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Article

Disaster and Dignity: Palliative Care Action Plan for Flooding in Garo Hills, Meghalaya

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ABSTRACT

Palliative care is an essential component of healthcare systems, which aims to improve the quality of life for people facing life-threatening illnesses and their families through symptom control, psychosocial support, and dignity in care. In disaster situations where health systems are often overwhelmed and resources are strained, the integration of palliative care becomes crucial to address the needs of vulnerable populations. The Garo Hills region of Meghalaya, Northeast India, is geographically remote, vulnerable to annual flooding, and has limited access to health services. This paper explores the theoretical development of a palliative care action plan for the flood-prone region of Garo Hills, Meghalaya, conceptualized as a group exercise for the Fellowship of Palliative Care 2022 to address palliative care needs in a neglected setting. Strategies to obtain buy-in for a palliative care intervention are described based on three target groups: national and international support, neighboring regions, and the Garo community. Given the region's vulnerability to climate-related disasters, the action plan emphasises community-based preparedness and the integration of palliative care into humanitarian response efforts. This conceptual framework is intended as a guide for managers, humanitarian actors, and policymakers, with potential adaptation to other disaster-prone regions, where palliative care is necessary. No disaster response is complete without attention to those who may not survive.

KEYWORDS

Community health; disaster planning; health services accessibility; natural disasters; palliative care.

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1. Introduction

Palliative care is a specialized form of medical care aimed at improving the quality of life for individuals facing life-threatening illnesses and their families. It focuses on alleviating pain, managing symptoms, and addressing psychological, social, and spiritual distress. The principles of palliative care underscore dignity, compassion, and holistic support, emphasizing patient-centered care that respects individual preferences and cultural values (Sallnow et al., 2022). While palliative care is traditionally associated with chronic illnesses such as cancer or advanced organ failure, its scope extends far beyond these contexts. In disaster situations, where health systems are often overwhelmed and resources are strained, the integration of palliative care becomes crucial to address the needs of vulnerable populations (Schwartz et al., 2023).

Disasters, whether natural or human-made, disrupt lives and communities, often leaving behind widespread destruction, displacement, and loss. In these settings, healthcare systems are typically inundated with acute injuries and emergent medical needs, overshadowing the chronic and palliative care requirements of those already living with life-limiting conditions (Plagg et al., 2023). Additionally, disasters create new populations requiring palliative care, including individuals with severe injuries unlikely to survive, those experiencing psychological trauma, and older individuals separated from familial support systems. These circumstances call for a dual focus on emergency response and on providing dignified care for those who cannot be saved or who experience prolonged suffering.

The relevance of palliative care in disaster settings is increasingly recognized in global health policies and frameworks. The World Health Organization (WHO) advocates integrating palliative care into disaster preparedness and response strategies. It acknowledges that disasters magnify the vulnerability of specific populations, especially those with pre-existing health conditions, disabilities, or limited access to healthcare. The stakeholders include patients with life-limiting illness, caregivers, community volunteers, healthcare professionals, humanitarian responders, and policymakers who shape access and funding. Measures of effectiveness in palliative care typically focus on symptom burden, patient and caregiver wellbeing, quality of life, and dignity-preserving processes such as advance care planning. However, in disaster settings, this may extend to access to essential medications, timeliness of support, and culturally appropriate care practices. While palliative care is often overlooked in disaster response planning, evidence from disaster-affected regions underscores its critical role in providing comfort, preserving dignity, and mitigating suffering during these challenging moments (Wynne et al., 2020).

In disaster situations, the principles of palliative care can help address gaps in humanitarian responses that primarily focus on survival and recovery. During the 2010 earthquake in Haiti, the lack of palliative care resources left many patients with catastrophic injuries or terminal conditions enduring unnecessary pain and distress (Kroll et al., 2020). In the aftermath of Typhoon Haiyan in the Philippines, healthcare workers reported the need for training and resources to deliver palliative care to patients unlikely to recover (Su & Thayaalan, 2024). These examples highlight the ethical imperative to incorporate palliative care into disaster responses, ensuring that even in the chaos of a crisis, the principles of dignity and compassion are upheld.

The intersection of palliative care and disaster response brings unique challenges and opportunities. Disasters strain already limited resources, necessitating triage and prioritization that may devalue palliative needs. However, integrating palliative care into disaster planning can improve the effectiveness of humanitarian efforts. It forms part of a broader human security agenda, where ensuring a dignified death, mitigating suffering, and sustaining community trust in institutions are central to social cohesion and recovery (Wynne et al., 2020). Neglecting end-of-life needs can exacerbate inequalities, erode institutional legitimacy, and undermine disaster governance itself. Studies on disaster risk perception and management reinforce that demographic, socio-economic, and psychological dimensions shape preparedness and resilience (Cvetkovic et al., 2018; Peric & Cvetkovic, 2019; Cvetkovic & Martinovic, 2020). By training healthcare workers in palliative care principles, equipping them with essential medications such as opioids for pain management, and strengthening community-based approaches, disaster response teams can better address the full spectrum of

health needs in affected populations. Furthermore, the inclusion of psychosocial and spiritual support, which are core components of palliative care, promotes resilience and recovery in communities grappling with loss and displacement (Powell et al., 2017).

The Garo Hills region of Meghalaya is emblematic of these challenges. A geographically remote and marginalized area, it experiences recurrent flooding that displaces entire communities, disrupt healthcare services, and exacerbates existing health inequities (Mucherera & Spiegel, 2021). Health systems are fragile, cultural beliefs strongly influence health-seeking behaviors, and poverty and political exclusion compound vulnerabilities. This paper explores the theoretical development of a palliative care action plan for the flood-prone region of Garo Hills, Meghalaya, conceptualized as a group exercise during the Fellowship of Palliative Care 2022 to address palliative care needs in a neglected setting.

The action plan takes into account perspectives from local cultural contexts, resource limitations, and community resilience, with an emphasis on early identification of palliative care needs, community engagement, and capacity-building among healthcare workers. It highlights the role of intersectoral collaboration, ensuring that palliative care is recognized as an integral component of disaster response, bridging the gap between emergency relief and long-term recovery. By anchoring the discussion in the specific context of Garo Hills, this paper contributes to the growing discourse on disaster and dignity, advocating for a compassionate and inclusive approach to disaster management.

2. Situational Analysis:

The Fellowship in Palliative Care is an international program organized through a partnership between the Institute of Palliative Medicine, India (also the WHO Collaborating Centre for Building Country Capacity in Palliative Care and Long-Term Care), St Christopher's hospice London, Sanjeevan Palliative Care Project, Pondicherry and Bangabandhu Sheikh Mujib Medical University of Bangladesh. As part of the fellowship, participants underwent a group exercise to plan strategies for integrating palliative care in challenging situations (Shahriah et al., 2024). The group authors are clinicians who practice palliative care, with varying backgrounds in terms of specialties ranging from orthopedics, anesthetics, community medicine and geriatrics, and countries including India, Bangladesh, Iran, Thailand, Myanmar and Brunei. The action plan was developed over several meetings totaling ten hours of facilitated discussions. Drafts were iteratively refined through rounds of feedback. While no primary data collection was undertaken, the process reflects an applied participatory methodology grounded in expert consensus. This theoretical and methodological approach provides a framework for future piloting and validation in real-world disaster contexts.

The Garo Hills, Meghalaya, are at a border area between India and Bangladesh, which is geographically isolated with limited healthcare infrastructure. Annual monsoons lead to frequent flooding. At the first group discussion, a team member shared that she saw an elderly woman floating on a mattress down a river, with many more people likely abandoning their flooded homes and putting loved ones on floating items, hoping they would survive. It is likely that dependent, immobile or frail people may be left behind, with an associated high rate of suffering, death and an urgent need for palliative care.

Based on what team members familiar with Meghalaya shared, there is generally limited education and literacy, complicated by the people using different alphabets. There is limited trust or a sense of belonging within the Bengali or Indian population, but they are compassionate communities. There was limited road access, poor connectivity and internet access even prior to the floods. The Bangladesh side is less developed compared to Indian side so they tend to cross borders for certain goods or facilities. At the Indian side, the health center is within 100km but doctors are not always available (Saravanabavan, Sangma, & Vinothini 2024). Some superstitions and beliefs lead people to seek help from 'shamans' or alternative health practitioners for healthcare (Lyngdoh, 2022).

Based on online reading, the Garo people are a marginalized ethnic minority living in Garo Hills and adjacent lowland areas in India and Bangladesh. There are also distinct ethnic identities between highland and lowland Garos, with attempts to establish linkages across borders (Singha &

Nayak, 2015). While they value traditional cultural norms and practices such as Wangala dancing during the annual Republic Day parade, this is gradually changing due to the Christian influence and interactions with other societies. There were government interventions causing land ownership conflicts and disputes, which led to evictions, physical assaults and violence from different agencies and influential people, which may contribute to a possible mistrust of authorities (Pathak & Brahma, 2024). There is much poverty, and dependence on natural resources for food, water and livelihood. There is limited income security and sustainability, which are vulnerable to climate change, with storms and alternating droughts disrupting cultivation and livelihoods.

While cancer rates are high in India, Meghalaya has the third highest cancer-associated disability adjusted life years (Sharma et al, 2014). The traditional cultural practices influence health management, rooted in a belief that disease result from dissatisfaction of gods or curses. This makes it likely the community will seek treatment from traditional health practitioners even if modern medicine is available (Mal & Saikia, 2025). Barriers to changing health behaviors include unawareness regarding prevention of non-communicable diseases, limited health literacy and lack of advocacy for health intervention programs (Dkhar et al, 2024).

Taken together, the geographic isolation, low literacy, poverty and reliance on traditional healers pose a significant challenge for any health intervention. For palliative care, these barriers may affect training delivery, service uptake, and long-term sustainability. However, these same factors underscore the urgency of a community-based, culturally adapted approach. These insights informed the design of the action plan by emphasizing the importance of culturally appropriate sensitization, narrative-based training, and phased implementation strategies that account for logistical and socio-cultural constraints.

1. **Overview of Strategy:**

There are 3 different target groups to obtain buy-in for a palliative care intervention in Garo Hills, Meghalaya. These are:

A: National and International Support

Non-governmental organizations (NGOs), societies and international communities are providing health care through medical camps and humanitarian aid to assist with the current crisis.

B: Neighbor Regions

Surrounding areas unafflicted by the natural disaster and potential sources of supplies, support and palliative care currently and in the future

C: Garo Hills community

Recipients of basic support, humanitarian aid and palliative care. This should be tailored to the community, taking into account capacity building, sustainability of services and prevention of disease through a public health approach. Potential strengths in the community include women, children, religious and spiritual leaders, and healthcare providers.

This is illustrated in Figure 1:

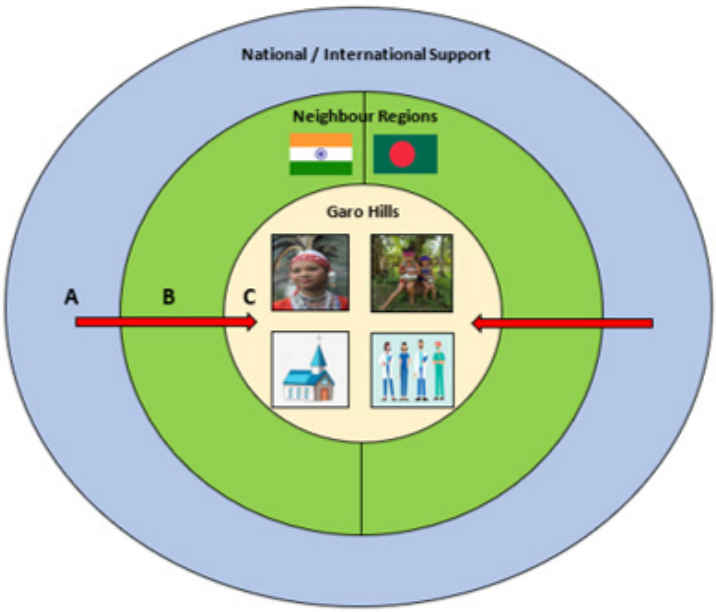

Figure 1: Multi-level engagement framework for integrating palliative care in disaster-prone Garo Hills.

Engagement mechanisms should ideally be formalized through memoranda of understanding (MOUs) with NGOs and health agencies, participation in humanitarian coordination clusters, and establishment of cross-sectoral working groups. Political and religious leaders may be engaged through targeted advocacy campaigns, while community champions can be identified through participatory workshops. Such mechanisms provide structure and continuity, ensuring partnerships move beyond ad hoc relief towards long-term integration of palliative care. This multi-level strategy reduces reliance on any single actor, introduces redundancy into support systems, and builds pathways for scaling interventions during and after acute crisis periods.

A: National and International Support

Humanitarian aid may be provided by established associations, which already have systems for distribution of supplies, aid or funds. International associations include Humanitarian Coalition, World Vision, United Nations High Commissioner for Refugees (UNHCR), World Health Organization, United Nations International Children's Emergency Fund (UNICEF) and Japan International Cooperation Agency (JICA). In contrast, national associations include Bosco Mount, HelpAge India, Cuddles Foundation, Yuvraj Singh Foundation, Sanjeevani Life Beyond Cancer, Bethany Society and True Christian Hospital Society (Egger & Schopper, 2022).

It is important to identify stakeholders among organizations and sensitize them regarding palliative care. Workshops can be offered targeting target managers for support and volunteers who may be sent to Garo Hills. Awareness raising regarding the plight of Garo people may raise interest from voluntary groups. It may be useful to place updated information regarding the crisis, what aid is needed and how palliative care helps in strategic locations, such as noticeboards in public libraries. For advocacy from civil society, it is possible to contact hospitals, healthcare organizations and professional associations, such as the Indian Association of Palliative Care to encourage involvement. Political or religious leaders can be lobbied to provide comments regarding the crisis and pledge assistance. Healthcare workers, particularly doctors, nurses and allied health professionals may be sought nationally or internationally for voluntary services at health camps. This could be an opportunity for national solidarity, where people collect and donate funds and items of need, support messages from schools and college students facilitated by teachers, and a potential social movement via social media to raise awareness about the crisis, with crowdfunding for fundraising.

For each interested person or association, information regarding the importance of palliative care may be shared in addition to sharing opportunities to join palliative care workshops. Advocacy, lobbying and coordinating tasks require an activist group with a sense of altruism and ability to ask for contributions towards this cause. With social media, small individual voices can be amplified easily.

The priorities are basic needs, such as food, clothing, shelter and security, providing palliative care for dying patients and grief or bereavement support for those with loss of displaced family, as well as rebuilding infrastructure, such as roads or bridges. These should be in place in order to strengthen palliative care within the Garo community.

B: Neighbor Regions & C: Garo Hills Community

The main strategy for advancing palliative care is to have narrative-based meetings and action learning groups (Campion-Smith et al., 2010). The vision is to develop strong community networks to support and sustain people needing palliative care as a basic human right with a mission to develop compassionate communities (Dumont et al., 2022). The aims are to recruit and empower peer-group support within the community, build ownership and program sustainability by the Garo people. This requires teaching palliative skills blended with a local flavor, utilizing the local community to increase the dimensions of discussions, find local champions and recruit a range of stakeholders and laypersons for these sessions. Table 1 outlines the suggested participants and target number to recruit for this initiative.

Table 1. Suggested participants (stakeholders and laypeople) and target number

Groups	Participants	Target Number
Stakeholders	Palliative patients and those in need of palliative care	30
	Community Leader	1
	Local administrative organization	1
	Physicians / Healthcare workers / hospice staff	5
	Nutritionist	1
	Physiotherapist	1
	Bereavement Counsellors	5
	Social Workers	5
	Chaplains	10
	Religious leaders	1
	Politician / influencer	1
	Project manager	1
	Non-profit organizations	5
Laypersons	Family members	10
	Caregivers	10
	Neighbors	30
	Students	30
	Volunteer coordinators	5
	Retiree volunteers	5

For hospice staff, such as community nurse, doctor, administrative secretaries and marketing director, part time or monthly visits may be adequate.

Laypersons serve in multiple capacities for palliative care: provide physical, spiritual and emotional comfort to patients and caregivers, assist with information exchange, referral support as a bridge to hospice care, socialization and companionship.

Recruitment closer to the Garo Hills community is preferred, depending on their availability and readiness and taking into account the recent crisis.

This may be planned in four phases: contacting relevant stakeholders, awareness raising and recruiting laypeople, narrative based meetings and action learning groups, followed by evaluation.

Firstly, relevant stakeholders should be contacted, particularly community leaders and local administrations to seek buy-in and propose the palliative care project. Awareness raising requires creating promotional materials outlining an introduction to palliative care, successful community models and experience sharing or storytelling about how palliative care relieves suffering. This can be advertised in hospitals, mosques, temples or churches, and shared in social media and traditional media such as radio and television.

Once interest has been generated, an action learning group should be set-up to assess the knowledge and attitudes of stakeholders, barriers to provision of palliative care from their viewpoint, cultural issues, resources, finances, benefits, expectations, ownership and what needs to be supported or sustained. This discussion invites Garo Hills representatives to share their experiences and identify champions among volunteers within the cluster.

A narrative-centered approach as a learning strategy should integrate case methods teaching, problem-based learning, and encourage participant engagement. This enables them to acquire a deeper understanding of palliative or end-of-life care and acknowledge death is an extension of life (Laskow, Small, & Wu 2019). Two-hour sessions are suggested, facilitated by healthcare professionals with experience in palliative care. As these sessions involve reflection and application to daily life, they may be scheduled at two-month intervals. Table 2 outlines the suggested content of the narrative based meetings and action learning groups. At the end of the sessions, evaluation is required via a questionnaire and getting feedback from participants. Key performance indicators include the number of attendees in one year, range of participants (number and type of stakeholder or laypersons), number of attendees in palliative training and number of participants volunteering in palliative care at one year.

Table 2. Content of Narrative Based Meetings and Action Learning Groups

No.	Aim	Content	Homework
1	Sharing experience of palliative care	Lecture: What is Palliative Care Video: Narratives of cancer patients Group Discussion	Write down understanding of palliative care based on session / readings
2	Understand changes experienced by people with life-limiting illness / facing death and how we can support them	Lecture: Process of acceptance and active listening Group Discussion	Write down understanding of session / readings
3	Engaging in decision making with loved ones	Lecture: Decision making process Role Play: Case Scenario Group Discussion	Reflect on one's view of life / death, thoughts for one's family and write these in a letter
4	Our views on life and death	Sharing Learning from Previous Sessions	
5	Visit Garo Hill residents (with life-limiting conditions, poor access to health care, neglected/flood areas)	Group Discussion: Sharing experiences / observations during community visit	

3. Palliative Care Training and Orientation:

The main aim of the training is to provide basic knowledge and skills for volunteers and caregivers of palliative care patients. The objectives are to understand basic concepts of palliative care and what can be done in the community, to determine the roles and responsibilities of a caregiver and to understand physical, psychological and spiritual issues faced by a person requiring palliative care. The content or curriculum can be divided into two sessions; session 1 offers the theoretical knowledge and foundations of palliative care, while session 2 covers hands-on and practical skills in palliative care for caregivers and volunteers. A follow-up session may be offered, tailored to the needs

of the attendees. This may include refresher of content, information or skills not covered in the first two sessions, experience sharing and debrief, as well as feedback for advancing palliative care in the region. Table 3 outlines the main content for the palliative care sessions.

Table 3: Content of palliative care training sessions

Session 1: Knowledge

Introductions

What is palliative care?

What can be done in the community?

Roles and responsibilities of caregivers

Where can you get help or support locally? – List of available services within the community

Socio-economic issues - How to support earning families, vocational rehab, supports e.g. Ayushman Bharat

Emotional Health – How to manage stress

Spiritual Health

How to reduce suffering?

Grief and bereavement support

Discussion / Question and Answer Session

Session 2: Practical Skills

Introductions

Roles and responsibilities of caregivers

Symptoms and how to manage them – pain, vomiting, constipation, diarrhea, breathlessness

(Focus on severity, self-management, when to seek medical attention)

Administering medications

Oral hygiene, nutrition, nasogastric tube feeding, careful hand feeding

Catheter cares

Pressure injury prevention

Wound care

Manual handling – turning, moving and lifting

Social and emotional support

Discussion / Question and Answer Session

The palliative care training sessions may be adapted to each specific target audience.

A. Healthcare workers (HCW), volunteer, humanitarian aid

Engage national or international organizations providing humanitarian aid and health camps to Garo Hills, and healthcare organizations who are interested in providing palliative support to the region, including Asha workers. Both sessions 1 and 2 may be held on the same day and offered two to three months a year. A debrief and follow-up session for volunteers deployed to Garo Hills may be provided. Selected participants should be able to run sensitization programs for laypeople after six months.

B. Neighbor Regions

Engage relevant stakeholders from neighboring regions or towns unaffected by the natural disaster. Strengthening palliative care in these regions is crucial, as a source of 'palliative champions' for Garo Hills. Local infrastructure and training venues may be utilized for Garo Hills representatives. Session 1 for laypeople and members of public may be provided monthly, while caregivers or those interested in practical sessions have the option of participating in Session 2 held three monthly. Only those who completed Session 1 may proceed to Session 2.

C. Garo Hills laypeople and members of public

During the first six months, Garo Hills residents may travel to neighboring areas to attend the palliative care sessions, while repair and restoration works are done to recover from the natural disaster. Once this has been done, Garo Hills venues will be utilized for these sessions. This can link into medical camps that provide health checks to sensitize staff and patients regarding palliative care. Session 1 content may be adapted for use as topics for sensitization, with more time allocated for listening and discussion to explore what palliative care needs are. Similar to neighbor regions, those who are interested and completed Session 1 may progress to Session 2 and be potential providers for sensitization sessions with support of visiting organizations and local healthcare workers. Translators and local representatives are required to adapt information into pictorial resources for pamphlets.

Other points to consider are as follows:

A maximum of 50 participants per session is optimal for adequate engagement and participation, with priority given to caregivers and potential stakeholders, such as community and religious leaders. Due to resource constraints, it is important to maximize opportunities, such as providing palliative care information during health checks, and empower attendees and volunteers to help and sensitize family and friends. Content should be tailored towards what is important or essential for participants at the time, which may range from information gathering, raising awareness or practical skills. Training materials should be culturally and linguistically adapted to the Garo context. Visual aids and pictorial resources should be prioritized over text, supported by local translators familiar with multiple alphabets and dialects. Traditional beliefs regarding illness and healing should also be respectfully acknowledged and integrated into discussions to improve cultural congruence. A full day session may be preferable for healthcare workers and volunteers to overcome difficulties in attending subsequent sessions. Humanitarian volunteers may be deployed quickly to Garo Hills; thus a rapid overview is more practical.

Advanced palliative care approaches or details require time, experience and skilled staff. General skills and knowing where and when to ask for help are more important. Effectiveness and acceptance of palliative care requires familiarization to local customs, beliefs and practices. Thus, sensitization sessions require discussions and time for listening and understanding, with subsequent sessions being reviewed and updated, possibly incorporating roleplays to clarify common misconceptions. A training-of-trainers model should be implemented through identifying motivated participants from neighboring regions and the Garo Hills community to serve as peer trainers. These individuals can co-facilitate future sessions, ensuring sustainability and local ownership.

Key performance indicators include the number of participants reached per year, number of laypeople who proceed to practical sessions, pre-test and post-test performance, satisfaction rate and feedback from participants, as well as case reports or success stories before and after the intervention. Specific palliative outcomes to show application to practice can be considered but are not practical indicators as they require a longer time period. These include improved pain scores, reduced severity of symptoms, complication rates such as pressure injuries and advance care plans. Monitoring and evaluation should include pre- and post-training assessments, competency checklists for practical skills, satisfaction surveys, and follow-up tracking of participant engagement in caregiving. These indicators capture knowledge acquisition and also translation of skills into clinical application, providing a feedback loop for iterative improvement.

The suggested Dos and Donts for layperson carers are included as Appendix 1 for orientation purposes.

4. Risk Analysis and Sustainability Plan:

There are several foreseeable barriers to the action plan: maintaining motivation among participants to continue to progress activities related to palliative and end-of-life care, application for funds to financially support palliative care projects, language and communication barriers, internet access for online training, selection and recruitment of trainers, and contextual barriers, such as an underdeveloped health system and unanticipated crises, including political instability or conflicts. As part of the planning process, possible challenges and suggestions to move forward based on the group discussions are described.

4.1. Maintaining motivation among participants to continue to progress activities related to palliative and end-of-life care

Timely reminders are suggested fortnightly regarding the roles of volunteers and potential impact they make individually and collectively. This can be done through active WhatsApp groups to update and sharing what has been done. Data and testimonies of the impact volunteers have on the lives of people serve as positive reinforcement and encouragement to continue their work. Constant involvement of participants through ongoing discussions and welcoming ideas gives participants ownership and credit to successful programs. Based on experience, it is helpful to allow them autonomy and trust, where they decide how to work within set parameters, with support available if there are uncertainties. Goals may be set based on their skills and expectations given, with the possibility of being offered larger projects or more responsibility to show that they are trusted. Participants should be kept well-informed in terms of palliative care knowledge and the output of their contributions. Appendix 2 contains free resources on palliative care that can be used by healthcare and humanitarian workers.

4.2. Application for funds to financially support palliative care projects

Funders should be identified from national or international grants, government or non-government sources and charitable foundations (Shahriah et al., 2024). Potential agencies that may assist include the Open Society Foundations' International Palliative Care Initiative, the World Health Organization's Health Emergencies program, and other national foundations supporting disaster relief. Securing diversified funding across these actors is essential for sustainability. Eligibility criteria are important; it is advisable to learn about the philosophy of the fund provider and what programs they have interest in funding. The timeline for submission, funding cycle and geographical restrictions should be evaluated and plans made based on the budget. It is possible that multiple grants are required to cover the financial needs. Preparation of the funding proposal should showcase the project value and expected deliverables such as how many people will benefit. Essential contents include the action plan, evaluation, required resources and budget, sustainability, future funding and long-term impact. It may be useful to build trust through face-to-face meetings with program officers or invite them to showcase planned services. Follow-up including providing updates, reporting outcomes achieved and a thank-you letter may encourage ongoing support.

4.3. Language and communication barriers

As the participants originate from different ethnicities and personal backgrounds, it is expected that different languages, cultural norms or values, perspectives and expectations will be encoun-

tered. Facilitators should be found to negotiate interactions within the diverse community in culturally responsive manner. It is useful to identify and assign experienced people in these roles to ensure group cohesion and get help from local people who understand the language and culture. It is advisable to use simple and accurate factual language. Some terms may need to be defined to ensure there is a common understanding. Universal or understandable visual images may be used to illustrate points; graphs, charts, diagrams or video clips may be more effective than text for communication. in place of text may be more effective. An efficient centralized communication hub should be identified early, such as WhatsApp group chats. This allows real-time sharing of conversations to exchange thoughts, feelings and experiences. It is useful to have teambuilding through group activities, where participants learn by doing and at the same time get to know and understand each other.

4.4. Internet access for online training

Internet connectivity is a major issue in rural parts of India, especially in the Northeastern states. This limits online training or access to information for stakeholders and volunteers. It was suggested that early communication with the Ministry of Electronics and Information Technology, or BharatNet (a large fiber-based rural broadband connectivity project) may be required to appeal for prioritizing access to Garo Hills. A temporary facility may be set-up such as libraries or churches to keep print versions of palliative care learning resources or computer access for online learning materials and online training for palliative care.

4.5. Selection and recruitment of trainers

There is a need to enroll the right number and type of people at the right place and right time to do the right things to achieve the goals of any action plan. It is advisable to recruit active professionals as trainers and influential community members as volunteers. We found that a snowball approach is useful, and a need for constant volunteer recruitment. They may experience burnout or leave the project, and volunteer reserves are needed to account for potential turnover. It is useful to conduct meetings or informal interviews with volunteers to determine their skills, interest and boundaries before bringing them on-board and assigning roles within a project.

4.6. Contextual barriers and unanticipated crises

Contextual barriers are challenging especially in unfamiliar places such as Garo Hills, yet are important to understand before engaging stakeholders. It is useful to review previous data or carry out situational or stakeholder analysis to better understand the situation better. Consulting local providers to identify barriers and drivers for the action plan will help navigate challenges related to acceptability or appropriateness of interventions, and adapting interventions to respond to needs of service users.

Similar risks were documented in Haiti after the 2010 earthquake, where the lack of structured palliative care resulted in patients with catastrophic injuries left with unmanaged pain (Kroll et al., 2020). In the Philippines after Typhoon Haiyan, providers highlighted the lack of training and resources to deliver end-of-life care in overwhelmed facilities (Su & Thayaalan, 2024). In refugee camps across Sub-Saharan Africa, humanitarian agencies reported barriers of language, cultural norms and volunteer attrition, similar to the anticipated constraints in Garo Hills (Powell et al., 2017). These parallels suggest that the proposed strategies, such as visual aids, peer-to-peer learning and phased volunteer recruitment, are grounded in lessons from comparable disaster contexts.

5. Conclusion

This paper presents a conceptual framework for integrating palliative care into disaster preparedness and response, using the Garo Hills of Meghalaya as a case study. This action plan emphasizes the importance of building local capacity and cross-sectoral collaboration for equitable access to care and embed dignity and compassion within disaster risk management. No disaster response is complete without care for those who may not survive.

The practical implications extend beyond disaster risk management and policy. Integrating palliative care into disaster planning strengthens humanitarian responses by ensuring comprehensive health coverage, addressing overlooked populations, such as frail, immobile, or terminally ill. This framework can be used to establish training programs and mobilize local champions, while for practitioners, the strategies describe concrete approaches that can be adapted to other disaster-prone regions with limited health infrastructures.

There are several limitations: this paper provides a conceptual model rather than empirical fieldwork. Further research is required to pilot and validate this approach to real-world settings. The contextual focus on the Garo Hills also means that cultural, geographic and systemic factors may limit transferability of all strategies in other settings. Further research is required to pilot and evaluate this framework in disaster-affected areas. Comparative studies across different disaster contexts to refine the model, and mixed-methods research to understand how palliative care can be operationalized alongside emergency or recovery services are also needed. Sustainable funding models, policy integration, and digital innovations may also supplement this framework to scale palliative care in humanitarian crises.

In conclusion, this paper strengthens the theoretical base for including palliative care within disaster governance, linking human security, disaster resilience and compassionate care. It is hoped that this approach may be adapted to similar disaster-prone settings, not only to alleviate suffering but also to build trust, equity, and resilience in disaster-affected communities.

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Appendix 1: Dos and Donts for layperson carers

Introduction:

- Carers play an important role, enabling palliative patients to get care at home
- They enable discharge from hospital, with readmissions likely during absence of carer support
- Caregivers have a demanding and stressful role, which is physically and emotionally draining

Aims:

- Promote and provide actionable insights to layperson carers on beneficial practices in palliative care
- Deter layperson carers from harmful practices that may be detrimental to physical, social, psychological, emotional well-being of patients and family

Dos for Caregivers:

- ✓ Involve the person with decision making regarding their treatment
- ✓ Provide adequate information about the person's medical, psychosocial and spiritual status
- ✓ Answer the person's queries truthfully

- ✓ Provide information regarding advance care plans or living wills
- ✓ Be emotionally available to the person
- ✓ Show compassionate behavior
- ✓ Be a good listener
- ✓ Seek help when needed – from community groups, NGOs, health care, family, friends
- ✓ Make necessary arrangements for respite care
- ✓ Share information about caregiver burden and burnout
- ✓ Attend training workshops to learn and understand how to be a better caregiver
- ✓ Attempt to learn more about nursing cares
- ✓ Give adequate medicine prescribed by palliative care team
- ✓ Have access to emergency contact numbers of ambulance / support staff at all times
- ✓ Seek professional help whenever necessary
- ✓ Get rest periods in between and try to get enough sleep
- ✓ Make a carer workbook / journal and update it regularly
- ✓ Document physical / mental / psychological problems or symptoms and communicate them to health-care workers
- ✓ Ensure safety of the home environment to prevent falls or accidents
- ✓ Read and understand caregiver guidelines

Donts for Caregivers:

- ❖ Don't lie about the stage or severity of the disease
- ❖ Don't give false hopes
- ❖ Don't give unnecessary reassurances that are not warranted
- ❖ Don't say bad things about the current treatment, whether it is working or not
- ❖ Don't deny / restrict specific food or activities citing health reasons (for terminally ill)
- ❖ Don't always talk about the disease or condition; try to have conversations about other general topics
- ❖ Don't consider their problems as insignificant, however small they seem
- ❖ Don't underestimate suffering that can be caused by pain (physical, psychological, spiritual)
- ❖ Don't compare with other patients
- ❖ Never compromise dignity, even if the person is non-responsive
- ❖ Don't force the person into treatment / therapy they don't want
- ❖ Don't force your opinions
- ❖ Don't suggest magic therapies / alternative treatment without informing the doctor
- ❖ Don't underestimate the risk of burnout – seek help early
- ❖ Don't talk too much or interrupt the person when they are trying to express their thoughts / feelings

Target Audience:

Family: Spouse, siblings, sons / daughters, relatives

Caregivers: Professional caregivers from organizations / agencies

Volunteers: Community volunteers trained in palliative care

Other Considerations:

Volunteer caregivers from outside Garo Hills:

- Do consider the carbon footprint e.g., try to source items locally, optimize what is done during each travel trip: global warming contributed to current flooding crisis
- Be understanding / accepting of their viewpoints, culture and way of life
- Do ensure what is done is as sustainable as possible i.e., whether it can be provided by the community long-term

Confidentiality – this may be culture specific, as Asian populations may be more family oriented in decision making (collectivistic) rather than individualistic approaches

Documentation – useful for professional caregivers, but may not be practical with language differences / literacy levels

The Dos and Donts are ground rules that can be disseminated to volunteers as a core component for community palliative care programs.

Appendix 2: Free Palliative Care Educational Resources for Palliative Care

Integrating palliative care and symptom relief into the response to humanitarian emergencies and crises. WHO Guide?

https://apps.who.int/iris/rest/bitstreams/1151607/retrieve

Palliative Care in Refugee Camps and Humanitarian Crises – Briefing Note. WHPCA.

http://globalpalliativecare.org/covid-19/uploads/briefing-notes/briefing-note-refugee-camps-and-humanitarian-crises.pdf

IAHPC Manual of Palliative Care. Edited by Derek Doyle, Roger Woodruff.

https://hospicecare.com/what-we-do/publications/manual-of-palliative-care/

Palliative Care: A Workbook for Carers. By Institute of Palliative Medicine.

http://www.instituteofpalliativemedicine.org/downloads/Palliative%20Care%20Workbook%20for%20Carers.pdf

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