Ebola virus disease and palliative care in humanitarian crises

Favila Escobio  
*Medecins Sans Frontieres*

Elysée Nouvet  
*The University of Western Ontario*

Follow this and additional works at: [https://ir.lib.uwo.ca/healthstudiespub](https://ir.lib.uwo.ca/healthstudiespub)

Part of the Medicine and Health Sciences Commons

Citation of this paper:  
*Health Studies Publications*. 93.  
[https://ir.lib.uwo.ca/healthstudiespub/93](https://ir.lib.uwo.ca/healthstudiespub/93)
Ebola virus disease and palliative care in humanitarian crises

DR Congo is currently facing its tenth outbreak of Ebola virus disease (EVD) since the virus was discovered in 1976. As of March 3, 2019, there were 897 confirmed cases, with 563 deaths (including confirmed and probable deaths). Although potentially effective ring vaccination trials have been integrated into the response against EVD, the risk of further propagation of the outbreak remains high. The virus has spread to densely populated urban areas, and parts of the country where optimal surveillance and health-care delivery are dangerous and sometimes interrupted due to the presence of armed groups.

Since the mortality in individuals with EVD is high (around 50%) and no effective pharmacological treatments have been identified, many patients with EVD will die, even in the best circumstances. In October, 2017, the Lancet Commission on palliative care pointed out that palliative care has been largely ignored, especially for the most vulnerable populations and those living in humanitarian crises. In The Lancet, François Lamontagne and colleagues highlighted just how entrenched the problem is.

Although Lamontagne and colleagues’ guidelines stress the importance of supportive and psychosocial care to alleviate the burden of suffering and severe distress associated with EVD, these guidelines do not acknowledge the value of this care for all patients regardless of outcome, even death. This is consistent with other published recommendations for EVD patient management. The value of these guidelines is clear: to facilitate faster and more standardised care informed by a synthesis of existing (albeit limited) evidence on what is most likely to help patients affected by EVD. Nevertheless, until curative treatments for the management of EVD are available, clinical guidelines and specific protocols for EVD must include clear recommendations and instructions on the integration of palliative care into the delivery of optimum care for patients with suspected and confirmed EVD.

Guidelines on palliative care for EVD need to be clearly defined so that its value and place in high-fatality humanitarian crises can begin to gain practical traction and acceptance. Clearly defined guidelines on palliative care would also legitimise training and dialogue on palliative care in contexts where staff have no previous experience treating patients with EVD. Palliative care and pain relief are essential elements of universal health coverage, but much more should be done to make it part of any health intervention. A first step is to ensure that health professionals, patients, and families understand that palliative care can improve patient quality of life and prevent and alleviate suffering. Ensuring that palliative care gets explicitly integrated into guidelines for care of critically ill people, including but not limited to patients with EVD, is of equal importance.

EN report grants from Elrha Research for Health in Humanitarian Crises. FE declares no competing interests.

*pFavila Escobio, Elysée Nouvet p.favila@gmail.com

Medecins Sans Frontieres, Rome 00185, Italy (FE); and School of Health Studies, Western University, London, ON, Canada (EN)