefing a few months after returning to enable team members to further process their experiences (120); and
- follow-up medical examination.

*Note:* One study found that immediate, formal psychological debriefing was poor in preventing PTSD and in some cases may be harmful (102). Nevertheless, sequential debriefings are still recommended.









## 7

## Ethical issues

Several ethical principles should guide palliative care and symptom control in humanitarian responses to Humanitarian emergencies and crises (5, 122, 123).

### **Respect for persons**

- Each patient's dignity and human rights must be respected.
- Patients with decision-making capacity have the right to all information pertinent to their condition and treatment in language they can understand. They also have the right to decide what treatments to accept or decline. Clinicians should provide their best recommendations based on the diagnosis and prognosis and on the patient's values.
- All communications between a patient and a clinician must remain private and confidential except in the case of compelling public health concerns. In that case, only the minimum information necessary to protect public health should be revealed.

### **Non-maleficence**

- Do no harm:
  - Always weigh the benefits and burdens of any current or potential intervention in the context of the clinical situation and the patient's values as best they can be ascertained. Interventions highly likely to be more harmful than beneficial in these contexts should be withheld or withdrawn.
  - Palliative care and symptom control should be accessible by all patients to minimize suffering from illness or injury or treatment. Palliative care and symptom control are essential parts of curative or life-sustaining treatment for many patients. When patients are deemed expectant, palliative care and symptom control become the only type of treatment.
  - Never withhold palliative care or symptom control from a patient in need based on ethnicity, religion, gender, age or political affiliation.
  - Avoid exposing people affected by Humanitarian emergencies and crises to further harm.
  - Avoid indirect or inadvertent complicity with torture, for example, by revealing information that could lead to torture or by providing treatment that might prepare a patient to survive torture.

### **Beneficence**

- Work for the good of the patient and to protect them from harm:
  - It is an ethical imperative to relieve the suffering of all people affected by Humanitarian emergencies and crises, whether that suffering is physical, psychological, social or spiritual, regardless of whether the patient's life can be saved or not, and regardless of the patient's sex/gender, ethnicity, religion or political affiliation. Failure to provide this care is medically and ethically indefensible.
  - Anticipate future suffering of patients so as to prevent it. For example, if a patient's burns must be debrided or dressing changed each day and this is likely to cause severe pain, treat pre-emptively to prevent pain and psychological trauma.

- Protect people from violence and coercion.
- a situation where the good of the patient or family may conflict with public health concerns, great judiciousness is needed. For example, in an outbreak of a serious infectious disease, any restriction on mourning or burial rituals due to public health concerns should be of the lowest severity consistent with public health and should be applied equitably.

### **Justice**

- Patients with similar conditions or symptoms must receive equal medical treatment. There should be no discrimination based on ethnicity, religion, gender, age or political affiliation:
  - Exceptions:
    - Patients who are particularly vulnerable due to poverty, stigmatization, or social or political discrimination may require more or more intense services than others.
    - Principle of reciprocity: those who face disproportionate risk in helping or protecting others should have a proportional return for their contributions.
    - For example, in an infectious disease epidemic where few doctors or nurses are available, treatment may be prioritized for a doctor or nurse who acquired the infection while participating in the response and may continue to contribute if they recover.
- A patient's autonomy should not be restricted except for compelling public health concerns. In that case, the restriction should be the minimum necessary to protect public health.

### **Solidarity**

- A community, including the global community, should stand together to face common threats and to overcome pathogenic inequalities.

### **Non-abandonment**

- No person in need of medical care ever should be ignored, neglected or abandoned.
- Expectant patients (Tables 1 and 2, triaged black) must be provided with palliative care and symptom control. Palliative care and symptom control are not optional but rather essential parts of all humanitarian responses to Humanitarian emergencies and crises.

### **Double effect**

- The principle of double effect states that an action with a possible good effect and possible bad effects is morally permitted if the action:
  - is not in itself immoral;
  - is undertaken only with the intention of achieving the possible good effect, without intending any possible bad effects even though they may be foreseen;
  - does not bring about the possible good effect by means of a possible bad effect; and
  - is undertaken for a proportionately grave reason (32).

For example, a patient dying from a mortal injury or metastatic lung cancer who has severe, intractable pain and who requests relief may be given medicines to provide relief even at the risk of side-effects, including sedation, hypotension, respiratory depression and death as long as the action (giving an opioid to relieve pain) is intended only to relieve suffering and does not intend to achieve relief by killing the patient.

- When a terminally ill or mortally injured patient wishes to be made comfortable, the intention of treatment should be to use the minimum doses of medications necessary for comfort – no more but also no less.
  - In rare situations when a severe symptom of a dying patient is refractory to intensive palliative care with standard palliative medicines and techniques, then palliative sedation to unconsciousness may be considered.
- When it is anticipated that adequate symptom control may risk unintentionally hastening the patient's death, the patient or surrogate should be advised of this, if possible, and reassured that this is medically and ethically appropriate as well as compassionate.

### ***Ethics and culture***

- Values are culturally situated. Therefore, local cultural informants should be sought who can help to determine the applicability of these ethical norms in the local context and to assist in adapting them as needed to be consistent with a patient's religious, cultural and personal values.
- Culture is important in emergencies and beneficiaries of assistance bring cultural practices to the humanitarian space. Deployees bring their own culture, and organizations will carry certain cultural traits and filters. Not considering these fundamental traditions and approaches to life is one of the biggest contributors to friction in the heightened world of emergencies.
- Culture can be visible, but much can be hidden. While obvious norms – such as dress and greetings – are easy to apply, others (such as personal space and gender norms) can be challenging to understand and incorporate.
- Culture does not override human rights. The right to participation in cultural life is enshrined in the United Nations Declaration of Human Rights. It cannot, however, infringe on fundamental human rights. Long-practised traditions, such as female genital mutilation, do not override the universal rights enshrined in international legal instruments, such as the Convention on the Rights of the Child or the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).
- Stereotyping is blinding. Stereotyping may be representative of more general so-called truths about cultures but it ultimately restricts one from seeing people as individuals and behaviours as flexible and unique. Try to see people for who they are and build teams and appreciate team dynamics based on the direct experience of people rather than the expected experience.

### ***Ethical dilemmas***

An ethical dilemma is a problem in making a decision when there are two or more conflicting moral imperatives, neither of which takes clear precedence, and when obeying one imperative would result in transgressing another. Often, the dilemma involves a conflict between the demands of two ethical principles or between two ways to apply a single principle. Such dilemmas occur in standard medical practice in HICs where resources are plentiful and clinical ethics committees can assist, and they likely occur at least as often in humanitarian response medicine where resources often are severely limited and decision-making support from an ethics committee is rare (36, 124). For example, with three patients dependent on mechanical ventilation and oxygen and gasoline needed to produce electricity running out, should all resources be used to almost certainly save the one ventilated patient with the best chance of

survival, or should the resources be divided equally with the risk that all patients might die. Does saving one patient based on the principle of beneficence outweigh equal division of resources based on the principle of justice?

Balancing competing ethical principles or arguments is difficult but necessary. Some basic rules for ethical deliberation and decision making are (122):

- Inlusiveness: seek input from all those affected.
- Communication: ensure two-way communication with all affected people.
- Transparency: in linguistically and culturally appropriate ways, explain both the decisions themselves and how decisions are made. Strictly avoid corruption or even any appearance of corruption.
- Accountability: provide a mechanism for any affected person to challenge a decision and a due process for disputes to be resolved.
- Consistency: allocation principles should be applied consistently.
- Ensuring comfort: ensure that palliative care is accessible for patients who cannot be saved with existing resources.









# 8

## The research imperative

Providing optimum care is the top priority during humanitarian response. However, optimum care requires an evidence base. Thus, humanitarian aid organizations should participate as much as possible in research consistent with ethical standards in order to inform and improve practice for humanitarian settings, even in the most extreme contexts. Local and/or national representatives should be included on the research team and involved with all aspects of the research, including formulating the research question(s), designing the study method, collecting, analysing and interpreting data, and disseminating the results (125).

Situation analyses of palliative care needs are crucial to designing and implementing optimum palliative care for specific locations and specific types of Humanitarian emergencies and crises. Data on the types of suffering, their prevalence, and the populations most at risk in each type of HEC are extremely useful (126). Outcomes research on the effectiveness, value and quality of palliative care interventions can help to improve care.

Not all research questions need to be examined in the midst of a high crisis situation (7). Vulnerabilities and desperation of affected communities may make it unethical and undesirable to do so. Some study questions can be addressed in times of relative calm, such as Phase I clinical trials on vaccine or treatment safety. In other circumstances, only in the context of an extreme crisis can questions truly be answered, such as the efficacy of interventions for crush injuries or effectiveness of treatments for unusual viral outbreaks such as Ebola. Thus it is necessary to choose the environment, population and intervention carefully.

Researchers must take care not to exploit the vulnerabilities of the context by pursuing research objectives that are trivial or irrelevant to the crisis-affected population. However, there should not be excessive restrictions on access to patients in humanitarian settings, including patients in need of palliative care. With proportionate review, it is possible to ethically involve patients in crisis settings, including patients who are at the end of their lives. When designing research in humanitarian settings involving persons with palliative care needs, and in keeping with widely accepted standards of research ethics, researchers should:

- respect international guidance for ethical research such as the Declaration of Helsinki (127, 128);
- make sure the research is responsive to the needs of the affected population and does not simply take advantage of the setting to advance other interests;
- obtain approval in advance from local research ethics committees as required by the local government;
- be respectful of local culture;
- obtain meaningful informed consent in a culturally sensitive and non-coercive manner;
- be aware of the potential introduction of bias because of the characteristics of those who are likely to agree or decline to participate in palliative care research in humanitarian settings;
- assure that the potential benefits of the research outweigh potential harms;
- avoid overburden patients with research interventions, but also recognize that some patients with palliative care needs express the desire to contribute where they can and see enrolment in research as meaningful;
- enable subjects to decline to participate or to withdraw from the research at any time without any penalty;
- avoid impeding overall response efforts and care of research subjects;

- provide any resources required by the study to ensure it does not become an additional burden to the locality or endanger affected persons or responders (127); and
- make sure that Material Transfer Agreements are in place that optimize stewardship of personal data (or bio-samples) collected from patients whose death is imminent and therefore will be uncontactable for further follow-up permissions on their use.

### ***Monitored emergency use of unregistered experimental interventions (MEURI)***

Other WHO guidance documents have stated that “in the context of an outbreak characterized by high mortality, it can be ethically appropriate to offer individual patients experimental interventions on an emergency basis outside clinical trials”, with certain provisions (122). These provisions include: local approval and oversight; adequate voluntary and informed consent; and assurance that the intervention is monitored and data formally collected to support future research. Because of the way it is justified, MEURI, by definition, will mostly involve patients suffering from life-threatening illness for whom palliative and supportive care are the only alternatives.

# References

1. World humanitarian data and trends 2016. Geneva: United Nations Office for the Coordination of Humanitarian Affairs; 2016 ([http://interactive.unocha.org/publication/2016\\_datatrends/WHDT2016.pdf](http://interactive.unocha.org/publication/2016_datatrends/WHDT2016.pdf), accessed 23 February 2018).
2. IASC Guidelines for mental health and psychosocial support in emergency settings. Geneva: Inter-Agency Standing Committee Geneva (IASC); 2007.
3. Norton I, Von Schreeb J, Aitken P, Herard P, Lajolo C. Classification and minimum standards for foreign medical teams in sudden onset disasters. Geneva: World Health Organization; 2013 (<https://extranet.who/emt/>, accessed 28 February 2018).
4. Fundamental principles of the Red Cross and Red Crescent Movement. Geneva: International Committee of the Red Cross (ICRC); 1986 (<https://www.icrc.org/en/fundamental-principles>, accessed 23 February 2018).
5. Humanitarian Charter and minimum standards in humanitarian response. The Sphere Project. Rugby, UK: Practical Action Publishing; 2011 ([www.sphereproject.org](http://www.sphereproject.org), accessed 23 February 2018).
6. Powell RA, Schwartz L, Nouvet E, Sutton B, Petrova M, Marston J et al. Palliative care in humanitarian crises: always something to offer. *Lancet*. 2017 April 15;389(10078):1498–9.
7. Smith J, Aloudat T. Palliative care in humanitarian medicine. *Palliat Med*. 2017 February;31(2):99–101. doi: 10.1177/0269216316686258.
8. O'Neill B, Fallon M. ABC of palliative care. Principles of palliative care and pain control. *BMJ*. 1997 September 27;315(7111):801–4. Review.
9. Devakumar D, Birch M, Osrin D, Sondorp E, Wells JC. The intergenerational effects of war on the health of children. *BMC Medicine*. 2014;12:57.
10. ReliefWeb Glossary of humanitarian terms. Geneva: United Nations Office for the Coordination of Humanitarian Affairs (OCHA); 2008 (<http://www.who.int/hac/about/reliefweb-aug2008.pdf>, accessed 23 February 2018).
11. Emergency Response Framework. Geneva: World Health Organization; 2017.
12. Obrecht A. “De-internationalising” humanitarian action: rethinking the “global–local” relationship. Humanitarian Affairs Think Tank; 2014 ([http://www.iris-france.org/docs/kfm\\_docs/docs/obs\\_questions\\_humanitaires/eng-obshuma-obrecht-octobre2014.pdf](http://www.iris-france.org/docs/kfm_docs/docs/obs_questions_humanitaires/eng-obshuma-obrecht-octobre2014.pdf), accessed 23 February 2018).
13. Shanks L. Why humanitarian aid became professional: the experience of MSF. *Journal of Humanitarian Assistance*. September 2014 (<http://sites.tufts.edu/jha/archives/2084>, accessed 23 February 2018).
14. Weiss TG. Humanitarian intervention, 3rd edition. Cambridge, United Kingdom: Polity Press; 2016.
15. Environmental health in emergencies and disasters. Geneva: World Health Organization; 2002 ([http://apps.who.int/iris/bitstream/10665/42561/1/9241545410\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/42561/1/9241545410_eng.pdf?ua=1), accessed 18 March 2018).
16. Attacks on health care: prevent, protect, provide. Geneva: World Health Organization; 2016 (<http://www.who.int/hac/techguidance/attacksreport.pdf?ua=1>, accessed 18 March 2018).
17. Global trends: forced displacement in 2015. Geneva: United Nations High Commissioner for Refugees; 2015 (<http://www.unhcr.org/576408cd7.pdf>, accessed 23 February 2018).
18. People affected by conflict: humanitarian needs in numbers. Brussels: Centre for Research on the Epidemiology of Disasters; 2013 (<http://cred.be/sites/default/files/PAC2013.pdf>, accessed 23 February 2018).
19. Haiti quake death toll rises to 230,000. BBC News. 11 February 2010 (<http://news.bbc.co.uk/2/hi/americas/8507531.stm>, accessed 23 February 2018).

20. Earthquake hazards program. How much bigger...? Calculator. Reston, Virginia: United States Geological Survey (<https://earthquake.usgs.gov/learn/topics/calculator.php>, accessed 23 February 2018).
21. Poverty & death: disaster mortality 1996–2015. Brussels: Centre for Research on the Epidemiology of Disasters; 2015 ([http://cred.be/sites/default/files/CRED\\_Disaster\\_Mortality.pdf](http://cred.be/sites/default/files/CRED_Disaster_Mortality.pdf), accessed 23 February 2018).
22. What is disaster risk reduction? Geneva: United Nations Office for Disaster Risk Reduction (<https://www.unisdr.org/who-we-are/what-is-drr>, accessed 23 February 2018).
23. Resolution 56/195. International strategy for disaster reduction. In: Fifty-sixth session of the United Nations General Assembly, New York, 21 January 2002 (<https://unisdr.org/files/resolutions/N0149261.pdf>, accessed 18 April 2018).
24. Sendai Framework for Disaster Risk Reduction. Geneva: United Nations Office for Disaster Risk Reduction (<http://www.unisdr.org/we/coordinate/sendai-framework>, accessed 17 March 2018).
25. WHO International health regulations 2005: areas of work for implementation. Geneva: World Health Organization; 2007 ([http://apps.who.int/iris/bitstream/10665/69770/1/WHO\\_CDS\\_EPR\\_IHR\\_2007.1\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/69770/1/WHO_CDS_EPR_IHR_2007.1_eng.pdf?ua=1), accessed 23 February 2018).
26. WHO Ebola data and statistics. Geneva: World Health Organization; 2016 (<http://apps.who.int/gho/data/view/ebola-sitrep/ebola-summary-latest?lang=en>, accessed 23 February 2018).
27. MSF Charter and principles. Geneva: Médecines Sans Frontières; 2018 (<http://www.msf.org/en/msf-charter-and-principles>, accessed 23 February 2018).
28. WHO Definition of palliative care. Geneva: World Health Organization; 2002 (<http://www.who.int/cancer/palliative/definition/en/>, accessed 17 March 2018).
29. Knaul FM, Farmer PE, Krakauer EL, De Lima L, Bhadelia A, Kwete X et al. On behalf of the Lancet Commission on Palliative Care and Pain Relief Study Group. Alleviating the access abyss in palliative care and pain relief: an imperative of universal health coverage. *Lancet*. Published online 12 October 2017; pii: S0140-6736(17)32513-8 ([http://dx.doi.org/10.1016/S0140-6736\(17\)32513-8](http://dx.doi.org/10.1016/S0140-6736(17)32513-8), accessed 17 March 2018).
30. Krakauer EL, Kwete X, Verguet S, Arreola-Ornelas H, Bhadelia A, Mendez O et al. Palliative care and pain control. In: Jamison DT, Gelband H, Horton S, Jha P, Laxminarayan R, Mock CN et al., editors. *Disease control priorities, 3rd edition, volume 9: Improving health and reducing poverty*. Washington DC: World Bank; 2018:235–46.
31. Strengthening integrated, people-centred health services. Geneva: World Health Organization; 2016 ([http://apps.who.int/iris/bitstream/10665/252804/1/A69\\_R24-en.pdf](http://apps.who.int/iris/bitstream/10665/252804/1/A69_R24-en.pdf), accessed 17 March 2018).
32. Krakauer EL, Penson RT, Truog RD, King LA, Chabner BA, Lynch TJ Jr. Sedation for intractable distress of a dying patient: acute palliative care and the principle of double effect. *Oncologist*. 2000;5(1):53–62.
33. Hayward-Karlsson J, Jeffery S, Kerr A, Schmidt H. Hospitals for war-wounded: a practical guide for setting up and running a surgical hospital in an area of armed conflict. Geneva: International Committee of the Red Cross (ICRC); 2005 ([https://www.icrc.org/eng/assets/files/other/icrc\\_002\\_0714.pdf](https://www.icrc.org/eng/assets/files/other/icrc_002_0714.pdf), accessed 23 February 2018).
34. Holbrook TL, Galarneau MR, Dye JL, Quinn K, Dougherty AL. Morphine use after combat injury in Iraq and post-traumatic stress disorder. *N Engl J Med*. 2010 January;362(2):110–17.
35. Joshi GP, Beck DE, Emerson R, Halaszynki T, Jahr J, Lipman A et al. Defining new directions for more effective management of surgical pain in the United States: highlights of the inaugural surgical pain congress. *Am Surg*. 2014;80:219–28.
36. Goodman A, Black L. The challenge of allocating scarce medical resources during a disaster in a low income country: a case study from the 2010 Haitian earthquake. *Palliat Med Hosp Care Open J*. 2015;1:24–9.

37. Model guidelines for the international provision of controlled medicines for emergency medical care. Geneva: World Health Organization; 1996 (<http://apps.who.int/medicinedocs/en/d/Jwho32e/>, accessed 23 February 2018).
38. Park M. Crush injuries can be deceptively dangerous. CNN. 21 January 2010 (<https://archive.fo/8cIXy>, accessed 24 November 2017).
39. Doocy S, Robinson C, Moodie C, Burnham G. Tsunami-related injury in Aceh Province, Indonesia. *Global Pub Health*. 2009;4:205–14.
40. Guha-Sapri D, van Panhuis WG. Health impact of the 2004 Andaman Nicobar earthquake and tsunami in Indonesia. *Prehosp Disaster Med*. 2009;24:493–9.
41. Aceh Epidemiology Group. Outbreak of tetanus cases following the tsunami in Aceh province, Indonesia. *Global Pub Health*. 2006;1(2):173–7.
42. Wilkinson A. The potential role for palliative care in mass casualty events. *J Palliat Care Med*. 2012;2:e112.
43. Karunakara U, Stevenson F. Ending neglect of older people in the response to humanitarian emergencies. *PLoS Med*. 2012;9(12):e1001357.
44. mhGAP Humanitarian intervention guide: clinical management of mental, neurological and substance use conditions in humanitarian emergencies. Geneva: World Health Organization; 2015 ([http://www.who.int/mental\\_health/publications/mhgap\\_hig/en/](http://www.who.int/mental_health/publications/mhgap_hig/en/), accessed 28 February 2018).
45. Ebola situation report: 30 March 2016. Geneva: World Health Organization; 2016.
46. Bah EI, Lamah MC, Fletcher T, Jacob ST, Brett-Major DM, Sall AA et al. Clinical presentation of patients with Ebola virus disease in Conakry, Guinea. *N Engl J Med*. 2015 January;372(1):40–7.
47. Brett-Major DM, Jacob ST, Jacquieroz FA, Risi GF, Fischer WA 2nd, Kato Y et al. Being ready to treat Ebola virus disease patients. *Am J Trop Med Hyg*. 2015 February;92(2):233–7.
48. Danis M. Weighing the importance of palliation of symptoms for Ebola patients during the epidemic in West Africa. *Am J Bioeth*. 2015;15(4):70–2.
49. Lamontagne F, Clement C, Fletcher T, Jacob ST, Fischer WA 2nd, Fowler RA. Doing today's work superbly well – treating Ebola with current tools. *N Engl J Med*. 2014;371(17):1565–6.
50. Fowler RA, Fletcher T, Fischer WA 2nd, Lamontagne F, Jacob S, Brett-Major D et al. Caring for critically ill patients with Ebola virus disease: perspectives from West Africa. *Am J Respir Crit Care Med*. 2014 October;190(7):733–7.
51. Awofeso N. Anti-tuberculosis medication side-effects constitute major factor for poor adherence to tuberculosis treatment. *Bull World Health*. 2008;86(3):B-D.
52. Pellicchia U, Crestani R, Decroo T, Van den Bergh R, Al-Kourdi Y. Social consequences of Ebola containment measures in Liberia. *PLoS One*. 2015;10(12):e0143036.
53. Leong IY, Lee AO, Ng TW, Lee LB, Koh NY, Yap E et al. The challenge of providing holistic care in a viral epidemic: opportunities for palliative care. *Palliat Med*. 2004 January;18(1):12–18.
54. Manguvo A, Mafuvadze B. The impact of traditional and religious practices on the spread of Ebola in West Africa: time for a strategic shift. *Pan Afr Med J*. 2015;22(Suppl. 1):9.
55. McMahan SA, Ho LS, Brown H, Miller L, Ansumana R, Kennedy CE. Healthcare providers on the frontlines: a qualitative investigation of the social and emotional impact of delivering health services during Sierra Leone's Ebola epidemic. *Health Policy Plan*. 2016 November;31(9):1232–9.
56. Van Bortel T, Basnayake A, Wurie F, Jambai M, Koroma AS, Muana AT et al. Psychosocial effects of an Ebola outbreak at individual, community and international levels. *Bull World Health*. 2016 March;94(3):210–14.
57. Farmer P. The caregivers' disease. *London Review of Books*. 37(10):25–8.
58. Psychosocial support during an outbreak of Ebola virus disease. Geneva: International Federation of Red Cross and Red Crescent Societies; August 2014.



59. Lee-Kwan SH, DeLuca N, Adams M, Dalling M, Drevlow E, Gassama G et al. Support services for survivors of Ebola virus disease: Sierra Leone, 2014. *Morb Mortal Wkly Rep.* 2014;63(50):1205–6.
60. Paladino L, Sharpe RP, Galwankar SC, Sholevar F, Marchionni C, Papadimos TJ et al. Reflections on the Ebola public health emergency of international concern, part 2: the unseen epidemic of posttraumatic stress among health care personnel and survivors of the 2014–2016 Ebola outbreak. *J Glob Infect Dis.* 2017;9(2):45–50.
61. Varghese SB. Cultural, ethical, and spiritual implications of natural disasters from the survivors' perspective. *Crit Care Nurs Clin North Am.* 2010;22:515–22.
62. Dunant H. A memory of Solferino. Geneva: International Committee of the Red Cross; 1959:117.
63. Matzo M, Wilkinson A, Lynn J, Gatto M, Phillips S. Palliative care considerations in mass casualty events with scarce resources. *Biosecur Bioterror.* 2009;7:199–210.
64. Doherty M, Khan F. Neglected suffering: the unmet need for palliative care in Cox's Bazar. London: World Child Cancer; 2018 (<https://reliefweb.int/sites/reliefweb.int/files/resources/Neglected%20Suffering.pdf>, accessed 17 March 2018).
65. Rieder H, Elbert T. Rwanda – lasting imprints of a genocide: trauma, mental health and psychosocial conditions in survivors, former prisoners and their children. *Conf Health.* 2013;7:6.
66. International Committee of the Red Cross (ICRC). *Anesthesia handbook.* Geneva: International Committee of the Red Cross; 2017.
67. Core humanitarian standard on quality and accountability. Geneva: CHS Alliance, Group URD and the Sphere Project; 2014 (<https://corehumanitarianstandard.org/the-standard>, accessed 23 February 2018).
68. Tanaka H, Oda J, Iwai A, Kuwagata Y, Matsuoka T, Takaoka M et al. Morbidity and mortality of hospitalized patients after the 1995 Hanshin-Awaji earthquake. *Am J Emerg Med.* 1999 March;17(2):186–91.
69. Cénat JM, Derivois D. Assessment of prevalence and determinants of posttraumatic stress disorder and depression symptoms in adult survivors of earthquake in Haiti after 30 months. *J Affect Disord.* 2014 April;159:111–17.
70. Phillips SJ, Knebel A, editors. *Mass medical care with scarce resources: a community planning guide.* Prepared by Health Systems Research, Inc., an Altarum company, under contract No. 290-04-0010. AHRQ Publication No. 07-0001. Rockville, MD: Agency for Healthcare Research and Quality; 2007.
71. *Crisis Standards of Care: a systems framework for catastrophic disaster response.* Washington DC: The National Academies Press, IOM (Institute of Medicine); 2012.
72. MacNeil A, Farnon EC, Wamala J, Okware S, Cannon DL, Reed Z et al. Proportion of deaths and clinical features in Bundibugyo Ebola virus infection, Uganda. *Emerg Infect Dis.* 2010 December;16(12):1969–72.
73. Schieffelin JS, Shaffer JG, Goba A, Gbokie M, Gire SK, Colubri A et al.; and the KGH Lassa Fever Program; Viral Hemorrhagic Fever Consortium; WHO Clinical Response Team. Clinical illness and outcomes in patients with Ebola in Sierra Leone. *N Engl J Med.* 2014 November;371(22):2092–2100.
74. Dallatomasina S, Crestani R, Sylvester Squire J, Declerk H, Caleo GM, Wolz A et al. Ebola outbreak in rural West Africa: epidemiology, clinical features and outcomes. *Trop Med Int Health.* 2015 April;20(4):448–54.
75. Mollica RF, Cardozo BL, Osofsky HJ, Raphael B, Ager A, Salama P. Mental health in complex emergencies. *Lancet.* 2004 December;364(9450):2058–67.
76. Angeletti C, Guetti C, Papola R, Petrucci E, Ursini ML, Ciccozzi A et al. Pain after earthquake. *Scand J Trauma Resusc Emerg Med.* 2012 June;20:43. doi: 10.1186/1757-7241-20-43.
77. Downar J, Seccareccia D and Associated Medical Services Inc. Educational Fellows in Care at the End of Life. Palliating a pandemic: "All patients must be cared for". *J Pain Symptom Manage.* 2010 February;39(2):291–5.
78. Roy N, Shah H, Patel V, Bagalkote H. Surgical and psychosocial outcomes in the rural injured: a follow-up study of the 2001 earthquake victims. *Injury.* 2005 August;36(8):927–34.

79. Rieder H, Elbert T. The relationship between organized violence, family violence and mental health: findings from a community-based survey in Muhanga, Southern Rwanda. *Eur J Psychotraumatol*. 2013 November;4.
80. Wu Z, Xu J, He L. Psychological consequences and associated risk factors among adult survivors of the 2008 Wenchuan earthquake. *BMC Psychiatry*. 2014 April;14:126.
81. Kristensen P, Weisæth L, Heir T. Bereavement and mental health after sudden and violent losses: a review. *Psychiatry*. 2012 Spring;75(1):76–97.
82. Li J, Chow AY, Shi Z, Chan CL. Prevalence and risk factors of complicated grief among Sichuan earthquake survivors. *J Affect Disord*. 2015 April;175:218–23.
83. Caffo E, Belaise C. Psychological aspects of traumatic injury in children and adolescents. *Child Adolesc Psychiatr Clin N Am*. 2003 July;12(3):493–535.
84. Catani C, Jacob N, Schauer E, Kohila M, Neuner F. Family violence, war, and natural disasters: a study of the effect of extreme stress on children's mental health in Sri Lanka. *BMC Psychiatry*. 2008 May;8:33.
85. West TE, von Saint André-von Arnim A. Clinical presentation and management of severe Ebola virus disease. *Ann Am Thorac Soc*. 2014 November;11(9):1341–50.
86. Teodorescu DS, Heir T, Siqveland J, Hauff E, Wentzel-Larsen T, Lien L. Chronic pain in multi-traumatized outpatients with a refugee background resettled in Norway: a cross-sectional study. *BMC Psychol*. 2015 March;3(1):7.
87. Guidelines for the management of conditions specifically related to stress. Geneva: World Health Organization; 2013.
88. WHO Model List of Essential Medicines (19th list). Geneva: World Health Organization; 2015 ([http://www.who.int/medicines/publications/essentialmedicines/EML2015\\_8-May-15.pdf](http://www.who.int/medicines/publications/essentialmedicines/EML2015_8-May-15.pdf), accessed 17 March 2018).
89. Ensuring balance in national policies on controlled substances: guidance for availability and accessibility of controlled medicines. Geneva: World Health Organization; 2011 ([http://apps.who.int/iris/bitstream/10665/44519/1/9789241564175\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/44519/1/9789241564175_eng.pdf), accessed on 17 March 2018).
90. Dowell D, Haegerich TM, Chou R. CDC Guideline for prescribing opioids for chronic pain: United States, 2016. *JAMA*. 2016;315(15):1624–45. doi:10.1001/jama.2016.1464.
91. Joranson D, Maurer M, Mwangi-Powell F, editors. Guidelines for ensuring patient access to, and safe management of, controlled medicines. Kampala: African Palliative Care Association; 2010 ([https://www.africanpalliativecare.org/images/stories/pdf/patient\\_access.pdf](https://www.africanpalliativecare.org/images/stories/pdf/patient_access.pdf), accessed 15 March 2018).
92. WHO War Trauma Foundation and World Vision International. Psychological first aid: guide for field workers. Geneva: World Health Organization; 2011.
93. Atif N, Lovell K, Husain N, Sikander S, Patel V, Rahman A. Barefoot therapists: barriers and facilitators to delivering maternal mental health care through peer volunteers in Pakistan: a qualitative study. *Int J Ment Health Syst*. 2016 March;10:24.
94. Belkin GS, Unützer J, Kessler RC, Verdelli H, Raviola GJ, Sachs K et al. Scaling up for the “bottom billion”: “5 x 5” implementation of community mental health care in low-income regions. *Psychiatr Serv*. 2011;62(12):1494–1502.
95. Patel V, Belkin GS, Chockalingam A, Cooper J, Saxena S, Unützer J. Grand challenges: integrating mental health services into priority health care platforms. *PLoS Med*. 2013;10(5):e1001448.
96. Weobong B, Weiss HA, McDaid D, Singla DR, Hollon SD, Nadkarni A et al. Sustained effectiveness and cost-effectiveness of the Healthy Activity Programme, a brief psychological treatment for depression delivered by lay counsellors in primary care: 12-month follow-up of a randomised controlled trial. *PLoS Med*. 2017;14:e1002385 (<https://doi.org/10.1371/journal.pmed.1002385>, accessed 17 March 2018).
- 97.

98. Jones, L. Grief and loss in societies affected by conflict and disaster. In: David Southall, editor. *International Maternal & Child Health Care: Chapter 1.23*. London: Radcliffe Publishing; 2015.
99. Hudson P, Remedios C, Zordan R, Thomas K, Clifton D, Crewdson M et al. Guidelines for the psychosocial and bereavement support of family caregivers of palliative care patients. *J Palliat Med*. 2012;15:696–702.
100. Horwitz AV. Distinguishing distress from disorder as psychological outcomes of stressful social arrangements. *Health (London)*. 2007 July;11(3):273–89.
101. Jones L, Asare JB, El Masri M, Mohanraj A, Sherief H, van Ommeren M. Severe mental disorders in complex emergencies. *Lancet*. 2009 August;374(9690):654–61.
102. Ezard N. Substance use among populations displaced by conflict: a literature review. *Disasters*. 2012 July;36(3):533–57.
103. Rose SC, Bisson J, Churchill R, Wessely S. Psychological debriefing for preventing post-traumatic stress disorder (PTSD). *Cochrane Database Syst. Rev*. 2002;2:Art. No.: CD000560.
104. Resolution 46/182. Strengthening of the coordination of humanitarian emergency assistance of the United Nations. In: *Seventy-eighth plenary meeting of the United Nations General Assembly, New York, 19 December 1991* (<http://www.un.org/documents/ga/res/46/a46r182.htm>, accessed 21 April 2018).
105. The Sphere training package. Geneva: The Sphere Project; 2015 (<http://www.sphereproject.org/learning/training-materials/>, accessed 17 March 2018).
106. The international drug control conventions. New York: United Nations; 2013.
107. United Nations Single Convention on Narcotic Drugs of 1961, as amended by the 1972 Protocol ([https://www.unodc.org/pdf/convention\\_1961\\_en.pdf](https://www.unodc.org/pdf/convention_1961_en.pdf), accessed 21 April 2018).
108. United Nations Convention on Psychotropic Substances of 1971 ([https://www.unodc.org/pdf/convention\\_1971\\_en.pdf](https://www.unodc.org/pdf/convention_1971_en.pdf), accessed 21 April 2018).
109. Berterame S, Erthal J, Thomas J, Fellner S, Vosse B, Clare P et al. Use of and barriers to access to opioid analgesics: a worldwide, regional, and national study. *Lancet*. 2016;387(10028):1644–56.
110. United Nations Disaster Assessment and Coordination (UNDAC) Field Handbook. New York: United Nations Office for the Coordination of Humanitarian Affairs; 2013.
111. Everybody's business – strengthening health systems to improve health outcomes. WHO's framework for action. Geneva: World Health Organization; 2007 ([http://www.who.int/healthsystems/strategy/everybodys\\_business.pdf](http://www.who.int/healthsystems/strategy/everybodys_business.pdf), accessed 21 April 2018).
112. Asgary R, Lawrence K. Characteristics, determinants and perspectives of experienced medical humanitarians: a qualitative approach. *BMJ Open*. 2014;4(12):e006460.
113. Cardozo BL, Salama P. Mental health of humanitarian aid workers in complex emergencies. *Sharing the front line and the back hills: peacekeepers, humanitarian aid workers and the media in the midst of crisis*. Amityville, NY: Baywood Publishing, 2002:242–55.
114. Blanchetière, P. The resilience of humanitarian workers. 2006 (<http://www.dochas.ie/Shared/Files/4/resilience-of-aid-workers.pdf>, accessed 28 February 2018).
115. Haik J, Brown S, Liran A, Visentin D, Sokolov A, Zilinsky I et al. Burnout and compassion fatigue: prevalence and associations among Israeli burn clinicians. *Neuropsychiatr Dis Treat*. 2017 June;13:1533–40.
116. Ehrenreich, JH. Managing stress in humanitarian aid workers: the role of the humanitarian aid organization. In: Reyes G, Jacobs G, editors. *Handbook of international disaster psychology*. Westport, CT: Praeger/Greenwood; 2006;4:99–112.
117. Young PD, Rushton CH. A concept analysis of moral resilience. *Nurs Outlook*. 2017 September–October;65(5):579–87.

118. Salama, P. The psychological health of relief workers: some practical suggestions. *Humanitarian Practice Network*; 2003 (<https://odihpn.org/magazine/the-psychological-health-of-relief-workers-some-practical-suggestions>, accessed 1 April 2018).
119. Jackson D, Firtko A, Edenborough M. Personal resilience as a strategy for surviving and thriving in the face of workplace adversity: a literature review. *J Adv Nurs*. 2007 October;60(1):1–9. Review.
120. WHO Mental health in the workplace information sheet. Geneva: World Health Organization; 2017 ([http://www.who.int/mental\\_health/in\\_the\\_workplace/en/](http://www.who.int/mental_health/in_the_workplace/en/), accessed 17 March 2018).
121. Hunt MR, Schwartz L, Elit L. Experience of ethics training and support for health care professionals in international aid work. *Public Health Ethics*. 2012;5,91–9.
122. Elsharkawi H, Sandbladh H, Aloudat T, Girardau A, Tjöflät I, Brunnström C. Preparing humanitarian workers for disaster response: a Red Cross/Red Crescent field training model. *Humanitarian Practice Network*. 2010 (<https://odihpn.org/magazine/preparing-humanitarian-workers-for-disaster-response-a-red-crossred-crescent-field-training-model/>, accessed 28 February 2018).
123. Guidance for managing ethical issues in infectious disease outbreaks. Geneva: World Health Organization; 2016.
124. Ethics in epidemics, emergencies and disasters: research, surveillance and patient care. Geneva: World Health Organization; 2015.
125. Etienne M, Powell C, Dennis Amundson D. Healthcare ethics: the experience after the Haitian earthquake. *Am J Disaster Med*. 2010;5:141–7.
126. Australian Red Cross. Localising the research process. 2017 (<http://humanitarianadvisorygroup.org/wp-content/uploads/2018/01/Localising-the-research-process.pdf>, accessed 28 February 2018).
127. Planning and implementing palliative care services: a guide for programme managers. Geneva: World Health Organization; 2016 (<http://apps.who.int/iris/bitstream/10665/250584/1/9789241565417-eng.pdf?ua=1>, accessed 18 March 2018).
128. Declaration of Helsinki Ethical Principles for Medical Research Involving Human Subjects. World Medical Association; 2016 (<https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects>, accessed 18 March 2018).
129. Ethical Principles of healthcare in times of armed conflict and other emergencies. International Committee of the Red Cross (ICRC), 2015 (<https://www.icrc.org/en/document/common-ethical-principles-health-care-conflict-and-other-emergencies>, accessed 18 March 2018).
130. WHO/ICRC Technical meeting for global consensus on triage 2017 ([https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/triage\\_2017\\_meeting\\_report-b.pdf](https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/triage_2017_meeting_report-b.pdf), accessed August 30, 2018)



# Annexes

## Annex 1

### Key passages from United Nations documents

#### Constitution of the World Health Organization

Adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946

[http://www.who.int/governance/eb/who\\_constitution\\_en.pdf](http://www.who.int/governance/eb/who_constitution_en.pdf)

“THE STATES Parties to this Constitution declare, in conformity with the Charter of the United Nations, that the following principles are basic to the happiness, harmonious relations and security of all peoples:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. ...

The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health. ...

Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.”

#### International Covenant on Civil and Political Rights

Ratified by United Nations General Assembly resolution 2200A (XXI) of 16 December 1966.

<http://www.ohchr.org/Documents/ProfessionalInterest/ccpr.pdf>

#### Preamble:

“ ... in accordance with the principles proclaimed in the Charter of the United Nations, recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world ... .”

(Also in: International Covenant on Economic, Social and Cultural Rights

Ratified by United Nations General Assembly resolution 2200A (XXI) of 16 December 1966.)

#### Article 7:

“No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.”

#### International Covenant on Civil and Political Rights

Ratified by United Nations General Assembly resolution 2200A (XXI) of 16 December 1966

<http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx>



**Article 2:**

1. "Each State Party to the present Covenant undertakes to respect and to ensure to all individuals within its territory and subject to its jurisdiction the rights recognized in the present Covenant, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."

**United Nations Committee on Economic, Social and Cultural Rights (CESCR) General****Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12)**

Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000 (Contained in Document E/C.12/2000/4).

<http://www.refworld.org/pdfid/4538838d0.pdf>

**Article 12:**

"The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

- (a) Availability. Functioning public health and health care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs;<sup>5</sup>
- (b) Accessibility. Health facilities, goods and services<sup>6</sup> have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds;

Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities;

Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households;

Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality;

- (c) Acceptability. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned;
- (d) Quality. As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation."

**Article 25:**

" ... the Committee ... reaffirms the importance ... of attention and care for chronically and terminally ill persons, sparing them avoidable pain and enabling them to die with dignity."

**Article 43:**

" ... in the Committee's view, these core obligations include at least the following obligations:

- (a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
- (b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
- (c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
- (d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
- (e) To ensure equitable distribution of all health facilities, goods and services;"

**Article 65:**

"The role of WHO, the Office of the United Nations High Commissioner for Refugees, the International Committee of the Red Cross/Red Crescent and UNICEF, as well as nongovernmental organizations and national medical associations, is of particular importance in relation to disaster relief and humanitarian assistance in times of emergencies, including assistance to refugees and internally displaced persons. Priority in the provision of international medical aid, distribution and management of resources, such as safe and potable water, food and medical supplies, and financial aid should be given to the most vulnerable or marginalized groups of the population."

## Annex 2

### **Sixty-seventh World Health Assembly resolution WHA67.19 Strengthening of palliative care as a component of comprehensive care throughout the life course**

[http://apps.who.int/gb/ebwha/pdf\\_files/WHA67/A67\\_R19-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_R19-en.pdf)

Adopted 24 May 2014

The Sixty-seventh World Health Assembly,

Having considered the report on strengthening of palliative care as a component of integrated treatment throughout the life course;<sup>1</sup>

Recalling resolution WHA58.22 on cancer prevention and control, especially as it relates to palliative care;

Taking into account the United Nations Economic and Social Council's Commission on Narcotic Drugs' resolutions 53/4 and 54/6 respectively on promoting adequate availability of internationally controlled licit drugs for medical and scientific purposes while preventing their diversion and abuse, and promoting adequate availability of internationally controlled narcotic drugs and psychotropic substances for medical and scientific purposes while preventing their diversion and abuse;

Acknowledging the special report of the International Narcotics Control Board on the availability of internationally controlled drugs: ensuring adequate access for medical and scientific purposes,<sup>2</sup> and the WHO guidance on ensuring balance in national policies on controlled substances: guidance for availability and accessibility of controlled medicines;<sup>3</sup>

Also taking into account resolution 2005/25 of the United Nations Economic and Social Council on treatment of pain using opioid analgesics;

Bearing in mind that palliative care is an approach that improves the quality of life of patients (adults and children) and their families who are facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and correct assessment and treatment of pain and other problems, whether physical, psychosocial or spiritual;

Recognizing that palliative care, when indicated, is fundamental to improving the quality of life, well-being, comfort and human dignity for individuals, being an effective person-centred health service that values patients' need to receive adequate, personally and culturally sensitive information on their health status, and their central role in making decisions about the treatment received;

- 1 Document 67/31.
- 2 Document E/INCB/2010/1/Supp.1.
- 3 Ensuring balance in national policies on controlled substances: guidance for availability and accessibility of controlled medicines. Geneva: World Health Organization; 2011.

Affirming that access to palliative care and to essential medicines for medical and scientific purposes manufactured from controlled substances, including opioid analgesics such as morphine, in line with the three United Nations international drug control conventions,<sup>1</sup> contributes to the realization of the right to the enjoyment of the highest attainable standard of health and well-being;

Acknowledging that palliative care is an ethical responsibility of health systems, and that it is the ethical duty of health care professionals to alleviate pain and suffering, whether physical, psychosocial or spiritual, irrespective of whether the disease or condition can be cured, and that end-of-life care for individuals is among the critical components of palliative care;

Recognizing that more than 40 million people currently require palliative care every year, foreseeing the increased need for palliative care with ageing populations and the rise of noncommunicable and other chronic diseases worldwide, considering the importance of palliative care for children, and, in respect of this, acknowledging that Member States should have estimates of the quantities of the internationally controlled medicines needed, including medicines in paediatric formulations;

Realizing the urgent need to include palliation across the continuum of care, especially at the primary care level, recognizing that inadequate integration of palliative care into health and social care systems is a major contributing factor to the lack of equitable access to such care;

Noting that the availability and appropriate use of internationally controlled medicines for medical and scientific purposes, particularly for the relief of pain and suffering, remains insufficient in many countries, and highlighting the need for Member States, with the support of the WHO Secretariat, the United Nations Office on Drugs and Crime and the International Narcotics Control Board, to ensure that efforts to prevent the diversion of narcotic drugs and psychotropic substances under international control pursuant to the United Nations international drug control conventions do not result in inappropriate regulatory barriers to medical access to such medicines;

Taking into account that the avoidable suffering of treatable symptoms is perpetuated by the lack of knowledge of palliative care, and highlighting the need for continuing education and adequate training for all hospital- and community-based health care providers and other caregivers, including nongovernmental organization workers and family members;

Recognizing the existence of diverse cost-effective and efficient palliative care models, acknowledging that palliative care uses an interdisciplinary approach to address the needs of patients and their families, and noting that the delivery of quality palliative care is most likely to be realized where strong networks exist between professional palliative care providers, support care providers (including spiritual support and counselling, as needed), volunteers and affected families, as well as between the community and providers of care for acute illness and the elderly;

1 United Nations Single Convention on Narcotic Drugs, 1961, as amended by the 1972 Protocol; United Nations Convention on Psychotropic Substances, 1971; United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

Recognizing the need for palliative care across disease groups (noncommunicable diseases, and infectious diseases, including HIV and multidrug-resistant tuberculosis), and across all age groups;

Welcoming the inclusion of palliative care in the definition of universal health coverage and emphasizing the need for health services to provide integrated palliative care in an equitable manner in order to address the needs of patients in the context of universal health coverage;

Recognizing the need for adequate funding mechanisms for palliative care programmes,

including for medicines and medical products, especially in developing countries;

Welcoming the inclusion of palliative care actions and indicators in the WHO comprehensive global monitoring framework for the prevention and control of noncommunicable diseases and in the global action plan for the prevention and control of noncommunicable diseases 2013–2020;

Noting with appreciation the inclusion of medicines needed for pain and symptom control in palliative care settings in the 18th WHO Model List of Essential Medicines and the 4th WHO Model List of Essential Medicines for Children, and commending the efforts of WHO collaborating centres on pain and palliative care to improve access to palliative care;

Noting with appreciation the efforts of nongovernmental organizations and civil society in continuing to highlight the importance of palliative care, including adequate availability and appropriate use of internationally controlled substances for medical and scientific purposes, as set out in the United Nations international drug control conventions;

Recognizing the limited availability of palliative care services in much of the world and the great avoidable suffering for millions of patients and their families, and emphasizing the need to create or strengthen, as appropriate, health systems that include palliative care as an integral component of the treatment of people within the continuum of care,

### **1. Urges Member States<sup>1</sup>:**

- (1) to develop, strengthen and implement, where appropriate, palliative care policies to support the comprehensive strengthening of health systems to integrate evidence-based, cost-effective and equitable palliative care services in the continuum of care, across all levels, with emphasis on primary care, community and home-based care, and universal coverage schemes;
- (2) to ensure adequate domestic funding and allocation of human resources, as appropriate, for palliative care initiatives, including development and implementation of palliative care policies, education and training, and quality improvement initiatives, and supporting the availability and appropriate use of essential medicines, including controlled medicines for symptom management;
- (3) to provide basic support, including through multisectoral partnerships, to families, community volunteers and other individuals acting as caregivers, under the supervision of trained professionals, as appropriate;
- (4) to aim to include palliative care as an integral component of the ongoing education and training offered to care providers, in accordance with their roles and responsibilities, according to the following principles:
  - basic training and continuing education on palliative care should be integrated as a routine element of all undergraduate medical and nursing professional education, and as part of in-service training of caregivers at the primary care level, including health care workers, caregivers addressing patients' spiritual needs and social workers;
  - intermediate training should be offered to all health care workers who routinely work with patients with life-threatening illnesses, including those working in oncology, infectious diseases, paediatrics, geriatrics and internal medicine;
  - specialist palliative care training should be available to prepare health care professionals who will manage integrated care for patients with more than routine symptom management needs;
- (5) to assess domestic palliative care needs, including pain management medication requirements, and promote collaborative action to ensure adequate supply of essential medicines in palliative care, avoiding shortages;
- (6) to review and, where appropriate, revise national and local legislation and policies for controlled medicines, with reference to WHO policy guidance, on improving access to and rational use of pain management medicines, in line with the United Nations international drug control conventions;
- (7) to update, as appropriate, national essential medicines lists in the light of the recent addition of sections on pain and palliative care medicines to the WHO Model List of Essential Medicines and the WHO Model List of Essential Medicines for Children;

<sup>1</sup> And, where applicable, regional economic integration organizations.

- (8) to foster partnerships between governments and civil society, including patients' organizations, to support, as appropriate, the provision of services for patients requiring palliative care;
- (9) to implement and monitor palliative care actions included in WHO's global action plan for the prevention and control of noncommunicable diseases 2013–2020;

## 2. Requests the Director-General:

- (1) to ensure that palliative care is an integral component of all relevant global disease control and health system plans, including those relating to noncommunicable diseases and universal health coverage, as well as being included in country and regional cooperation plans;
- (2) to update or develop, as appropriate, evidence-based guidelines and tools on palliation, including pain management options, in adults and children, including the development of WHO guidelines for the pharmacological treatment of pain, and ensure their adequate dissemination;
- (3) to develop and strengthen, where appropriate, evidence-based guidelines on the integration of palliative care into national health systems, across disease groups and levels of care, that adequately address ethical issues related to the provision of comprehensive palliative care, such as equitable access, person-centred and respectful care, and community involvement, and to inform education in pain and symptom management and psychosocial support;
- (4) to continue, through WHO's Access to Controlled Medicines Programme, to support Member States in reviewing and improving national legislation and policies with the objective of ensuring balance between the prevention of misuse, diversion and trafficking of controlled substances and appropriate access to controlled medicines, in line with the United Nations international drug control conventions;
- (5) to explore ways to increase the availability and accessibility of medicines used in palliative care through consultation with Member States and relevant networks and civil society, as well as other international stakeholders, as appropriate;
- (6) to work with the International Narcotics Control Board, the United Nations Office on Drugs and Crime, health ministries and other relevant authorities in order to promote the availability and balanced control of controlled medicines for pain and symptom management;
- (7) to further cooperate with the International Narcotics Control Board to support Member States in establishing accurate estimates in order to enable the availability of medicines for pain relief and palliative care, including through better implementation of the guidance on estimating requirements for substances under international control;<sup>2</sup>
- (8) to collaborate with UNICEF and other relevant partners in the promotion and implementation of palliative care for children;
- (9) to monitor the global situation of palliative care, evaluating the progress made in different initiatives and programmes in collaboration with Member States and international partners;
- (10) to work with Member States to encourage adequate funding and improved cooperation for palliative care programmes and research initiatives, in particular in resource-poor countries, in line with the Programme budget 2014–2015, which addresses palliative care;

<sup>2</sup> Ensuring balance in national policies on controlled substances: guidance for availability and accessibility of controlled medicines. Geneva: World Health Organization; 2011.



- (11) to encourage research on models of palliative care that are effective in low- and middle-income countries, taking into consideration good practices;
- (12) to report back to the Sixty-ninth World Health Assembly in 2016 on progress in the implementation of this resolution.

Ninth plenary meeting, 24 May 2014

## Annex 3

### **Sixty-fourth World Health Assembly resolution WHA64.10 Strengthening national health emergency and disaster management capacities and resilience of health systems**

[http://apps.who.int/gb/ebwha/pdf\\_files/EB128/B128\\_R10-en.pdf](http://apps.who.int/gb/ebwha/pdf_files/EB128/B128_R10-en.pdf)

Adopted 24 May 2011

The Sixty-fourth World Health Assembly,

Recalling resolutions WHA58.1 on health action in relation to crises and disasters, and WHA59.22 on emergency preparedness and response, resolution WHA61.19 on climate change and health, and other World Health Assembly and Regional Committee resolutions and action plans, inter alia, on health security and the International Health Regulations (2005), as well as on pandemic preparedness, safe hospitals and other matters related to emergencies and disasters at local, subnational and national levels;

Recalling United Nations' General Assembly resolution 60/195, which endorsed the Hyogo Declaration and the Hyogo Framework for Action 2005–2015: Building the Resilience of Nations and Communities to Disasters, as well as resolutions 61/198, 62/192, 63/216, 64/200 and 64/251, which, inter alia, called upon Member States to increase efforts to implement the Hyogo Framework, to strengthen risk-reduction and emergency preparedness measures at all levels, and to encourage the international community and relevant United Nations' entities to support national efforts aimed at strengthening capacity to prepare for and respond to disasters;

Reaffirming that countries should ensure the protection of the health, safety and welfare of their people and should ensure the resilience and self-reliance of the health system, which is critical for minimizing health hazards and vulnerabilities and delivering effective response and recovery in emergencies and disasters;

Regretting the tragic and enormous loss of life, injuries, disease and disabilities resulting from emergencies, disasters and crises of all descriptions;

Mindful that emergencies and disasters also result in damage and destruction of hospitals and other health infrastructure, weakened ability of health systems to deliver health services; and setbacks for health development and the achievement of the Millennium Development Goals;

Expressing deep concern that continuing poverty, increasing urbanization and climate change are expected to increase the health risks and impacts of emergencies and disasters on many countries and communities;

Acknowledging that most actions to manage the risks to health from natural, biological, technological and societal hazards, including the immediate emergency response, are provided by local- and country-level actors across all health disciplines, including mass casualty management, mental health and noncommunicable diseases, communicable diseases, environmental health, maternal and newborn health, reproductive health, and nutrition and other cross-cutting health issues;

Recognizing the contribution of other sectors and disciplines to the health and well-being of people at risk from emergencies and disasters, including local government, planners, architects, engineers, emergency services and civil protection, and academia;

Concerned that country and community capacities to manage major emergencies and disasters are often overwhelmed, and that coordination, communications and logistics are often revealed as the weakest aspects of health emergency management;

Appreciating that some countries, including those with low-income or emerging country development status, have reduced mortality and morbidity in disaster situations through their investment in emergency and disaster risk-reduction measures, with the support of local, regional and global partners;

Recognizing that WHO plays an important role as a member of the International Strategy for Disaster Reduction system and as the health cluster lead in the framework of humanitarian reform, and works closely with other members of the international community, such as the United Nations Secretariat of the International Strategy for Disaster Reduction, UNDP, UNICEF, the United Nations Office for the Coordination of Humanitarian Affairs, the International Red Cross and Red Crescent Movement, and other nongovernmental organizations, on supporting country capacity development and developing institutional capacities for multisectoral emergency and disaster risk-management, which includes disaster risk-reduction;

Building on the International Strategy for Disaster Reduction, the 2008–2009 World Disaster Reduction Campaign on Hospitals Safe from Disasters, the 2010–2011 Campaign on Disaster Resilient Cities, World Health Day 2008 on Climate Change and Health, World Health Day 2009 on Hospitals Safe in Emergencies, and World Health Day 2010 on Urban Health Matters, which have resulted in local, subnational, national and global actions on reducing risks to health from emergencies and disasters;

Recognizing that improved health outcomes from emergencies and disasters require urgent additional action at country, regional and global levels to ensure that the local, subnational and national health risk-reduction and overall response in emergencies and disasters are timely and effective and that health services remain operational when they are most needed, in this respect bearing in mind that emergencies and disasters affect men and women differently,

### **1. Urges Member States<sup>1</sup>:**

- (1) to strengthen all-hazards health emergency and disaster risk-management programmes (including disaster risk-reduction, emergency preparedness and response)<sup>2</sup> as part of national and subnational health systems, supported by, and with effective enforcement of, legislation, regulations and other measures, to improve health outcomes, reduce mortality and morbidity, protect health infrastructure and strengthen the resilience of the health system and society at large, and mainstream a gender perspective into all phases of these programmes;
- (2) to integrate all-hazards health emergency and disaster risk-management programmes (including disaster risk-reduction) into national or subnational health plans and institutionalize capacities for coordinated health and multisectoral action to assess risks, proactively reduce risks, and prepare for, respond to, and recover from, emergencies, disasters and other crises;
- (3) to facilitate access by concerned government and other related agencies to information on types and quantities of hazardous materials stored, used or transported, in order to support effective health emergency and disaster risk-management;
- (4) to develop programmes on safe and prepared hospitals that ensure: that new hospitals and health facilities are located and built safely so as to withstand local hazards; that the safety of existing facilities is assessed and remedial action is taken; and that all health facilities are prepared to respond to internal and external emergencies;
- (5) to establish, promote and foster regional and subregional collaboration, as well as interregional cooperation within WHO, including sharing of experience and expertise for capacity development, in risk-reduction, response and recovery;
- (6) to strengthen the role of the local health workforce in the health emergency management system, to provide local leadership and health services, through enhanced planning, training for all health care workers and access to other resources;

**2. CALLS UPON** Member States, donors and development cooperation partners to allocate sufficient resources for health emergency and disaster risk-management programmes and partners through international cooperation for development, humanitarian appeals, and support for WHO's role in health emergency and disaster risk-management matters;

**3. Requests the Director-General:**

- (1) to ensure that WHO at all levels has enhanced capacity and resources, and optimizes its expertise across all disciplines in the Organization, in order to provide the necessary technical guidance and support to Member States and partners for developing health emergency and disaster risk-management programmes at national, subnational and local levels;
- (2) to strengthen collaboration with and ensure coherence and complementarity of actions with those of relevant entities, including those in the public, private, nongovernmental and academic sectors, in order to support country and community health emergency and disaster risk-management, which includes disaster risk-reduction, as well as ongoing efforts by Member States to implement the International Health Regulations (2005);
- (3) to strengthen the evidence base for health emergency and disaster risk-management including operational research and economic assessments;
- (4) to support national and subnational assessments of risks and capacities for health emergency and disaster risk-management, as a basis for catalysing action and strengthening national and subnational health emergency and disaster risk-management capacities, including disaster risk-reduction;
- (5) to report to the Sixty-sixth World Health Assembly through the Executive Board at its 132nd session, on progress made in implementing this resolution;
- (6) to consider, as appropriate, providing support to regional and subregional networks, as well as interregional cooperation with WHO, in order to strengthen their collaboration on health emergency and disaster risk management.

Tenth plenary meeting, 24 May 2011

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1 And, where applicable, regional economic integration organizations.

2 Health emergency and disaster risk-management includes all measures to assess risks, proactively reduce risks, prepare for, respond to, and recover from, emergencies, disasters and other crises.

## Annex 4

### **WHO Model guidelines for the international provision of controlled medicines for emergency medical care**

World Health Organization, 1996

<http://apps.who.int/medicinedocs/en/d/Jwho32e/2.html>

#### **I. INTRODUCTION**

A sudden rise in the need for medical care in emergency situations following natural or man-made disasters creates an acute shortage of medical supplies. Several international organizations and nongovernmental organizations (NGOs) are actively involved in the provision of humanitarian assistance by delivery of medical supplies in emergency situations. However, they are often faced with serious difficulties in providing several essential medicines containing narcotic drugs or psychotropic substances partly because of the regulatory requirements concerning their importation and exportation. The lack of these medicines results in additional human suffering by depriving those in need of adequate pain relief and sedation.

In order to improve the provision of medical care for disaster-stricken peoples, there is an urgent need to work out a practical solution to this problem.

#### **Cause of the Problem**

Based on operational experiences, humanitarian aid agencies perceive the problem as follows.

The international transportation of humanitarian supplies containing narcotic drugs and psychotropic substances is regarded by the control authorities as "exportation" requiring prior import authorizations from the authorities of the receiving country. As such, the import/export authorization system makes the quick international transportation of controlled drugs to sites of emergencies virtually impossible. In addition, the rigorous application of the estimate system can further complicate the procedure. While the International Narcotics Control Board (INCB) has advised control authorities that emergency humanitarian deliveries are considered as being consumed in the exporting country and included as such in the estimate of the exporting country, in reality, authorities had often followed the procedure for normal import/export transactions. This procedure often takes too long to meet the acute need for relief in some emergency situations, particularly when the control authorities in the receiving country are rendered dysfunctional, or are not in a position to issue import authorizations for the inhabitants in the disaster-stricken area of the country.

#### **Consequences**

As a consequence, all humanitarian aid agencies have abandoned the provision of narcotic drugs in their emergency medical supplies. Instead, pentazocine or buprenorphine (in Schedule III of the Convention on Psychotropic Substances, 1971) has been provided as an alternative for narcotic analgesics. Even this has become increasingly difficult, as more and more Governments have introduced the export/import authorization and the "assessment" systems for Schedule III and IV psychotropic substances in response to the resolution adopted by the Economic and Social Council (ECOSOC). The same applies to diazepam and phenobarbital in Schedule IV of the 1971 Convention. Furthermore, difficulty has been encountered even with ephedrine, ergometrine, ketamine, tramadol, thiopental, and chlorpromazine as some national control authorities apply similar export/import control systems to these medicines.

## Search for a solution

WHO brought this issue to the attention of the INCB in an effort to find a practical solution. The INCB, in its report for 1994, recommended that control obligations could be limited to the authorities of exporting countries in emergency situations. This principle was endorsed at the 38th session of the UN Commission on Narcotic Drugs in 1995, and was further reinforced by its resolution entitled “Timely provision of controlled drugs for emergency care” adopted at the 39th session in 1996 (Annex 1). This and a similar resolution adopted by the 49th session of the World Health Assembly (Annex 2) request WHO to prepare model guidelines to assist national authorities with simplified regulatory procedures for this purpose, in consultation with the relevant UN bodies and interested governments.

These model guidelines are prepared in response to the above resolutions. In essence, the procedures proposed would allow certain suppliers to make international shipments of controlled medicines at the request of recognized agencies providing humanitarian assistance without prior export/import authorizations in emergency situations, following defined procedures acceptable to the control authorities and the INCB.

## II. DEFINITIONS

The following definitions are used in this document.

### Emergency

Any acute situation (e.g. earthquakes, floods, hurricanes, epidemics, conflicts, displacement of populations) in which the health conditions of a group of individuals are seriously threatened unless immediate and appropriate action is taken, and which demands an extraordinary response and exceptional measures.

### Availability of control authorities

Control authorities are considered unavailable, when an emergency occurs which results in a disruption of the function of such authorities to issue import authorizations.

When an emergency occurs in areas outside the control of the government, a solution should be found, on a case by case basis, through discussions with the control authorities of the exporting countries and the INCB.

### Control authorities

Control authorities mean the competent national authorities designated by their governments in accordance with the Single Convention on Narcotic Drugs, 1961, and the Convention on Psychotropic Substances, 1971 (ref. United Nations publication “Competent national authorities under the international drug control treaties”, available from the United Nations).

### Operator

International, governmental and/or nongovernmental organizations engaged in the provision of humanitarian assistance in health matters recognized by the control authorities of exporting countries (e.g. UNICEF, UNHCR, WHO, ICRC (International Committee of the Red Cross), IFRC (International Federation of Red Cross and Red Crescent Societies), MSF (Médecins sans Frontières), national aid agencies and bona fide NGOs).

### Supplier

Supplier of drugs for humanitarian assistance at the request of operators. A supplier may either be a separate entity or a section or department of an operator.

### III. PURPOSE AND PRINCIPLE

The model guidelines are aimed at enabling operators to supply, across international boundaries, essential narcotic drugs and psychotropic substances for emergency medical care.

To strike a delicate balance between the need for the timely provision of essential medicines, and the need to minimize the risk of their diversion, the procedures should be based on the principle of limiting control obligations to the control authorities of exporting countries.

### IV. SCOPE OF APPLICATION

These procedures would be applicable to the international provision of essential narcotic and psychotropic medicines by a limited number of operators in acute emergency situations, either with or without control authorities in the receiving country, as well as to less urgent humanitarian assistance by these operators in situations where the control authorities are not available in the receiving country.

### V. SELECTION OF SUPPLIERS

Suppliers should be limited to those recognized by the control authorities of exporting countries. They should at least have:

- (1) adequate experience as a supplier of good quality emergency medical supplies
- (2) managerial capability to assess the appropriateness of requests for the simplified procedure from operators
- (3) adequate level of stock and a responsible pharmacist
- (4) sufficient knowledge about the relevant international conventions
- (5) standard agreement with the control authorities of exporting countries (see section VI below)

### VI. OUTLINE OF STANDARD AGREEMENT BETWEEN SUPPLIERS<sup>1</sup> AND CONTROL AUTHORITIES OF EXPORTING COUNTRIES

The standard agreement should at least cover:

- (1) criteria for acceptance of shipment requests from operators (a model form is attached at the end)

The criteria for immediate acceptance of shipment requests from operators should at least specify the essential information to be furnished to the supplier concerning when an operator is also a supplier, the agreement will be between the operator and the control authorities.

a. credibility of the requesting operator.

A pre-determined list of credible operators ought to be prepared. A credible operator should (a) be an established organization; (b) have adequate experience for international provision of humanitarian medical assistance; (c) have responsible medical management (medical doctor(s) or pharmacist(s)); and (d) appropriate logistic support.

b. nature of the emergency and the urgency of the request.

A statement to the supplier on the nature of the emergency by the operator, or if appropriate, by a UN agency.

c. availability of control authorities in the receiving country.

d. diversion prevention mechanism after delivery.



Indicate if the requesting operator itself is the user of the supplies. If not, the name and organization of the person responsible for receipt and internal distribution of the supplies should be indicated. As far as possible, the recipients in the receiving country should be identified.

(2) timing and mode of reporting to the control authorities and the INCB.

When control authorities are available in the receiving country, they should be notified as soon as possible by the control authorities of the exporting country and the operator of a consignment of the emergency delivery, while their import authorization may not have to be required under the circumstances of an emergency situation.

Suppliers should inform the control authorities of the exporting country of each emergency shipment being made in response to a request from an operator so that the control authorities can intervene if necessary.

Suppliers should submit to the control authorities of the exporting country an annual report on emergency deliveries and quantities of drugs involved as well as their destinations in duplicate, so that one copy can be forwarded to the INCB.

Suppliers, or operators through the suppliers, should inform the control authorities of the exporting countries, with copy to the INCB, of any problems encountered in the working of emergency deliveries.

(3) other relevant matters

As appropriate, the agreement may include provisions on other relevant matters such as inspection and guidance by the control authorities. Although the quantities involved would be rather small, it may touch upon estimated/assessed requirements based on the principle that the drugs provided should be regarded as having been "consumed" in the exporting country.

## VII. SUMMARY OF THE REQUEST PROCEDURE

### Operator's role

The operator should make a written request for emergency supplies of controlled substances to the supplier, using the attached model form. The operator is responsible for:

- information provided on the form;
- actual handling of controlled drugs at the receiving end or adequate delivery to the reliable recipient;
- reporting to the control authorities of the receiving country (whenever they are available) as soon as possible;
- reporting to the control authorities of the receiving country on unused quantities, if any, when the operator is the end-user or to arrange for the end-user to do so;
- reporting to the control authorities of the exporting country through the supplier, with copy to the INCB, any problems encountered in the working of emergency deliveries.

### Supplier's role

Before responding to the request from the operator, the supplier should be convinced that the nature of the emergency justifies the application of the simplified procedure without export/import authorizations. The supplier is also responsible for:

- submitting immediately a copy of the shipment request to the control authorities of the exporting country;
- submitting an annual report on emergency deliveries and quantities of drugs involved as well as their destinations, with copy to the INCB;

- reporting to the control authorities of the exporting country, with copy to the INCB, any problems encountered in the working of emergency deliveries.

**Control authorities’ role**

The control authorities of the exporting country should inform their counterpart in the receiving country (whenever they are available) of the emergency deliveries.

The control authorities of the receiving country have the right to refuse the importation of such deliveries. Emergency deliveries need not be included in the estimate of the receiving country, since they are regarded as having been consumed in the exporting country.

Model Shipment Request/Notification Form for Emergency Supplies of Controlled Substances

Operator:

Name:.....

Address:.....

Name of the responsible medical director/pharmacist:.....

Title:.....

Phone No..... Fax No.....

Requests the supplier<sup>1</sup>

Name:.....

Address:.....

Responsible pharmacist:.....

Phone No..... Fax No.....

For an emergency shipment<sup>2</sup> of the following medicine(s) containing controlled substances:

Name of product (in INN/generic name) and dosage form. Amount of active ingredient per unit dose, number of dosage units in words and figures

Narcotic drugs as defined in the 1961 Convention (e.g. morphine, pethidine, fentanyl)

[e.g. Morphine injection 1 ml ampoule; morphine sulfate corresponding to 10 mg of morphine base per ml; two hundred (200) ampoules]

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.....

Psychotropic substances as defined in the 1971 Convention (e.g. buprenorphine, pentazocine, diazepam, phenobarbital)

1 If the operator is exporting directly from its emergency stock, it should be considered as a supplier.  
 2 Emergency deliveries do not affect the estimate of the recipient country since they have already been accounted for in the estimate of the exporting country.

.....  
.....  
.....  
.....  
.....

Others (nationally controlled in the exporting country, if applicable)

.....  
.....

To the following recipient (whichever is applicable)

Country of final recipient:.....

Responsible person for receipt:

Name:.....

Organization/Agency:.....

Address:.....

Phone No..... Fax No.....

For use by/delivery to:

Location:..... Organization/Agency:.....

Consignee (If different from above e.g. transit in a third country):

Name:..... Organization/Agency:.....

Address:.....

Phone No..... Fax No.....

Nature of the emergency (Brief description of the emergency motivating the request):

.....  
.....  
.....

Availability of, and action taken to contact the control authorities in the receiving country:

.....  
.....

I certify that the above information is true and correct. My Organization will:

- Take responsibility for receipt, storage, delivery to the recipient/end-user, or use for emergency care (strike out what is not applicable) of the above controlled medicines;
- Report the importation of the above controlled medicines as soon as possible to the control authorities (if available) of the receiving country;
- Report the quantities of unused controlled medicines, if any, to the control authorities of the receiving country (if available), or arrange for the end-user to do so (strike out what is not applicable).

Title:.....

Location:.....

Date:.....

.....

(Signature)

Annex 1

Resolution 7 (XXXIX)

### **Timely provision of controlled drugs for emergency care**

The Commission on Narcotic Drugs.

Recognizing that some controlled drugs are essential medicines for the treatment of human suffering,

Underlining the fact that timely international supplies of essential medicines are often vital for humanitarian disaster relief operations in emergency situations,

Aware that the speedy international transportation of narcotic drugs and psychotropic substances to sites of emergencies is difficult within the established international drug control system,

Noting with satisfaction the attention given to the issue by the International Narcotics Control Board in its report for 19941, and the positive reaction of the Commission to the opinion expressed by the Board and the further proposals of the Board in its report for 19952,

1. Endorses the position of the International Narcotics Control Board that the transportation and provision of controlled drugs needed for humanitarian aid in acute emergencies justify the application of simplified control procedures;
2. Further endorses the existing practice by some countries of applying simplified controls in emergency situations;
3. Recommends that the national authorities of exporting countries conclude, where appropriate, standing agreements with bona fide suppliers of humanitarian aid, specifying operational procedures to ensure the proper handling of controlled drugs;
4. Also recommends that the authorities of the recipient countries report to the exporting countries and to the Board, wherever possible, the quantity of the unused drugs for emergency care, if any, in order to permit the re-evaluation of the estimated annual requirements;

5. Invites the World Health Organization, in consultation with the Board and interested Governments, to draw up model guidelines to assist national authorities in developing such standard agreements with bona fide humanitarian organizations.
- 1 Report of the International Narcotics Control Board for 1994 (United Nations publication, Sales No. E.95.XI.4).
- 2 Report of the International Narcotics Control Board for 1995 (United Nations publication, Sales No. E.96.XI.1).

WHA 49.18

25 May 1996

Collaboration within the United Nations system and with other international organizations:

### **Supply of controlled drugs for emergency care**

The Forty-ninth World Health Assembly,

Recognizing that some controlled drugs, such as opioid analgesics, are essential medicines for the treatment of human suffering;

Also recognizing that timely international supplies of essential medicines are often vital for humanitarian disaster relief operations in emergency situations;

Concerned because speedy international supply of opioid analgesics to sites of emergencies is impossible because of the export and import control measures that apply to narcotic drugs;

Concerned further about the similar difficulties experienced even with regard to psychotropic substances, as an increasing number of national authorities apply stricter control measures than are provided under the relevant international treaty;

Noting, with satisfaction, that the International Narcotics Control Board shares such concern;

Convinced that a practical solution to this problem should be found through intensified dialogue between the health and drug control authorities at all levels,

1. URGES Member States to initiate or intensify dialogue between health and drug control authorities in order to establish simplified regulatory procedures that allow timely international supply of narcotic drugs and psychotropic substances in emergency situations;
2. REQUESTS the Director-General to prepare, in consultation with the relevant United Nations bodies involved in the international control of narcotic drugs and psychotropic substances, model guidelines to assist national authorities with simplified procedures for this purpose.

Sixth plenary meeting, 25 May 1996

## Annex 5

### Key passages from civil society and other documents

#### **Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field. Geneva, 12 August 1949**

<https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/Article.xsp?action=openDocument&documentId=B97B83DC12AC4998C12563CD00519F56>

Article 12 - Protection and care of the wounded and sick: Members of the armed forces and other persons mentioned in the following Article [ Link ], who are wounded or sick, shall be respected and protected in all circumstances. They shall be treated humanely and cared for by the Party to the conflict in whose power they may be, without any adverse distinction founded on sex, race, nationality, religion, political opinions, or any other similar criteria. Any attempts upon their lives, or violence to their persons, shall be strictly prohibited; in particular, they shall not be murdered or exterminated, subjected to torture or to biological experiments; they shall not wilfully be left without medical assistance and care, nor shall conditions exposing them to contagion or infection be created. Only urgent medical reasons will authorize priority in the order of treatment to be administered. Women shall be treated with all consideration due to their sex. The Party to the conflict which is compelled to abandon wounded or sick to the enemy shall, as far as military considerations permit, leave with them a part of its medical personnel and material to assist in their care.

#### **Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of Non-International Armed Conflicts (Protocol II), 8 June 1977**

<https://ihl-databases.icrc.org/applic/ihl/ihl.nsf/1a13044f3bbb5b8ec12563fb0066f226cb507989c1767179c12563cd0043a5d3>

Article 7 - Protection and care: 1. All the wounded, sick and shipwrecked, whether or not they have taken part in the armed conflict, shall be respected and protected. 2. In all circumstances they shall be treated humanely and shall receive, to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition. There shall be no distinction among them founded on any grounds other than medical ones.

Phillips SJ, Knebel A, eds. Mass Medical Care with Scarce Resources: A Community Planning Guide. Prepared by Health Systems Research, Inc., an Altarum company, under contract No. 290-04-0010. AHRQ Publication No. 07-0001. Rockville, MD: Agency for Healthcare Research and Quality 2007.

<https://archive.ahrq.gov/research/mce/mceguide.pdf>

“In the event of a catastrophic mass casualty event (MCE), it must be assumed that some people may survive the onset of the disaster but will have incurred such serious illness or injury that they will live only for a relatively short time. In addition, there will be vulnerable individuals (e.g., the elderly in the community, those sick in the hospital, those in nursing homes or group homes, the disabled, children) who were already ill with severe preexisting conditions and who may be negatively impacted by the resulting scarcity of resources. These individuals will suffer harm disproportionately during or following a catastrophic MCE, because they may not be able to seek help, care for themselves, or pursue other survival and recovery strategies pursued by non-vulnerable populations.

The goal of an organized and coordinated response to a catastrophic MCE should be to maximize the number of lives saved. At the same time, the goal also should be to provide the greatest comfort and minimize the physical and psychological suffering of those whose lives may be shortened as a result of either an immediate surge of patients or long-term exposure following a catastrophic event.”

## Annex 6

### Sample curriculum in palliative care for humanitarian responders to health emergencies and crises

#### Day 1

Introductions, goals of the training, and agenda

What is palliative care? Definition, principles, accessibility, and moral imperative

Palliative care assessment

Medical ethics, the patient–doctor relationship

- Ethical issues in palliative and end-of-life care
- Patient–doctor relationship, communication, breaking bad news

Group practice: role play breaking bad news

#### Day 2

Principles of pain management

Neurobiology of pain

Barriers to opioid analgesia

Group practice: pain case discussions

#### Day 3

Dyspnea

Group practice: dyspnea case discussion

Skin problems in palliative care

Constipation/diarrhoea

Nausea/vomiting/weight loss and cachexia

Small group practice: GI case discussion

#### Day 4

Loss, grief, bereavement

Psychosocial suffering and support

- Psychological first aid
- Basic social needs: shelter, food, clothing, sanitation

Role play: psychosocial support

Psychological/psychiatric problems Part 1: Adjustment disorder, depression, anxiety, PTSD

Psychological/psychiatric problems Part 2: Delirium, pre-existing serious psychiatric disorders

Health care worker resilience and self-care

Group practice: memorial ceremonies/communal grieving



## Day 5

Palliative care for patients with catastrophic injuries

Palliative care for patients with advanced malignancies

Palliative care for patients with advanced heart, lung, kidney or liver disease

Paediatric palliative care

Palliative care for non-viable neonates

Optimum use of life-sustaining treatment

Final examination

Conclusion

## Annex 7

### Sample curriculum in responses to humanitarian emergencies and crises for palliative care specialists

#### Day 1

Welcome, introductions, goals of the training, and agenda

Principles of humanitarian practice

- The Humanitarian Charter
- The Sphere minimum standards
- Minimum standards in health action

Culture and ethics

- Introduction and definitions
- Key questions
- Visible and hidden cultural norms and rules
- Culture in emergencies
- Cultural frameworks and dimensions
- Cultural issues checklist

Security

- Global security statistics
- Security principles
- Field security and driving
- Negotiation, checkpoints, and corruption
- Crowds and mobs

Group practice: role play security and cultural issues

- Crowd and mob scenarios
- Negotiation scenarios
- Cultural case studies

#### Day 2

Team collaboration and management

- Personal health: vaccinations, water and food safety, personal medical kit
- Managing stress and self-care
- Working in hot climates
- Returning home

Types of humanitarian emergencies

- Sudden onset disasters
- Epidemics
- Complex humanitarian emergencies
- Famine

Current issues in humanitarian emergencies

- Global snapshot of displacement and affected populations
- Palliative care responses in recent history

Group practice: palliative care needs in humanitarian emergencies

- Scenario exercises – What types of physical, psychological, social and spiritual suffering can be expected?

### Day 3

Palliative care issues in sudden onset emergencies

- Mass casualty settings
- Triage
- Expectant patients
- Care following initial phase

Group practice: organizing and leading palliative care in mass casualty settings

- Scenario exercises – earthquake, tsunami, armed conflict

Palliative care in epidemic disease

Palliative care in conflict and complex humanitarian emergencies (CHEs)

Palliative care for displaced populations

- Refugee settings
- Internally displaced person settings
- Managing pre-existing needs

### Day 4

Emergency medical teams

- Type 1 teams
- Type 2 teams
- Type 3 teams

National disaster management structures

Collaboration with international agencies: the cluster approach

- Local nongovernmental organizations
- International nongovernmental organizations
- International humanitarian organizations
- United Nations and related organizations

Group practice: mock health cluster meeting

- Collaboration scenario

Final examination

Conclusion

## Annex 8

### Glossary

Adapted from:

ReliefWeb Glossary of Humanitarian Terms (2008)

<http://www.who.int/hac/about/reliefweb-aug2008.pdf>

mhGAP Humanitarian intervention guide: clinical management of mental, neurological and substance use conditions in humanitarian emergencies. Geneva: World Health Organization; 2015

[http://www.who.int/mental\\_health/publications/mhgap\\_hig/en/](http://www.who.int/mental_health/publications/mhgap_hig/en/)

### Armed conflict

A dispute involving the use of armed force between two or more parties. International humanitarian law distinguishes between international or non-international armed conflicts.

International armed conflict: A war involving two or more states, regardless of whether declaration of war has been made or whether the parties recognize that there is a state of war.

Non-international armed conflict: A conflict in which government forces are fighting with armed insurgents, or armed groups are fighting among themselves. (United Nations Office for the Coordination of Humanitarian Affairs [UNOCHA])

### Asylum

The granting, by a state, of protection on its territory to persons from another state who are fleeing persecution or serious danger. A person who is granted asylum may be a refugee. Individuals who have left their country of origin and have applied for recognition as refugees in another country and whose requests or applications for refugee-status have not been finally decided by a prospective country of refuge are formally known as an asylum-seekers. They are normally entitled to remain on the territory of the country of asylum until their claims have been decided upon and should be treated in accordance with basic human rights standards.

### Asylum-seeker

An individual who is seeking international protection. In countries with individualized procedures, an asylum-seeker is someone whose claim has not yet been finally decided on by the country in which it was submitted. Not every asylum-seeker will ultimately be recognized as a refugee, but every refugee is initially an asylum-seeker.

### Bilateral aid/assistance

Aid that is controlled and spent by donor countries at their own discretion. It may include staff, supplies, equipment, funding to receipt governments and funding to nongovernmental organizations (NGOs). It also includes assistance channelled as earmarked funding through international and United Nations organizations.

### Biological disaster

Disaster caused by the exposure of living organisms to germs and toxic substances.

**Biological hazard**

Processes of organic origin or those conveyed by biological vectors, including exposure to pathogenic microorganisms, toxins and bioactive substances, which may cause the loss of life or injury, property damage, social and economic disruption or environmental degradation. Examples include outbreaks of epidemic diseases, plant or animal contagion, insect or other animal plagues and extensive infestations.

**Biological weapon**

A weapon of mass destruction based on pathogenic biological agents. It may include ammunition loaded with biological agents (e.g. missile warheads, bombs, tube or rocket artillery ammunition) and their delivery systems.

**Biological warfare**

The intentional use of disease-causing microorganisms or other entities that can replicate themselves (e.g. viruses, infectious nucleic acids and prions) against humans, animals or plants for hostile purposes. It may also involve the use of toxins: poisonous substances produced by living organisms, including microorganisms (e.g. botulinum toxin), plants (e.g. ricin derived from castor beans) and animals (e.g. snake venom). If they are utilized for warfare purpose, the synthetically manufactured counterparts of these toxins are biological weapons.

**Child soldier**

For the purposes of prevention, disarmament, demobilization and reintegration programmes, a child soldier is any person under 18 years of age who is compulsorily, forcibly or voluntarily recruited or used in hostilities by any kind of armed forces or groups in any capacity, including but not limited to soldiers, cooks, porters and messengers, and those accompanying such groups. It includes girls or boys recruited for sexual purposes and forced marriage. It does not, therefore, refer exclusively to a child who is carrying or has carried arms.

**Civil defense**

The system of measures, usually run by a governmental agency, to protect the civilian population in wartime, to respond to disasters and to prevent and mitigate the consequences of major emergencies in peacetime.

**Civil society**

Refers to structures independent from governments such as nongovernmental organizations and human rights groups, independent activists and human rights defenders, religious congregations, charities, universities, trade unions, legal associations, families and clans. Domestic civil society represents one of the most critical sources of humanitarian assistance and civilian protection during humanitarian emergencies.

**Civilian personnel**

United Nations non-military staff members who form part of a peacekeeping operation and perform duties, among other things, relating to the human rights, humanitarian or political situation on the ground, and the financial and administrative management of a mission.

**Civilian populations**

Groups of unarmed people, including women, children, the sick and elderly, refugees and internally displaced persons (IDPs), who are not directly engaged in the armed conflict.

**Cluster**

A cluster is essentially a sectoral group, and there should be no differentiation between the two in terms of their objectives and activities; the aim of filling gaps and ensuring adequate preparedness and response should be the same.

## Cluster approach

The cluster approach aims to strengthen humanitarian response capacity and effectiveness in five key ways: (i) ensuring sufficient global capacity is built up and maintained in key gap sectors/areas of response; (ii) identifying predictable leadership in the gap sectors/areas of response; (iii) facilitating partnerships and improved inter-agency complementarity by maximizing resources; (iv) strengthening accountability; and (v) improving strategic field-level coordination and prioritization in specific sectors/areas of response by placing responsibility for leadership and coordination of these issues with the competent operational agency.

## Cluster Lead

An agency/organization that formally commits to take on a leadership role within the international humanitarian community in a particular sector/area of activity to ensure adequate response and high standards of predictability, accountability and partnership.

## Cognitive behavioural therapy (CBT)

Psychological treatment that combines cognitive components (aimed at thinking differently, for example, through identifying and challenging unrealistic negative thoughts) and behavioural components (aimed at doing things differently, for example, by helping a person to do more rewarding activities).

## Cognitive behavioural therapy with a trauma focus (CBT-T)

Psychological treatment based on the idea that people who were exposed to a traumatic event have unhelpful thoughts and beliefs related to that event and its consequences. These thoughts and beliefs result in unhelpful avoidance of the reminders of the event and a sense of current threat. The treatment usually includes exposure to those reminders and challenging unhelpful trauma-related thoughts or beliefs.

## Common Humanitarian Action Plan (CHAP)

CHAP is a strategic plan for humanitarian response in a given country or region and includes these elements: (i) a common analysis of the context in which humanitarian action takes place; (ii) an assessment of needs; (iii) best, worst and most likely scenarios; (iv) stakeholder analysis, i.e. who does what and where; (v) a clear statement of longer-term objectives and goals; (vi) prioritized response plans; and (vii) a framework for monitoring the strategy and revising it if necessary.

## Complex emergency

A multifaceted humanitarian crisis in a country, region or society where there is a total or considerable breakdown of authority resulting from internal or external conflict and which requires a multisectoral, international response that goes beyond the mandate or capacity of any single agency and/or the ongoing United Nations country programme. Such emergencies have, in particular, a devastating effect on children and women, and call for a complex range of responses.

## Coping capacity

The ability of people or organizations, using available resources and skills, to face and manage adverse conditions that potentially could lead to a disaster. In general, this ability involves awareness, resources and good management both in normal times as well as during crises or adverse conditions. The strengthening of coping capacities is a means to build resilience to the effects of natural and human-induced hazards.

## Critical facilities

The major physical structures or facilities that are socially, economically or operationally essential to a society's functioning, both in general as well as in the extreme circumstances of an emergency. Critical facilities include such things as roads, railways, bridges, air and sea ports, electricity and water supplies, communications systems, hospitals, public administration centres and police stations.

## **Customary international law**

International norms derived from a general and consistent practice of states followed by them out of a sense of legal obligation (*opinio juris*), rather than from formal expression in a treaty or legal text. Despite not being written, such norms are legally binding on all states with the exception of states that are persistent objectors.

## **Declaration of disaster**

Official issuance of a state of emergency upon the occurrence of a large-scale calamity, in order to activate measures aimed at the reduction of the disaster's impact.

## **Disaster**

A serious disruption of the functioning of a community or a society causing widespread human, material, economic or environmental losses that exceed the ability of the affected community or society to cope using its own resources. Disasters are often described as a result of the combination of a natural hazard, the conditions of vulnerability, and insufficient capacity or measures to reduce or cope with the potential negative consequences. A disaster also may be seen as an outcome of the risk process, the interactions of the above three factors over time that lead to the development of disaster risks and the expression of that risk through disaster events.

## **Disaster preparedness**

The organization, education and training of the population and all relevant institutions to facilitate effective control, early warning, evacuation, rescue, relief and assistance operations in the event of a disaster or emergency.

## **Disaster response**

A sum of decisions and actions taken during and after disaster, including immediate relief, rehabilitation and reconstruction.

## **Disaster risk management**

The systematic process of using administrative decisions, organization, operational skills and capacities to implement policies, strategies and coping capacities of the society and communities to lessen the impacts of natural hazards and related environmental and technological disasters. This comprises all forms of activities, including structural and non-structural measures to avoid (prevention) or to limit (mitigation and preparedness) adverse effects of hazards.

## **Disaster team**

Multidisciplinary, multisectoral group of persons qualified to evaluate a disaster and to bring the necessary relief.

## **Displacement**

Forcible or voluntary uprooting of persons from their homes by violent conflicts, gross violations of human rights and other traumatic events, or threats thereof. Persons who remain within the borders of their own country are known as internally displaced persons (IDPs). Persons who are forced to flee outside the borders of their state of nationality or residence for reasons based on a well-founded fear of persecution on the grounds identified in the 1951 Refugee Convention or to flee conflict in the case of States Parties to the 1969 OAU Convention or 1984 Cartagena Declaration on Refugees are known as refugees.

## **Emergency Relief Coordinator (ERC)**

A person responsible for the oversight of all emergencies requiring United Nations humanitarian assistance and acts as the central focal point for governmental, intergovernmental and nongovernmental relief



activities. The ERC also leads the Inter-Agency Standing Committee (IASC), a unique inter-agency forum for coordination, policy development and decision-making involving the key United Nations and non-United Nations humanitarian partners.

### **Epidemic(s)**

Non-pandemic disease attacking many individuals in the same community, region or population during short terms (days, weeks, months maximum) such as cholera, typhoid, bubonic plague, etc.

### **Flash Appeal**

A tool for structuring a coordinated humanitarian response for the first three to six months of an emergency. The United Nations Humanitarian Coordinator triggers it in consultation with all stakeholders. The Flash Appeal is issued within one week of an emergency and provides a concise overview of urgent life-saving needs, and may include recovery projects that can be implemented within the timeframe of the Appeal.

### **Flashback**

An episode where the person believes and acts for a moment as though they are back at the time of the event, living through it again. People with flashbacks briefly lose touch with reality, usually for a few seconds or minutes.

### **Geneva Conventions and additional protocols**

The four Geneva Conventions of 12 August 1949 and their two Additional Protocols of 1977 relating to the protection of victims in armed conflict are the principal instruments of international humanitarian law. Together, these instruments seek to limit the effects of armed conflict by protecting persons who are not or are no longer participating in the hostilities, including wounded or sick military and naval personnel, prisoners of war and civilian populations, and to restrict the means and methods of warfare. The four Geneva Conventions and the Additional Protocol I apply during international armed conflicts between two or more states, whereas only Article 3 common to the four Conventions and Additional Protocol II apply during non-international or internal conflicts. As of March 2003, 190 states are party to the Geneva Conventions, 161 states are party to Additional Protocol I and 156 states are party to Additional Protocol II. These instruments are monitored principally by the International Committee of the Red Cross.

### **Genocide**

As defined by Article II of the 1948 Convention on Prevention and Punishment of the Crime of Genocide: genocide means any of the following acts committed with intent to destroy, in whole or in part, a national, ethnic, racial or religious group, as such: killing members of the group; causing serious bodily or mental harm to members of the group; deliberately inflicting on the group conditions of life to bring about its physical destruction in whole or in part; imposing measures intended to prevent births within the group; and forcibly transferring children of the group to another group.

### **Hazard**

Natural processes or phenomena or human activities that can cause the loss of life or injury, property damage, social and economic disruption or environmental degradation.

### **Humanitarian access**

Where protection is not available from national authorities or controlling non-state actors, vulnerable populations have a right to receive international protection and assistance from an impartial humanitarian relief operation. Such action is subject to the consent of the state or parties concerned and does not prescribe coercive measures in the event of refusal, however unwarranted.

**Humanitarian action**

Assistance, protection and advocacy actions undertaken on an impartial basis in response to human needs resulting from complex political emergencies and natural hazards.

**Humanitarian assistance**

Aid that seeks to save lives and alleviate suffering of a crisis-affected population. Humanitarian assistance must be provided in accordance with the basic humanitarian principles of humanity, impartiality and neutrality, as stated in the United Nations General Assembly resolution 46/182. In addition, the United Nations seeks to provide humanitarian assistance with full respect for the sovereignty of states. Assistance may be divided into three categories – direct assistance, indirect assistance and infrastructure support – which have diminishing degrees of contact with the affected population.

**Humanitarian coordination**

An approach based on the belief that a coherent response to an emergency will maximize its benefits and minimize potential pitfalls. In each country, the coordination of United Nations humanitarian assistance is entrusted to the United Nations Resident Coordinator and Humanitarian Coordinator. The United Nations Office for Humanitarian Affairs (OCHA), under the direction of the Emergency Relief Coordinator, is responsible for the coordination of a humanitarian response in the event of a crisis and carries out this role according to approved policies and structures set by the Inter-Agency Standing Committee (IASC). This coordination involves developing common strategies with partners both within and outside the United Nations system, identifying overall humanitarian needs, developing a realistic plan of action, monitoring progress and adjusting programmes as necessary, convening coordination forums, mobilizing resources, addressing common problems to humanitarian actors and administering coordination mechanisms and tools. It does not involve OCHA in the administration of humanitarian assistance.

**Humanitarian engagement**

The involvement of humanitarian agencies and organizations within a complex emergency to deliver protection, assistance and relief.

**Humanitarian operating environment**

A key element for humanitarian agencies and organizations when they deploy, consists of establishing and maintaining a conducive humanitarian operating environment, sometimes referred to as humanitarian space. The perception of adherence to the key operating principles of neutrality and impartiality in humanitarian operations represents the critical means by which the prime objective of ensuring that suffering must be met wherever it is found, can be achieved. Consequently, maintaining a clear distinction between the role and function of humanitarian actors from that of the military is the determining factor in creating an operating environment in which humanitarian organizations can discharge their responsibilities both effectively and safely. Sustained humanitarian access to the affected population is ensured when the receipt of humanitarian assistance is not conditional upon the allegiance to or support to parties involved in a conflict but is a right independent of military and political action.

**Humanitarian operations**

Operations conducted to relieve human suffering, especially in circumstances where responsible authorities in the area are unable or unwilling to provide adequate service support to civilian populations.

**Humanitarian principles**

As per United Nations General Assembly resolution 46/182 (19 December 1991), humanitarian assistance must be provided in accordance with the principles of humanity, neutrality and impartiality. Adherence to these principles reflects a measure of accountability of the humanitarian community.

**Humanity:** Human suffering must be addressed wherever it is found, with particular attention to the most vulnerable in the population, such as children, women and the elderly. The dignity and rights of all victims must be respected and protected.

**Neutrality:** Humanitarian assistance must be provided without engaging in hostilities or taking sides in controversies of a political, religious or ideological nature.

**Impartiality:** Humanitarian assistance must be provided without discriminating as to ethnic origin, gender, nationality, political opinions, race or religion. Relief of the suffering must be guided solely by needs and priority must be given to the most urgent cases of distress.

### **Humanitarian, United Nations and associated personnel**

Includes the following groups of persons whose safety and security must be ensured during complex emergencies: persons deployed by a humanitarian nongovernmental organization or agency under an agreement with the United Nations Secretary-General to carry out activities in support of the fulfilment of the mandate of a United Nations operation; persons engaged or deployed by the United Nations Secretary-General, whether as humanitarian personnel, members of the military, police or civilian components of a United Nations operation, or experts on mission; and persons assigned by a government or an intergovernmental organization with the agreement of the competent United Nations organ.

### **Humanitarian worker**

Includes all workers engaged by humanitarian agencies, whether internationally or nationally recruited, or formally or informally retained from the beneficiary community, to conduct the activities of that agency.

### **Human rights**

All human rights derive from the dignity and worth inherent in the human person. The concept of human rights acknowledges that every single human being is entitled to enjoy his or her human rights without distinction as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Human rights are legally guaranteed by human rights law, which is expressed in treaties, customary international law, bodies of principles and other sources of law. Human rights law places an obligation on states to act in a particular way and prohibits states from engaging in specified activities, thereby clarifying and protecting formally the rights of individuals and groups. It is noteworthy that human rights law applies in peace and in war. The 1948 Universal Declaration of Human Rights (UDHR) together with the 1966 International Covenant on Civil and Political Rights (ICCPR) and the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR) are known as the International Bill of Rights.

### **Human rights law**

The body of customary international law, human rights instruments and national law that recognizes and protects human rights. Refugee law and human rights law complement each other.

### **Inter-Agency Standing Committee (IASC)**

A body established in June 1992 in response to United Nations General Assembly resolution 46/182 to serve as the primary mechanism for inter-agency coordination of humanitarian assistance in response to complex and major emergencies. IASC is chaired by the Emergency Relief Coordinator (ERC) and has the membership of all United Nations operational humanitarian agencies, with a standing invitation to the International Committee of the Red Cross (ICRC), the International Federation of Red Cross and Red Crescent Societies (IFRC), United Nations Office of the High Commissioner for Refugees (OHCHR), the United Nations Population Fund (UNFPA), the representative of the Secretary-General on internally displaced persons (IDPs), the World Bank; and the three NGO consortia (the International Council of Voluntary Agencies [ICVA], InterAction, and the Steering Committee for Humanitarian Response [SCHR]). IASC meets at least twice a year to deliberate on issues brought to its attention by the ERC and the IASC

Working Group (IASCWG), which is formed by senior representatives of the same agencies and meets four to six times a year. The primary objectives of IASC are: (i) to develop and agree on system-wide humanitarian policies; (ii) to develop and agree on a common ethical framework for all humanitarian activities; (iii) to advocate common humanitarian principles to parties outside IASC; (iv) to identify areas where gaps in mandates or lack of operational capacity exist; and (v) to resolve disputes or disagreement about and between humanitarian agencies on system wide humanitarian issues.

### **Intergovernmental organization (IGO)**

An organization made up of state members. Examples include the United Nations (UN), the Organization of African Unity (OAU), the Organization of American States (OAS), the European Union (EU) and the Commonwealth of Independent States (CIS).

### **Internal displacement**

Involuntary movement of people inside their own country. This movement may be due to a variety of causes, including natural or human-made disasters, armed conflict or situations of generalized violence.

### **Internally displaced persons (IDPs)**

Persons or groups of persons who have been forced or obliged to leave their homes or habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized state border. A series of 30 non-binding Guiding Principles on Internal Displacement based on refugee law, human rights law and international humanitarian law articulate standards for protection, assistance and solutions for IDPs.

### **Interpersonal therapy (IPT)**

Psychological treatment that focuses on the link between depressive symptoms and interpersonal problems, especially those involving loss, conflict, isolation and major life changes.

### **Malnutrition**

Malnutrition encompasses a range of conditions, including acute malnutrition, chronic malnutrition and micronutrient deficiencies. Acute malnutrition refers to wasting (thinness) and/or nutritional oedema, while chronic malnutrition refers to stunting (shortness). Stunting and wasting are two forms of growth failure. (Sphere Project)

### **Mandate**

The legal framework that defines the responsibilities of United Nations agencies, peacekeeping operations and other international organizations such as the International Committee for the Red Cross (ICRC). The mandates of United Nations agencies, such as the United Nations's Children's Fund (UNICEF) and the United Nations High Commissioner for Refugees (UNHCR), are agreed upon by the United Nations General Assembly. It is imperative that the agencies have clear and adequate mandates to ensure that all humanitarian issues are addressed appropriately and consistently. The protection of internally displaced persons (IDPs) is one issue that does not fall squarely within any agency's mandate. Until such time, it is the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) responsibility through the IDP Unit to collaborate with agencies to ensure that IDP interests are protected.

### **Mourning**

The processes through which a bereaved person pays attention, bids farewell and memorializes the dead, both in private and in public. Mourning usually involves rituals such as funerals and customary behaviours such as changing clothing, remaining at home and fasting.

**Natural disaster**

Natural disasters are events brought about by natural hazards that seriously affect the society, economy and/or infrastructure of a region. Depending on population vulnerability and local response capacity, natural disasters will pose challenges and problems of a humanitarian nature.

**Nongovernmental organization (NGO)**

An organized entity that is functionally independent of, and does not represent, a government or state. It is normally applied to organizations devoted to humanitarian and human rights causes, a number of which have official consultative status at the United Nations.

**OCHA (Office for the Coordination of Humanitarian Affairs)**

OCHA is the part of the United Nations responsible for coordinating humanitarian actors to ensure a coherent response to emergencies, to ensure there is a framework within which each actor can contribute to the overall response effort, and thereby to ensure that crisis-affected people receive the assistance and protection they need. OCHA works to overcome obstacles that impede humanitarian assistance from reaching people affected by crises, and it provides leadership in mobilizing assistance and resources on behalf of the humanitarian system. OCHA is not an operational agency directly engaged in the delivery of humanitarian programmes.

**Psychological first aid (PFA)**

Provision of supportive care to people in distress who have recently been exposed to a crisis event. The care involves assessing immediate needs and concerns, ensuring that immediate basic physical needs are met, providing or mobilizing social support, and protecting from further harm.

**Refugee**

A person, who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, or for reasons owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of that person's country of origin or nationality, is compelled to leave the place of habitual residence in order to seek refuge outside the country of origin or nationality and is unable or, owing to such fear, is unwilling to benefit from the protection of the country of origin or nationality.

**Resilience**

The capacity of a system, community or society potentially exposed to hazards to resist, adapt and recover from hazard events, and to restore an acceptable level of functioning and structure.

**Sexual and gender-based violence (SGBV)**

Acts that inflict physical, mental or sexual harm or suffering, threat of such acts, coercion and other deprivations of liberty, that target individuals or groups of individuals on the basis of their gender.

**Sexual exploitation**

Any abuse of a position of vulnerability, differential power, or trust for sexual purposes; this includes profiting monetarily, socially or politically from the sexual exploitation of another.

**SSRI (selective serotonin reuptake inhibitors)**

Class of antidepressant drugs that selectively block the reuptake of serotonin. Fluoxetine is an SSRI.

**TCA (tricyclic antidepressants)**

Class of antidepressant drugs that block the reuptake of the neurotransmitters noradrenaline and serotonin. An example is amitriptyline.



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