Palliative Care Policy for Kerala

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1. PRE-AMBLE

1.1. The suffering in incurable and debilitating diseases:

a. Life with an incurable and debilitating disease is often associated with a lot of suffering. Pain, many other symptoms like breathlessness, nausea and vomiting, paralysis of limbs, fungating ulcers etc can make life unbearable not only for that person, but also for the family. Such suffering exists in incurable cancer, HIV/AIDS, many neurological, pulmonary, cardiovascular, peripheral vascular and end-stage renal diseases, incapacitating mental illnesses and in problems of old age.

b. In addition to physical problems, they usually suffer from social, emotional, financial and spiritual issues caused by the illness. Many have clinical states of anxiety or depression. On the social domain, when wage-earners get the disease, in the absence of any social security system, families often get financially ruined. Cost of treatment adds to the problem. It may lead to their children dropping out of school; families losing their homes, and often going into debt.

1.2. The relevance of palliative care:

a. Modern Principles of palliative care can take care of the suffering in patients with incurable diseases, considerably diminishing the anguish for the patient and the family. Palliative care is aimed at improving quality of life, by employing what is called "active total care", treating pain and other symptoms, at the same time offering social, emotional and spiritual support.

b. The World Health Organization in 2002 defined palliative care as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable

assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

Palliative care:

- Provides relief from pain and other distressing symptoms
- Affirms life and regards dying as a normal process
- Intends neither to hasten or postpone death
- Integrates the psychological and spiritual aspects of patient care
- Offers a support system to help patients live as actively as possible until death
- Offers a support system to help the family cope during the patient's illness and in their own bereavement
- Uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
- Will enhance quality of life, and may also positively influence the course of illness
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

c. In a study done in Malappuram District of Kerala (it was found that around 40% of those people who are dying would have benefited from applying the principles of palliative care in their management. In Kerala, with a population of 32 million and a crude death rate of 6.3 (Reference: Census 2001) around 80,000 dying patients and their families would be benefited each year. To this if we add the number of people living for years with chronic conditions the total number will be much more.

d. To ensure that palliative care is available and accessible to the majority of the needy, a major thrust should be on a primary health care approach. World Health Organisation observes that "The fundamental responsibility of health profession to ease the suffering of patients can not be fulfilled unless palliative care has priority status with in public health and disease control programme; it

is not an optional extra. In countries with limited resources, it is not logical to provide extremely expensive therapies that may benefit only a few patients, while the majority of patients presenting with advance disease and urgently in need of symptom control must suffer with out relief" (National Cancer Control Programmes, Policies and Managerial Guidelines. WHO, Geneva 2002)

e. Even when the disease is amenable to curative treatment, especially if the treatment is a long-drawn out process like in cancer, all principles of palliative care need to be applied from the time of diagnosis. This is commonly called supportive care and needs to be incorporated into the disease-specific treatment program.

f. Palliative care is a well-established branch of health care in most developed countries. The state, under Article 21 of the constitution of India, is duty-bound to ensure the fundamental right to live with dignity. This policy is aimed at ensuring that palliative care services are established and integrated into routine health care in the state.

1.3. Present palliative care scene in Kerala

a. At present there are around 100 palliative care units in Kerala. Majority of them are:

- organised and supported by Community Based Organisations (CBO) and the rest are based in government and private hospitals.
- supported by local communities
- self-sustainable in terms of manpower, money and other amenities.
- dependent on trained volunteers for organising the services and psychosocial support
- supported by Local Self Governments Institutions (LSGI) and are
- able to provide home visits, outpatient service and free drugs for the poor.

In some districts however, palliative care services are rudimentary.

b. Currently palliative care training programmes for professionals are run by Institute of Palliative Medicine, Kozhikode and Regional Cancer Centre, Thiruvananthapuram. Calicut Medical College has been offering regular placement in palliative care for house officers as part of training.

c. There are around 4000 trained volunteers in palliative care in Kerala at the moment. About 25 doctors, 15 staff nurses and 50 trained nurses are working full time in palliative care in the state. I addition to this there are many health care professionals who contribute part of their time for palliative care.

2. AIMS AND OBJECTIVES

2.1. Aim: To provide palliative care to as many of the needy in Kerala as possible.

2.2. Objectives

2.2.1 Short-term objectives for the first two years

2.2.a.1. To train at least 300 volunteers in palliative care in each district to facilitate the development and involvement of CBOs with emphasis on districts where there are no palliative care facilities.

2.2.a.2. To conduct sensitisation programmes in pain relief and palliative care for 25% of all doctors, nurses and other health / social welfare workers in the state

2.2.a.3. At least 150 doctors and 150 nurses in the state to successfully complete Foundation Course in Palliative Care. (Ten days 'hands on' training in Palliative Care with three days/20 hours of interactive theory sessions)

2.2.a.4. At least 50 more doctors and 50 more nurses in the state to successfully complete six weeks training in palliative care (Basic Certificate Course in Palliative Care). In addition to this availability of essential drugs including oral morphine and protected time for trained professionals and provision for inpatient beds where appropriate to be ensured in government hospitals having doctors and nurses successfully completed six weeks courses.

2.2.a.5. To develop more than 100 new community based palliative care programmes with home care services in the state with active participation of CBOs, LSGIs and local government and other health care institutions.

2.2.a.6. To develop common bodies/platforms in at least 25% of the LSGIs to coordinate the activities of CBOs, LSGIs and local health care programmes in the field of palliative care.

2.2.a.7. To establish a palliative care service, with availability of essential drugs including oral morphine and with at least one trained doctor and

trained nurse, in all government medical college hospitals in the state and in district hospitals in districts without Medical College.

2.2.a.8. To integrate the provision for palliative care into the house visit and field level activities of the field workers (Junior Health Inspector and Junior Public Health Nurse) and their supervisors.

2.2.a.9. To make essential medicines for palliative care available to patients covered by palliative care services through palliative care units / Primary Health Centres/other government hospitals.

2.2.a.10. To develop at least four more training centres in the state for advanced training in palliative medicine and nursing.

2.2.a.11. To develop and incorporate palliative care modules in medical, dental, nursing, pharmacy and paramedical courses.

2.2.a.12. To introduce palliative care in to the training programmes for elected members to LSGIs and concerned officials.

b. Long term objectives (five - ten years)

2.2.b.1. To ensure the presence of at least 1000 active volunteers trained in palliative care in each district at any time.

2.2.b.2. To make community based palliative care programmes with home care services available to most of the needy in the state with active participation of CBOs, LSGIs and local health care programmes

2.2.b.3. To develop common bodies/platforms in most of the LSGIs to coordinate the activities in the field of palliative care of CBOs, LSGIs and local health care programmes.

2.2.b.4. To ensure the presence of the minimum necessary trained professionals in palliative care in each district. This will mean all the doctors, nurses and other health / social welfare workers sensitised; Minimum of 75 doctors and 75 nurses to complete Foundation course; Minimum of 25 doctors and 25 nurses to complete Six week course in Palliative Care. There should be a mechanism to utilise the services of trained professionals in the delivery of services.

2.2.b.5. To empower the LSGIs in the state to develop programmes for training volunteers in palliative care and facilitating the development and involvement of CBOs.

2.2.b.6. To develop a system of monitoring the palliative care service in the state to facilitate quality assurance. A guideline for quality control to be developed at state level with a monitoring / implementing mechanism at the district level.

2.2.b.7. To develop a system to document and compile data on the palliative care related activities and patient population at district and state level.

2.2.b.8. To continue training and facilitation to empower community to share the care and support of people needing palliative care by organising human and financial resources available locally

2.2.b.9. To develop post graduate courses in palliative care in Medical and Nursing Colleges in the state

2.2.b.10. To establish Palliative care as part of basic health care available at the community level

3. DEVELOPMENT OF SERVICES

3.1. Guiding principles:

a. Home-based care should be the cornerstone of palliative care in the state. The role of family in the care of chronically ill patients should be recognised. They should be socially supported and empowered to cope with the situation. The patient and the family should be the focal points of the palliative care programmes.

b. Palliative care should be part of general health care system of the Government machinery.

c. The three tier governance system in Kerala in which health care institutions up to the district level are transferred to the LSGIs, gives good opportunity for the LSGIs to facilitate the development of pain and palliative care services through the existing network of institutions in co-ordination with CBOs and community in general.

d. Field level health workers and their supervisors should be able to incorporate the principles of palliative care into their routine activity at the household level. For this purpose the existing manpower and institutions in health need to be oriented and equipped adequately.

e. The Government machinery will make use of the experience that CBOs / NGOs have acquired in training and delivery of palliative care in the state and will work with them.

3.2. Involvement by different sectors

a. **Government Sector:** There should be adequate facilities in govt. hospitals and other health institutions for providing palliative care services at the institutional level and field level. They are expected to work closely with the CBOs and NGOs under the overall coordination of the LSGIs.

3.2.a.1. Field level and Sub Centre level activity: Male and Female Multi purpose health workers, who are expected to provide the components of comprehensive primary health care services at the household level through the sub centers and at the PHCs, can be provided with the

necessary orientation cum skill development training to play a major role along with the CBO volunteers and family members in providing home based care. CBOs and LSGIs should be encouraged to participate in palliative care delivery at this level.

3.2.a.2. Primary Health Centres and Community Health Centres: The PHCs and CHCs in the rural areas should be empowered to provide the necessary institutional level palliative care. Through the necessary training programmes and by filling the critical gaps in availability of drugs and other components of service provision, these institutions are to be equipped for the above purpose. The medical officer of the PHC/CHC will have a crucial role along with the CBOs and the LSGIs in developing a common platform for the co ordination.

3.2.a.3. Taluk Head Quarters hospitals: Where ever the existing palliative care services are located at far away centres, efforts should be made to provide full fledged palliative care services in Taluk hospitals. Efforts should also be made for the integration of the pain and palliative care concepts and skills into the existing specialty services of the Govt. Hospitals

3.2.a.4. District Hospitals & Medical Colleges: Each district must have a tertiary level pain and palliative care service with a trained doctor and staff nurse, housed either in a Medical College Hospital or a District Hospital. They should have specialist and inpatient palliative care services and ideally, facilities for training too.

3.2.a.5. Creation of training centres: More training centres need to be developed in the state. In addition to training centres which may evolve in the NGO/CBO sector, efforts should be made to start more training centres in government sector.

b. Community Based Organisations (CBOs) Issues associated with patients needing palliative care are as much social as emotional or physical. The society can pool its resources through CBOs to address many of these issues. As shown by experience in some Northern districts of Kerala, there is tremendous improvement is palliative coverage where CBOs are active. So participation of CBOs in palliative care should be encouraged.

3.2.b.1. Proposed minimum criteria for involving community based organisations in palliative care**.**

a) They should be local organisations having clearly stated interest in the care of patients with needing palliative care in their area.
b) The organisation should take the lead role in providing home care services to the bedridden patients.
c) Should not charge patients or family for their services.
d) The persons involved in the care of patients needing palliative care – volunteers, nurses, doctors and other health care workers – should have basic training in palliative care.

3.2.b.2. Responsibilities of CBOs

a) Identify patients needing palliative care in the area with the help of Local Self Governments (LSGI).
b) Assess the needs of each patient and provide care accordingly.
c) Provide home care service for needy patients.
d) Empower the patients and their families; provide social support and rehabilitation where ever necessary.
e) Conduct awareness programmes in palliative care for the community and provide training for volunteers and health care workers.
f) Work together with Local Self Governments and the Government / Non Government Health Institutions in the area for improving the care received by the patients.

3.2.b.3. Identification of CBOs: With the help of palliative care programmes in the neighbourhood, the LSGIs can identify and support CBOs.

3.2.b.4. Support for CBOs

a) Local Self Governments can take initiative to form a common platform for CBOs, Governmental and Non Governmental Health Institutions for organising support to the patients and family.

b) Local Self Governments should take steps to provide medicines and other accessories to the poor patients with chronic diseases identified by the CBOs, with the help of Government health care system.

c. Private Sector: Private sector plays a major role in the health care scenario in Kerala. Many private hospitals in Kerala are providing palliative care to needy patients free of cost. Palliative care initiatives by private hospitals should also conform to the quality control and training criteria set by the palliative care policy.

4. CAPACITY BUILDING:

In Kerala at any time there may be a minimum of one lakh people needing palliative care. So each Panchayat will be having approximately 100 patients at any given time. To give adequate care to these patients there should be at least one doctor and two nurses trained in palliative care in every Panchayath to work along with CBOs and other health care institutions. Also there should be enough trained volunteers for effectively organising and running the programme at local level.

a. Capacity building in government sector Considering the higher prevalence of the Non Communicable Diseases including cancers in Kerala, the significant number of people with HIV/AIDS and due to the increase in the percentage of the elderly population and the associated conditions requiring the palliative care services, it is essential that the health staff including the doctors are equipped with adequate technical and humanitarian skills for dealing the pain and palliative care services in a systematic manner.

4.1.a.1. Palliative care sessions will be built into existing educational programs (some of them are given in appendix V)

4.1.a.2. Deputation of staff will be given for the following training programs:

4.1.a.2.1. One to two day sensitisation programs in palliative care arranged for the purpose in collaboration with existing training programs in the field.

4.1.a.2.2. 10 day foundation course on pain relief for doctors and nurses. This course will authorise the doctors to man Recognised Medical Institutions (RMIs) which can store and dispense oral morphine and can provide basic pain relief to the needy.

4.1.a.2.3. Six weeks' certificate course for doctors and nurses in approved centres.

4.1.a.2.4. Other training programs yet to be developed for other categories of staff including pharmacists, public health nurses, health inspectors etc.

b. **Capacity building at CBO/ NGO level:** There are many NGOs and CBOs actively involved in palliative care training programmes for doctors, nurses and volunteers. Along with supporting these initiatives these training programmes should be validated and guidelines given. The experience the NGOs and CBOs have in training can be used to formulate and initiate palliative care training programmes in government sector. There should be efforts from governments, CBOs and NGOs to recruit and train more volunteers at local level.

5. AVAILABILITY OF MEDICINES AND OTHER EQUIPMENTS

5.1. A palliative care programme cannot exist unless it is based on a rational drug policy. Persons with incurable and other chronic illnesses need medicines for prolonged periods, which they may not be able to afford. In many areas CBOs and NGOs are now providing medicines and other equipments, which is not enough to cover the enormous needs in the state.

5.2. Medicines commonly needed for palliative care should be included in the essential drug list of the government hospitals. (Appendix II: List of medicines to be added to the present 'Essential Drug List') Also LSGIs should have provisions to purchase and distribute medicines and other equipments based on the need in their area with the help of health care institutions and CBOs.

5.3. There should be clear and adequate guidelines for procuring, storing and dispensing medicines needing special licenses like morphine. (Appendix III: Guidelines on training)

6. ROLE OF OTHER SYSTEMS OF MEDICINE

6.1. Currently palliative care services are developing more as part of Modern Medicine. The possibility of having similar programmes in other recognised Systems of Medicine should be explored.

7. RESEARCH

7.1. There should be provisions for locally relevant audit and research at various levels for improving the programmes and for sharing the experiences.

8. BUDGET ALLOCATION

8.1. There should be separate provision for budget allocation for palliative care services under

- **a.** Directorate of Health Service
- **b.** Directorate of Medical Education
- **c.** Local Self Government Institutions
- **d.** National Health Programmes
- **e.** Employees State Insurance Scheme

8.2. There should be provisions for deputation of government doctors and nurses to palliative care services for supporting clinical work and training programmes.

9. PALLIATIVE CARE POLICY AND OTHER HEALTH PROGRAMMES

9.1. Palliative care can be a component of many health programmes like National Cancer Control Programmes, National AIDS control Programme, National Non-communicable Disease Control Programme, National Rural Health Mission etc. The state palliative care policy is also in line with these related health care programmes.

10. EVALUATION AND MONITORING

10.1. It is necessary to evaluate the progress of the program at the end of one year, so as to analyse the strengths and weaknesses of the system and to formulate strategy for the long term policy. An advisory panel of palliative care workers will be formed comprising of representatives of the concerned government departments along with palliative care workers. The annual review will be followed by revision of short term strategy for the second year as well as formulation of long term strategy.

APPENDIX I

ACTION PLAN FOR TWO YEARS

Ref. No: (See Policy)	Objective	Action	Responsibility	Outcome measure
2.2.1.1	To train at least 300 volunteers in palliative care in each district to facilitate the development and involvement of CBOs with emphasis on districts where there are no palliative care facilities.	▪ Identification and training of volunteers ▪ Facilitation of formation of CBOs	▪ Existing palliative care groups, Networks and training centres ▪ Local Self Government Institutions (LSGIs)	▪ Number of volunteers trained ▪ Number of districts covered
2.2.1.2.	To conduct sensitisation programmes in pain relief and palliative care for 25% of all doctors, nurses and other health / social welfare workers in the state	▪ Formulate and conduct sensitisation programmes for doctors, nurses and other health / social welfare workers. ▪ Inclusion of palliative care sessions in Government health training programmes ▪ Inclusion of palliative care sessions in Cancer control and HIV/AIDS training programmes	▪ Training centres, palliative care organisations (Formulation and training) ▪ Director of Health Services (Facilitation)	▪ Number of government training programmes in which palliative care incorporated ▪ Total number of sensitisation programmes conducted ▪ Number of doctors, nurses and health / social welfare workers sensitised
2.2.1.3.	At least 150 doctors and 150 nurses in the state to successfully complete Foundation Course in Pain management. (Ten days	▪ Formulate training programmes ▪ Announcement of the programme	▪ Existing Training centres (Institute of Palliative Medicine, Kozhikode and Regional Cancer Centre,	▪ Training module for Foundation Course ▪ Number of doctors and nurses trained

	'hands on' training in with three days/20 hours of interactive theory sessions)	▪ Self selection by the candidates	Trivandrum) ▪ Newly identified training centres ▪ Director of Health Services (Authorise DMOs for deputing interested doctors and nurses for training)	
2.2.1.4	At least 50 more doctors and 50 more nurses in the state to successfully complete six weeks training in palliative care (Basic Certificate Course in Palliative Care). In addition to this availability of essential drugs including oral morphine and protected time for palliative care and provision for inpatient beds where appropriate to be ensured in government hospitals having doctors and nurses successfully completed six weeks courses.	▪ Formulate training programmes ▪ Announcement of the programme ▪ Self selection by the candidates ▪ Ensure availability of essential medicines	▪ Existing Training centres (Institute of Palliative Medicine, Kozhikode) ▪ Newly identified training centres ▪ Director of Health Services (Authorise DMOs for deputing interested doctors and nurses for training and provision of medicines)	▪ Training module for 6 Weeks Course ▪ Number of doctors and nurses trained ▪ Number of Government hospitals having palliative care services with essential drugs including oral morphine
2.2.1.5.	To develop more than 100 new community based palliative care programmes with home care services in the state with active participation of CBOs, LSGIs and local government and other health care institutions.	▪ Identify CBO/volunteers ▪ Training of volunteers ▪ Facilitation of establishment of palliative care services with Home Care programmes ▪ LSGI support through projects	▪ Existing palliative care units and networks, State and District palliative care Associations and training centres. ▪ LSGIs (Formulation and implementation of projects) ▪ Dept. of Local Administration (Modification of rules if necessary and evolving guide lines for projects)	▪ Number of palliative care programmes established ▪ Number of patients covered ▪ Number of projects from LSGIs

2.2.1.6.	To develop common bodies/platforms in at least 25% of the LSGIs to coordinate the activities of CBOs, LSGIs and local health care programmes in the field of palliative care.	▪ Identify interested LSGIs ▪ Identify CBOs ▪ Instruction to local government health care programmes / institutions ▪ Local workshops by LSGIs	▪ Dept. of Local Administration (Facilitation) ▪ Dept of H&FW (Instruction to concerned local health care programmes) ▪ Existing palliative care units and networks, State and District palliative care Associations and training centres.(Help in identifying CBO)	▪ Number of LSGIs in which common bodies formed ▪ Number of CBOs and health programmes involved ▪ Frequency of meetings by the common body
2.2.1.7.	To establish a palliative care service, with availability of essential drugs including oral morphine and with at least one trained doctor and trained nurse, in all government medical college hospitals in the state.	▪ Identification of trained and interested doctors ▪ To provide protected time for the trained health professionals ▪ Purchase of medicines	▪ Director of Medical Education ▪ Principals of Government Medical Colleges ▪ Existing Training Centres (Facilitation)	▪ Number of medical college with regular palliative care services ▪ Number of trained professionals in these units ▪ Availability of essential medicines for palliative care in medical colleges
2.2.1.8	To establish palliative care service, with availability of essential drugs including oral morphine and with at least one trained doctor and trained nurse, in all district hospitals in districts without a govt. medical college	▪ Identification of trained and interested doctors ▪ To provide protected time for the trained health professionals ▪ Purchase of medicines	▪ Director of Health Services ▪ District Medical Officers ▪ Existing Training Centres (Facilitation) ▪ Local palliative care units	▪ Number of district hospitals with regular palliative care services ▪ Number of trained professionals in these units ▪ Availability of essential medicines for palliative care in district hospitals
2.2.1.9.	To integrate the provision of the home care services for bedridden and chronically ill patients into the house visit and field level activities of the field workers	▪ Training JHI, JPHN and supervisors ▪ Interaction between local health programmes, CBOs and LSGIs	▪ Dept of H&FW (Instruction to concerned local health care programmes) ▪ Existing Training	▪ Number of Local Health Programmes involved in home care services. ▪ Number of trained JHI, JPHN and supervisors

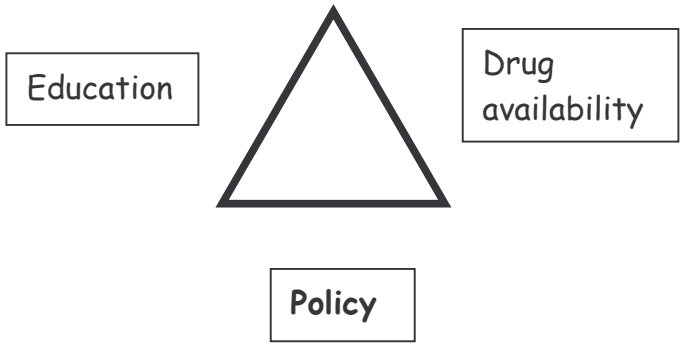
	(Junior Health Inspector and Junior Public Health Nurse) and their supervisors.		Centres, palliative care units and networks (Facilitation) ▪ Common bodies / platforms as in 2.2.1.6., (Facilitation)	involved in home care services in these units
2.2.1.10	To make essential medicines for palliative care available to patients covered by palliative care services through palliative care units /Primary Health Centres/other government hospitals.	▪ Inclusion of medicine needed for palliative care to 'Essential Drugs List' ▪ To make provision for annual indent for relevant health institutions ▪ Evolve guidelines for purchase and uninterrupted distribution of medicines by LSGI to the patients identified by CBOs / palliative care units	▪ Discussion group for palliative care policy (preparation of essential drugs list for palliative care) ▪ Dept of H& FW (purchasing and distribution of medicines) ▪ Dept. of Local Administration (Modification of rules if necessary and evolving guide lines for purchase and supply of medicines through projects)	▪ Essential drugs list for palliative care ▪ Number health institutions with regular supply of medicine for palliative care ▪ Development of guidelines for purchase and uninterrupted distribution of medicines by LSGI to the patients identified by CBOs / palliative care units
2.2.1.11.	To develop at least four more training centres in the state for advanced training in palliative medicine and nursing.	▪ Formulate criteria for training centres ▪ Identification / self selection from palliative care centres satisfying the criteria for training centres ▪ Provision for additional infra structure and other facilities including staff ▪ Provision of trainers	▪ Advisory Panel to Drugs controller on RMIS (Formulating and Identification) ▪ Local CBO/NGO/LSGIs (Infrastructure building) ▪ Local CBO/ existing training centres/ Dept of H& FW	▪ Criteria for training centres ▪ Number of new training centres ▪ Number of trainers
2.2.1.12	To develop and incorporate palliative care modules in medical, dental, nursing,	▪ Workshop for preparing the modules ▪ Introducing modules in	▪ Indian Association of Palliative Care – Kerala (Workshops)	▪ Modules developed for each course ▪ Number of Undergraduate

	pharmacy and paramedical courses.	Government teaching institution in Kerala ▪ Taking up the issue with Medical, Dental, Nursing and Paramedical Councils	▪ National level palliative care programmes (Facilitation) ▪ DME, DDE, State Nursing and Paramedical councils (introduction of modules) ▪ Dept. of H&FW (Taking up the issue with National Councils)	course in which palliative care is introduced.
2.2.1.13	To introduce palliative care in to the training programmes for elected members to LSGIs and concerned officials.	▪ To develop module for training ▪ Incorporate the module in to training programmes	▪ Kerala Institute of Local Administration (KILA) ▪ Existing palliative care training centres	▪ Modules developed for training ▪ Number of elected members and officials trained
2.2.1.14	To modify current regulations regarding recognition of Recognised Medical Institutions and for improving availability of opioids for medical use	▪ To restructure current procedures bringing in updated standard operating procedures	▪ Drugs controller with help of advisory panel	▪ New standard operating procedures
2.2.1.15	To review results and formulate/modify action plans after two years, in accordance with long-term objectives.	▪ Compiling data ▪ Comparing with targets ▪ Identifying deficiencies ▪ Suggestions for improvement	▪ Existing State and District level organisations in palliative care ▪ Department of H&FW ▪ Department of Local Administration ▪ Advisory panel to Drugs Controller	▪ Action plan for future

APPENDIX II

WORLD HEALTH ORGANISATION RECOMMENDATIONS.

The World Health Organization (WHO) recommends that, to be effective, any palliative care policy has to address all three sides of the following triangle with the State Policy at the base, their broad objective being to improve access to palliative care to all those who need it.



The WHO also gives the following specific guidelines

1. Governments should establish national policies and programmes for palliative care.
2. Governments of member states should ensure that palliative care programmes are incorporated into their existing health care systems; separate systems of care are neither necessary nor desirable.
3. Governments should ensure that health-care workers (physicians, nurses, pharmacists, or other categories appropriate to local needs) are adequately trained in palliative care.
4. Governments should review their national health policies to ensure that equitable support is provided for programmes of palliative care in the home.

5. In the light of the financial, emotional, physical, and social burdens carried by family members who are willing to care for cancer patients in the home, governments should consider establishing formal systems of recompense for the principal family caregivers.
6. Governments should recognize the singular importance of home care for patients with advanced cancer and should ensure that hospitals are able to offer appropriate back-up and support for home care.
7. Governments should ensure the availability of both non-opioid and opioid analgesics, particularly morphine for oral administration. Further, they should make realistic determinations of their opioid requirements and ensure that annual estimates submitted to the INCB reflect actual needs.
8. Governments should ensure that their drug legislation makes full provision for the following:
    - regular review, with the aim of permitting import, manufacture, prescribing, stocking, dispensing, and administration of opioids for medical reasons;
    - legally empowering physicians, nurses, pharmacists, and where necessary, other categories of health-care worker to prescribe, stock, dispense, and administer opioids;
    - review of the controls governing opioid use, with a view to simplification, so that drugs are available in the necessary quantities for legitimate consumption by patients.

APPENDIX III

DRUGS TO BE ADDED TO THE "ESSENTIAL DRUGS LIST" OF GOVT. Of KERALA FOR PALLIATIVE CARE SERVICES

PRIMARY CARE HOSPITALS (DISPENSARY & MINI P H C)

Sl. No.	NAME OF THE DRUG	STRENGTH
I. ANTI INFLAMMATORY & ANTIARTHRITICS		
1	T. MELOXICAM	15 mg
2	T/C. DEXTROPROPOXYPHENE+ PARACETAMOL	65 mg + Paracetamol
VI. ANTI ALLERGIC AND DRUGS USED IN ANAPHYLAXIS		
1	T. DEXAMETHAZONE	0.5 OR 4 mg
2	INJ. DEXAMETHAZONE	8 mg vials
3.	T. CETRIZINE	10mg
VII. ANTI EPILEPTIC DRUGS		
1	T. SODIUM VALPROATE	200mg
X. ANTI FUNGAL DRUGS		
1	T. FLUCONAZOLE	150 mg
XXI. G I T DRUGS		
1	Liq. Paraffin + Milk of Magnesia	
2	T. METOCLOPRAMIDE	10 mg
3	T. BISACODYL	5 mg
4	SODIUM PHOSPHATE ENEMA	
5	CAP. OMEPRAZOLE	20 mg
OTHERS		
1	T. ALDACTONE	100 mg
2	T. ETHAMSYLATE	500 mg
3	LIGNOCANE GEL	
ANTI DEPRESSANT/ ANTIPSYCHOTICS		
1	T. IMIPRAMINE	25 mg
2	T. FLUOXETINE	20 mg
3	T. HALOPERIDOL	5 mg

SECONDARY CARE HOSPITALS (BLOCK PHC & CHC)

I. ANALGESICS & ANTIPYRETICS		
1.	T. MELOXICAM	15 mg
2.	T/C. DEXTROPROPOXYPHENE+ PARACETAMOL	65 mg + Paracetamol
3.	T. CODEINE	10MG
4	T. MORPHINE	10 mg/ 20 mg
VI ANTI ALLERGICS AND DRUGS USED IN ANAPHYLAXIS		

1.	T. DEXAMETHAZONE	4 mg
X ANTIFUNGAL DRUGS		
1.	T. FLUCONAZOLE	150 mg
IXX PSYCHOTROPIC DRUGS		
1.	T. FLUOXETINE	20 mg
XXII DIURETICS		
1.	T. ALDACTONE	100 mg
XXIII G. I .T DRUGS		
1.	T. METOCLOPRAMIDE	10 mg
2	LIQ. PARAFFIN + MILK OF MAGNESIA	
3	SODIUM PHOSPHATE ENEMA	
4	BISACODYL SUPPOSITORY	

THALUK HOSPITALS

I ANALGESICS, ANTIPYRETICS, ANTIINFLAMATORY, ANTIARTHRITICS		
1	T. MELOXICAM	15 mg
2	T/C. DEXTROPROPOXYPHENE+ PARACETAMOL	65 mg + Paracetamol
3	T .CODEINE	10 mg
4	T. MORPHINE	10/20 mg
5	Inj. MORPHINE	15 mg /ml
XI ANTI ALLERGIC USED IN ANAPHYLAXIS		
1	Tab. DEXAMETHAZONE	4 mg/ml
XII ANTIFUNGAL DRUGS		
1	FLUCONAZOLE	150 mg
XXV G.I.T DRUGS		
1.	LIQ. PARAFFIN + MILK OF MAGNESIA	
2.	SODIUM PHOSPHATE ENEMA	
3.	BISACODYL SUPPOSITORY	

TERTIARY HOSPITALS

I ANALGESICS, ANTIPYRETICS, ANTI-INFLAMMATORY, ANTIARTHRITICS		
1	T. MELOXICAM	15 mg
2	T/C. DEXTROPROPOXYPHENE+ PARACETAMOL	65 mg + Paracetamol
3	T . CODEINE	10 mg
4	T. MORPHINE	10/20 mg
5	Inj. MORPHINE	15 mg / ml
XI ANTIFUNGAL		
1.	FLUCONAZOLE	150 mg
XXV G.I. T DRUGS		
1.	LIQ. PARAFFIN + MILK OF MAGNESIA	
2.	SODIUM PHOSPHATE ENEMA	
3.	BISACODYL SUPPOSITORY	

APPENDIX IV

Minimum training required for doctors-in-charge of Recognised Medical Institutions (RMI) for storage and dispensing of oral Morphine

Educational Qualification: -

- The doctor should have MBBS with successful completion of internship and Indian Medical Council Registration
- He/ she should have successfully completed the foundation course at a recognised centre for Palliative Care training, The course should have a minimum of .ten days 'hands on' training in Palliative Care with three days interactive theory sessions

Recognised Training Centre: -

For recognition by the government as a training centre in palliative care for doctors and nurses, the training unit should have the following minimum facilities

a) Out patient Services
b)Home care services
c) Inpatient Unit or access to Inpatient care facilities
d) A minimum of 100 patient contacts every week.
e) A minimum of 20 % of the working time of the doctors and nurses identified as trainers should be kept protected for the training activities.

The trainer doctor:

Should be a qualified doctor with Indian medical council Registration. She/He should have the experience of at least one year as a full time Palliative Care Physician at a centre described above.

Or

She / He should have six months experience as a full time Palliative Care Physician at a centre described above after successful completion of a minimum of six weeks training in Palliative Care at a recognised training centre

It should be mandatory for the recognised training centres to submit a report of training activities to the government every year.

The Government will notify the training programmes conducted by the Recognised Training Centres.

APPENDIX V

Human Resource Development in the Government Sector as part of Capacity Building in Palliative Care.

I. Human Resources Development of doctors and other health staff on pain and palliative care services.

Considering the higher prevalence of the Non Communicable Diseases including cancers in Kerala, and due to the increase in the percentage of the elderly population and the associated conditions requiring the palliative care services, it is essential that the health staff including the Doctors are equipped with adequate technical and humanitarian skills for dealing the pain and palliative care services in a systematic manner.

Training programmes for the Health staff can be organized as separate programme indented for the above purpose, and also in the various ongoing training programmes of the Health services department it can be included as a component.

AN OVERVIEW OF THE TRAINING PROGRAMMES CONDUCTED BY THE HEALTH SERVICES DEPARTMENT.

A. RCH training:

i. **Integrated skill development training. It is the purpose of this training to** develop comprehensive skill development in their respective area of work. It is intended to develop clinical skill, communication skill and managerial skill connected to their respective job responsibilities. **Since all these trainings are long duration trainings extending few weeks, it may be possible to allocate at least few theory and practical sessions on pain and palliative care.**

a. For JPHNs : Duration -Two weeks. (12 Working days) . It includes theory classes, along with hospital and field level on the job training. Theory classes, and hospital based and field level training on the pain and palliative care can be very well incorporated as part of this package.

b. For JHIs, HIs & HSs : One week training.

c. For LHIs & LHS s; Three week (18 Working days)

d. Medical Officers : Two weeks training.

e. Staff Nurses : Two weeks training.

f. Pharmacists : Two weeks training.

Palliative care can be incorporated in the RCH trainings taking place in all the 14 districts.

B. Training Programmes implemented through the State institute of Health and Family Welfare Thiruvananthapuram and Family Welfare training center, Kozhikode, and training center Trippunithura , Ernakulam.

i. **Trainings included in the plan schemes**: Generally these trainings for various category of health staff are being implemented through the state institute of the

Health and family Welfare located at Thiruvananthapuram. In various training programmes sessions on the pain and palliative care can be included.

Also based on the requirements next year onwards special pain and palliative trainings can be included for doctors and other paramedical on co ordination with Institute of Palliative Medicine, Kozhikode and Regional Cancer Centre, Thiruvananthapuram.

ii. **State training Policy trainings**: Based on the training need assessment of the health Services Department for the last three years state training Policy trainings were planned and being implemented to major category of the health staff (For clinical and field level workers)including doctors.

Two sessions on palliative care can be included in these training programmes.

C. Training programmes implemented through the state level cancer control Programme.

Utilizing the plan fund under the head of the cancer Care, for last few years state level orientation training of 2-3 days duration for the medical officers working in the peripheral institutions are being provided. It is the aim of these trainings to make them familiar with the components of the national cancer control Programme. The importance of the awareness generation, prevention, early diagnosis, and case management, and the importance of the pain and palliative care in the cancer are being covered in these short duration trainings. Utilizing the services of these trained doctors district level training of two days were conducted for the field workers and supervisors in most of the district.

In co ordination with the regional Early Caner Detection Centres (ECDCs) of the RCC cancer detection camps are also being arranged in many districts.

Based on the requirements training programmes in palliative care to be formulated and implemented through this scheme.

D. Training Programmes organized through the KSACS:

HIV /AIDS training including that on care and support are being provided to doctors (3 days duration)and various category of Paramedical staff(2 days duration) through the KSACS. Awareness training for Anganwadi Workers and Kudumbasre volunteers is also provided. Palliative care of course is a component of the care and support part of the HIV/ADS programme. Sessions on the importance of the palliative care in general and HIV/AIDS in particular can be organized through the KSACS trainings.

E. Special training for Medical Officers and paramedical staff for providing the institution based palliative care services.

Considering the requirements of the palliative clinics in the peripheral institutions, skill development trainings can be provided for more number of doctors and other paramedical staff, so that adequate service centres can be started. The existing training programmes may be evaluated and modified if necessary by a review committee (and the duration of the training programme may be reduced if possible) and necessary training programmes may be planed and implemented at the Institute of palliative Medicine, Kozhikode and Regional Cancer Centre, Thiruvananthapuram.

II. Awareness Generation Training (AGT) of One day duration: May be newly planned and organized for the LSGI representatives, for the other departmental officials etc.

National Rural Health Mission and palliative care:

Next year onwards preparation of the implementation plans will be done by the village Health and sanitation committees, at village levels. District action plans are in reality the consolidation of the village plans. If there is a genuine requirement of the pain and palliative care services in the periphery, it can be very well included in the village/ panchayath / district action plans and fund requests can be made.

The multi purpose health workers in their annual household survey can make an assessment of the patients requiring palliative care in their respective field areas. Then under the National Rural Health Mission(NRHM) framework for every village, while preparing health and sanitation plans, the requirement of the pain and palliative care services can also be brought into the planning process from the grass-root level through the health workers.

III. Integrating the component of the Pain and Palliative care services into the Medical, Nursing, Dental and Paramedical curriculum

Considering the field level requirement of the pain and palliative care services at the various levels of the Health care services, a basic understanding of the theory and practice of the palliative care is to be made available for all the Medical and Para-medical students as part of their regular course For the above purpose specific allocation of the theory class hours and facility for attending the pain and palliative clinic to be made mandatory. Medical council, Nursing council and other paramedical councils may take necessary steps for this.

IV. Post Graduate Training in palliative care

All the postgraduate students in clinical departments in various medical colleges in the state should undergo a minimum of two weeks training in palliative care as part of their regular training program.

Action will be taken to initiate post graduate courses in palliative medicine and nursing in Kerala.

APPENDIX VI

Proposed Structure of Monitoring Committees

Sate Level Monitoring Committee

Chairman/Chairperson	:	Minister for Health and Family Welfare
Vice Chairman/Vice Chairperson	:	Health Secretary
Convenor	:	Director of Health Services
Members	:	Director of Medical Education
		Director of Social Welfare
		Director of Local Self Government Institutions
		Drugs Controller
		Representative, Indian Association of Palliative Care – Kerala Chapter
		Representatives from Training Centres (Institute of Palliative Medicine, RCC)
		Convenor, Advisory Panel on Palliative care to the Drugs Controller, Kerala

Frequency of meeting: The state level monitoring committee should meet at least 1 – 2 times an year.

District level Monitoring Committee

Chairman/Chairperson	:	President, Jilla Panchayath
Vice Chairman/Vice Chairperson	:	District Collector
Convenor	:	District Medical Officer
Joint Convenor	:	Secretary, District level Palliative Care Initiative
Members	:	Superintendent, District Hospital
		Deputy Director Panchayath Department
		District Social Welfare Officer
		Representatives from Govt. Hospitals at Taluk level and above having palliative care clinics
		Representatives from Training Centres in the district
		Representatives from CBOs (Through the District level Palliative Care Initiatives)

Frequency of meeting: The district level monitoring committee should meet at least 3 – 4 times a year.

Local Self Government Level Monitoring Committee

Common body / platform formed (see policy)

Chairman/Chairperson	:	President, LSGI
Convenor	:	Medical Officer in Charge, Local Govt. Health Facility
Joint Convenor	:	Secretary, Local Palliative Care Unit
Members	:	Nurse/Doctor from Local Palliative Care Unit
	:	Health Supervisors

Frequency of meeting: The LSGI level monitoring committee should meet at least once every month.

APPENDIX VII

Proposed Budgetary Sources

I. 11th Five Year Plan

Efforts have been taken for the inclusion of the public health programmes for the Non Communicable Diseases, Elderly care, Palliative Care etc in the 11th Five year plan. If the above schemes may be included as

A. Centrally Sponsored Schemes

- National Rural Health Mission (NRHM)
- National Disease Control Programmes (Cancer, AIDS etc.)

B. State sponsored Schemes

- **Directorate of Health Services, support to**
  1. Training
  2. Home care services and field level activities
  3. Institutional support to develop palliative care facilities

- **Directorate of Medical Education, support to**
  1. Training
  2. Institutional support to develop palliative care facilities

A separate budget at DME and DHS for palliative care is necessary

II. Local Self Government Institutions (LSGIs)

Budget allocation to health care including palliative care from both

1. Plan funds
2. Own funds
