# Implementation Framework for

# 12th Plan Strategies to Improve Access to Palliative Care in India

# 15 March 2013

# Executive Summary

Presently, there are about 5 million people who are in need of palliative care in India. They include those suffering from incurable and systemic diseases like AIDS or cancer, or those suffering from spinal injuries or who have had a stroke. By addressing pain and other symptoms and by offering psychosocial support, palliative care can dramatically improve quality of life for the patient and their families. Unfortunately, it is estimated that less than 1% of the population who need it have access to palliative care (Help the Hospice, 2012[1]). With the increase in the life-span and growing burden of chronic diseases, it is evident that the need for palliative care is on a rise in India (India Together, 2010)[2].

With a view to respond to the present and future needs, the Ministry of Health and Family Welfare (MoH), Government of India, created a working group on palliative care in August 2012. The members included subject experts from the Ministry of Health and Family Welfare, Drugs Controller General of India, Central Drugs Standard Control Organization, Narcotics Control Division of Department of Revenue, World Health Organization's Country Office for India (WCO-India), Trivandrum Institute of Palliative Sciences /Pallium India, and the Institute Rotary Cancer Hospital-All India Institute of Medical Sciences.

Further the subject experts were tasked to draft "Strategies for Palliative Care in India" to be included and financed under the government's 12th Five Year Plan. This draft plan has been submitted to the government in November 2012 for final approval and decision on fund allocation. In anticipation of this approval, the MoH expressed interest in the development of a framework that will provide overall guidance for the implementation of the future programme. WCO-India and TIPS/Pallium India co-organized the development of the implementation framework. Leaders representing Ministry of Health and Family Welfare, Department of Revenue, non-profit/non-governmental organizations, health educational and professional associations and advisory boards, and private health institutions participated in the development of the implementation framework.

The Implementation Framework serves as an action plan document that complements the "Strategies for Palliative Care in India", Ministry of Health and Family Welfare

[1] Help the Hospices.(http://www.helpthehospices.org.uk/about-hospice-care/international/the-need/ accessed on 14/11/2012)

[2] Growing focus on palliative care, (http://www.indiatogether.org/2010/mar/hlt-palliate.htm accessed on 14/11/2012

# Introduction

In response to the essential public health need for palliative care services, the Ministry of Health and Family Welfare (MoH) developed a 12th plan strategy to facilitate access to affordable, safe and quality pain relief and palliative care to all those requiring it in the country.[3] The MoH plan aims to:

1. Improve the capacity to provide palliative care service delivery within government health programs such as the National Program for Prevention and Control of Cancer, Cardiovascular Disease, Diabetes, and Stroke; National Program for Health Care of the Elderly; the National AIDS Control Program; and the National Rural Health Mission.

2. Refine the legal and regulatory systems and support implementation to ensure access and availability of opioids for medical and scientific use while maintaining measures for preventing diversion and misuse

3. Encourage attitudinal shifts amongst healthcare professionals by strengthening and incorporating principles of long term care and palliative care into the educational curricula (of medical, nursing, pharmacy and social work courses).

4. Promote behaviour change in the community through increasing public awareness and improved skills and knowledge regarding pain relief and palliative care leading to community owned initiatives supporting health care system.

5. Encourage and facilitate delivery of quality palliative care services within the private health centres of the country.

6. Develop national standards for palliative care services and continuously evolve the design and implementation of the National program to ensure progress towards the vision of the program.

**Organization of the Implementation Framework**

The implementation framework is organized around the above six objectives from the MOH palliative care strategy document. The strategies and activities presented in this implementation framework are guided by the following principles:

√ Palliative care is an integral part of universal health care.

[3] "Strategies for Palliative Care in India (Expert Group Report)." Directorate General of Health Services, Ministry of Health and Family Welfare, November 2012.

- √ Access to effective and affordable pain relief is acknowledged as a human right for all.
- √ Civil society representation and participation in the planning and implementation of the MoH palliative care strategy is recognised as essential for promoting community involvement.
- √ Public-private partnerships are encouraged for universal access to palliative care services across the country.
- √ Ensuring governance, monitoring and evaluation of the MoH 12th plan palliative care strategy is critically important to ensure plan objectives are met.

It is anticipated that during years 1 and 2 of launching the MoH palliative care strategy, national-level activities are required to develop guidelines for the program, establish systems of governance, host a steering committee, launch a national sensitization workshop, and develop a monitoring mechanism with baseline assessments to support the MoH in its efforts. The National Rural Health Mission will provide funding and capacity building to ensure integration and mainstreaming of palliative care within programs focused on non-communicable disease (including cancer), HIV/AIDS, Tb, and efforts targeting elderly, children, and other populations that require palliative care services. Next, the palliative care strategy highlights the need for an amendment to the Narcotic Drug and Psychotropic Substances (NDPS) Act to ensure balance and improve accessibility and availability of opioids for medical use. The Department of Revenue (Ministry of Finance) will work towards this objective and support state excise departments and drug controllers to implement the modified NDPS regulations across all states.

As health is a state subject in India, the implementation processes will be made functional at the state level. Stregthening capacity across all health care delivery sectors will be required to ensure strong support for the palliative care strategy and narcotics law implementation. Strategies and activities to integrate palliative care into health care-related curriculum will be done in collaboration with the Medical Council of India, the Indian Nursing Council, Indian Dental Council, Pharmacy Council of India, and universities across the country.

The Indian health care system is a mix of public and private providers. As the government continues to increase its investment in the public health system, concurrent efforts to strengthen the private health sector is also needed as 70% of the health care provision is in the private domain. The strategy recommends that the private health sector also strengthen delivery of palliative care services.

Finally, standard clinical guidelines must be established for developing quality palliative care services within public, NGO and private health sectors.

# Objective 1

**Improve the capacity to provide palliative care service delivery within various government programs of Ministry of Health and Family Welfare (e.g. National Rural Health Mission, National Program for Prevention and Control of cancer, CVD, Diabetes & Stroke; National AIDS Control Program; National Program for Health Care of the Elderly; etc.)**

Strategies to achieve Objective 1 include:

A. MOH provides budget and overall guidance and establishes operational national implementat[io]n and monitoring cell
B. Support the integration and monitoring of the MoH 12th Palliative Care Strategy & Improved Access to Medical Use of Opioids
C. Build capacity within the government health system for all states and Union Territories

D. **A.**
E. MOH provides budget and overall guidance and establishes operational national implementat[io]n and monitoring cell

| **Activities** | **Who – Authority/Responsibility** | **Timeline** |
|---|---|---|
| **1.1 Approval of the strategy document by EPC[4] and release of budget** | **DGHS** | March-April 2013 |
| **Constitution of National Steering committee** | **DGHS / MoH** | |
| **Appointment of National Program Officer[5]** | **NSC** | |

| | | |
|---|---|---|
| **1.2 Establish cell** | | |
| 1.2.1 Recruit staff for national cell (including appointment of a national program officer) | NSC at MOH | May 2013 |
| a. Create job descriptions<br>b. Interview candidates<br>c. Select and hire staff | MOH | April 2013<br>April 2013<br>May 2013 |
| 1.2.2 Training for program manager of national cell | MOH | June 2013 |
| a. Identify the centre for training of staff at the PC Cell<br>b. PC sensitization course for selected staff at the PC center | NSC, TRG | June 2013 |
| 1.2.3. Create 1 and 2 year workplan for the National PC Cell (includes strategies and activities listed below) | MOH | June 2013 |
| **1.3 Constitute Technical Resource Group for palliative care** | **MOH, PC cell** | **April 2013** |
| 1.3.1. Create terms of reference and identify deliverable(s) for the Technical Resource Group (TRG) | | |

[4] Empowered Program Committee
[5] TOR – Doctor with PC training / experience and administrative experience

| | | |
|---|---|---|
| **1.4. Development of operational guidelines for national palliative care strategy** | **MOH, PC cell** | |
| 1.4.1. select the team of experts to work on operational guidelines. Contents of the guidelines would encopass the following;<br>1. for training - Develop terms of reference for regional resource centers<br>1.4.2. Develop protocols and guidelines for palliative care delivery in out-patient and in-patient departments including home based care at all secondary and tertiary level institutions in the country (e.g., district hospitals, medical colleges, HIV/AIDS centers, community health centers, among other health institutions) including:<br>a. Identification of specialties that can start PC services - Anaesthesia/Radiotherapy/ Medical Oncology/ Community medicine/Family medicine/pediatrics/among others<br>b. Formulation of the qualification and experience for manpower to be recruited<br>c. Incorporation of RMI requirements into guideline<br>1.4.3. Interact with Working Group for Education Programs (from objective 4) to adapt training materials for training of trainers (TOT) for physicians/nurses/ volunteers/medical social workers/pediatricians/child psychologists/among others<br>1.4.4. Design the national and state level plan for TOT<br>1.4.5. Develop guidelines for state steering and technical resource committees<br>1.4.6. Identify addl guiding documents, etc. needed for program implementation | NSC and TRG with PCC at the MOH | May – August 2013 |
| For all guidelines, the following workplan is proposed:<br>a. Appoint short-term expert agency/consultant to create draft guidelines in consultation with the TRG and other PC and/or health experts<br>b. EA/Consultant creates draft guidelines<br>c. Share drafts of the guideline(s) with TRG for consultation.<br>d. Conduct a 2 day meeting of TRG to review all guidelines and finalize<br>e. Submit to MoH palliative care cell for final review and adoption | a. MOH<br>b. Expert agency/ consultant<br>c. EA/Consultant<br>d. MOH<br>e. TRG | a. April 2013<br>b. May 2013<br>c. June 2013<br>d. July 2013<br>e. August 2013 |
| 1.4.7. Disseminate all guidelines from MOH to States | MOH | August 2013 |
| **1.5. Develop and execute national PC training plan** | **MOH, PC cell** | |
| 1.5.1. Hire expert agency/consultant to develop a | MoH | April 2013 |

| | | |
|---|---|---|
| national training plan and training materials for a national workshop | | |
| 1.5.2. Identify centers which may be promoted as regional resource centers | Expert Agency/ Consultant (EA/C) | April 2013 |
| 1.5.3. Develop a national training plan in line with overall MoH palliative care strategy (in consultation with PC experts) | EA/C | June 2013 |
| 1.5.4. Submit plan to MoH | EA/C | June 2013 |
| 1.5.5. Identify pool of master trainers from different regions of the country to undergo Training of Trainers program. | EA/C | May-June 2013 |
| 1.5.6. Conduct 1 national Training of Trainers<br>a. Draft workshop schedule and develop training modules<br>b. Create a working group to oversee training<br>c. Create training modules<br>d. Invite trainers<br>e. Provide timely communications to trainers (prior to attending workshop)<br>f. Launch train-the-trainer workshop<br>g processes in place to evaluate effectiveness of the training program | a. MoH<br>b. MoH + 2-3 PC experts<br>c. EA/C<br>d. MoH w support from EA/C<br>e. MoH or EA/C<br>f. MoH + 2-3 PC experts + EA/C | a. July 2013<br>b. July 2013<br>c. Aug-Sept 2013<br>d. Aug 2013<br>e. Aug-Oct 2013<br>f. Oct 2013 |
| 1.5.7. develop training modules, facilitater guide and handbook/manual for state level implementation | EA/C | Nov 2013 |
| 1.5.8. Disseminate training framework and modules to state P.C. cells along with information on centres, list of trainers etc. | MoH | Dec 2013 |
| **1.6. Leverage opportunities to share 12th plan palliative care strategy within MoH, other Union ministries, state governments, and other institutions** | **MOH** | |
| 1.6.1. Communicate 12th plan PC strategy at meetings of Union and state health ministers, secretaries, and other key policymakers. | MOH | Ongoing |
| 1.6.2. ensure information sharing and discussion on the 12th plan PC strategy at meetings of the National and State Institutes of Health and Family Welfare and meetings of the National Health Resource Centre and State Health Resource Centres | MOH, PC Experts | Ongoing |
| 1.6.3. Share information on the palliative care strategy with the Ministry of Women and Child Development for children's health programs & outreach | MoH | Ongoing |
| 1.6.4. Share information on the palliative care strategy with the public through media and through public announcement by the Health Minister at a program | MoH | June 2013 |

| | | |
|---|---|---|
| formally launching the project | | |
| **1.7. Conduct baseline assessment for PC services in India and identify program monitoring mechanisms** | **MOH, PC cell** | |
| 1.7.1. Baseline assessment (include RMI status) of 170 teaching institutions (which includes medical colleges and 28 regional cancer centers). Include baseline analysis for pediatric, elder care, and HIV/AIDS palliative care needs | MOH | August 2013 |
| a. Hire expert agency/consultant to conduct baseline analysis | PC Cell | June 2013 |
| b. Develop methodology | Expert Agency/ Consultant | July 2013 |
| c. Launch survey | EA/C | August 2013 |
| d. Collect data | EA/C | Oct 2013 |
| e. Analyze data | EA/C | Nov 2013 |
| f. Write report | EA/C | Nov – Dec 2013 |
| 1.7.2. Disseminate report of baseline assessment of palliative care services within medical colleges and cancer centers | MOH | Jan 2014 |
| 1.7.3. Share assessment protocol with state cells to conduct assessment of district hospitals | MOH, PC cell | Jan 2014 |
| 1.7.4. Identify indicators to monitor 12th plan strategies. Key indicators could include:<br>• State cell established and functioning (e.g., staff hired)<br>• Amount of allocated central budget received at state level<br>• Level of utilization of allocated central budget at state level<br>• Number of state level workshops held<br>• Number of state steering committees formed<br>• Level of functioning of state steering committees (state plan developed, # of meetings held)<br>• Number of new RMIs<br>• Data collection from RMIs on morphine consumption<br>• Number of professionals trained – nurses and doctors<br>• Staff positions in PC filled within medical colleges and district hospitals by state | MOH, PC cell | |
| **1.8. Create and conduct 1 national sensitization and orientation workshop for state palliative care cell (nodal officers, staff) and others. 100-150 attendees (October 2013)** | **MOH, PC cell** | |
| 1.8.1. Define batch size, expenditure, frequency, location | MOH, PC cell | April 2013 |

| | | |
|---|---|---|
| 1.8.2. Develop agenda for workshop | MOH, PC cell | May 2013 |
| 1.8.3. Identify trainers/resource persons | MOH, PC cell | May 2013 |
| 1.8.4. Conduct workshop | MOH, PC cell | Oct 2013 |
| **1.9. Establish palliative care in 40 Medical Colleges, including 5 RCCs.** | **MOH** | |
| 1.9.1. Directive from national to state government to form a state steering committee and TRG. Committee should include palliative care experts and CSO representatives | DDG (NCD) | April 2013 |
| 1.9.2. Directive from national to state government to identify 1-3 medical colleges/RCCs in each state in which palliative care services are to be started | DDG (NCD) | April 2013 |
| 1.9.3. Identify the RCCs and medical colleges where programme has to be implemented | PC cell, SSC | May 2013 |
| 1.9.4. Situational analysis of the identified RCCs and Medical colleges | MoH report (see activity 1.6.2.) | Jan 2014 |
| 1.9.5. identify champions from the institution and Strengthen capacity in these institutions to deliver palliative care | State Steering Committee | July 2013 - 2017 |
| **1.10. Advise and recommend to concerned national programs (for example, TB and HIV/AIDS) to sensitize and train existing program staff on essentials of palliative care** | **PC cell** | |
| 1.10.1. Communicate and interact with concerned national program offices (such as Tb, HIV/AIDS, children, elderly) | PC cell | |
| a. Introduce the PC strategy (via letters, leverage existing communications opportunities) | PC cell | April 2013 |
| b. Provide update on PC strategy (via letters, leverage existing communications opportunities) | PC cell | Dec 2013 |
| 1.10.2. Develop training module for inclusion within existing training programs for NRHM, HIV/AIDS, RNTCP, etc. at all levels of medical, nursing, and para-medical providers | PC cell | April 2013 |
| a expert agency/consultant may be hired for the national training plan/content development | NSC, PCC, SSC, EA/C | April-May 2013 |
| 1.10.3. Deliver palliative care training within existing NRHM, HIV/AIDS, RNTCP trainings | National and state Institute for Health and Family Welfare; | |
| 1.10.4. Establish palliative care service including access to oral morphine in identified HIV/AIDS care centers in every state | PC cell, National AIDS Control Organization | |

## B. integration and monitoring of the MoH 12th Plan Palliative Care Strategy

| **1.11. Create and have a functioning national steering committee** | | |
|---|---|---|
| 1.11.1. Constitute the steering committee. Stakeholders to be included are: Secretary (Health), heads of health services, medical education, DoR, and palliative care experts.<br>Purpose: Steering committee will advise and support monitoring overall progress of the palliative care plan in the country and identify any gaps and propose solutions. | MoH | May 2013 |
| 1.11.2. Host 1st meeting of the steering committee | MoH | July 2013 |
| 1.11.3. Host 2nd meeting of the steering committee | MoH | Jan 2014 |
| 1.11.4. Host 3rd meeting of the steering committee | MoH | Jan 2015 |

## C. Build capacity within the government health system for all states and Union Territories

The 12th Plan Strategies for Palliative Care identified the following for implementation within the government health system:

| | **Infrastructure Requirements** | **Personnel Requirements** |
|---|---|---|
| Medical Colleges | 4-8 beds dedicated to PC; twice a week OPD service | 1 trained physician and 2 specialist nurses |
| District Hospitals | 2-4 beds dedicated to PC; twice a week OPD service | 1 trained physician and specialist nurses at 1:3 ratio of nurses to patients |
| Community Health Centers | Have OPD PC services and home-based services at least 3 times/week | Training of existing personnel under NRHM, NCD, other related programs |
| Primary Health Centers | Referral system in place for community health centers, district hospitals, home care service | Training of existing personnel under NRHM, NCD, other related programs |

At time of writing, states have varying levels of palliative care capacity:

| **Category** | **Criteria** | **States** |
|---|---|---|
| A | Palliative services including possible centres of excellence available.<br>Champions active.<br>Government policy makers aware. | Kerala, Maharashtra, Karnataka, Delhi, Tamil Nadu, Andhra Pradesh, Assam, Tripura |
| B | Some professional services exist.<br>Few champions present.<br>State government is interested in the rolled out policy | Orissa, Uttar Pradesh, Gujarat, West Bengal |
| C | States with no services ongoing | other states outside the criteria |

| **Year 1 Strategies for all states** |
|---|

| | Who – Authority/Responsibility | Timeline |
|---|---|---|
| 1.12.1. Constitute state palliative care cell | State Health Dept, NRHM | Timeline TBD based on launch of PC strategy at centre |
| 1.12.2. Receive funds from centre for palliative care strategy | State NRHM, State H&FW Society (NRHM) | |
| 1.12.3. Constitute state steering committee | State NRHM, state PC cell | |
| 1.12.4. Develop a state level plan to improve access to palliative care defining objectives, strategies, and action plan. | Dept of H&FW, State H&FW Society (NRHM), CSOs in PC and health, technical support from PC experts | |
| 1.12.5. Conduct 3 day training in palliative care for 1 doctor, nurse, and any other health care worker, from 50% of government hospitals at identified training centers | State PC cell, State health training institutes/organizations, PC experts | |
| 1.12.6. Provide 6 weeks training for interested doctors and nurses | PC Regional Resource Centers, state PC cell | |

**Year 1 Strategy for states A and B (in addition to cell, funding release, steering committee)**

| | | |
|---|---|---|
| 1.12.7. Establish palliative care in 10% of districts as outlined in the MOH strategies document. | State NRHM | |

**Year 2 Strategy for Category A States (in addition to cell, funding release, steering committee)**

| | | |
|---|---|---|
| 1.12.8. Establish palliative care in 40% of districts as outlined in the MOH strategies document. | State NRHM | |

**Year 2 Strategy for Category B and C States (in addition to cell, funding release, steering committee)**

| | | |
|---|---|---|
| 1.12.9. Establish palliative care in 20% of districts as outlined in the MOH strategies document. | State NRHM | |

# Objective 2

**Refine the legal and regulatory systems and support implementation to ensure access and availability of opioids for medical and scientific use while maintaining measure for preventing diversion and misuse.**

Strategies to achieve Objective 2 include:

A. Simplify and adopt rational NDPS regulations and develop realistic standard operating procedures (SOPs) for their implementation
B. Ensure implementation of amended narcotic act and regulations using SOPs for all states and Union Territories
C. Conduct community level activities to improve awareness and to ensure acceptance of WHO method of pain relief
D. Improve awareness and ensure acceptance of WHO method of pain relief and assure making available essential medicines within the private health sector.

## A. Simplify and adopt rational NDPS regulations and develop realistic standard operating procedures (SOPs) for their implementation

| Activities | Who – Accountable/ Responsible | Timeline |
|---|---|---|
| **2.1. Ensure alignment of India's central narcotic drug law and regulations with the U.N. Single Convention on Narcotic Drugs through amendments in relevant sections of the NDPS Act.** | **DoR** | |
| 2.1.1. Pass the proposed NDPS amendment (including regulations and SOPs) during the 2013 Parliament Budget Session | DoR (MOF) | March – May 2013 |
| **2.2. Facilitate capacity at state level to implement NDPS amendment and regulations** | | |
| 2.2.1. Prepare and send directive to states summarizing the details of the NDPS amendment and modified regulations to states and union territories | DoR (MOF) | July – October 2013 |
| 2.2.2. Create a reference manual including hand-outs for conducting state-level workshops | DoR (MOF) | |
| 2.2.3. Create a computerized system through the NIC[6] for RMIs to report consumption statistics directly to the Narcotics Commissioner | | July – October 2013 |
| 2.2.4. Conduct national workshop on opioid availability | DoR (MOF) | August, December 2013 |

## B. Ensure implementation of amended narcotic act and regulations using SOPs for all states and Union Territories

[6] National Informatics Centre

| Activities | Who – Accountable/ Responsible | Timeline |
|---|---|---|
| 2.3.1. Conduct state workshops on opioid availability to ensure compliance with amended regulations as per contents defined in the National strategy document for Palliative Care. | Health Secretary, Drugs Controller, excise officials (State); palliative care experts; and CSOs | August 2013 – April 2015 |
| 2.3.2. Constitute a consultative committee under the NDPS Act to ensure the smooth implementation of the regulations related to medical and scientific use of narcotic drugs. | DoR | July 2013 |
| 2.3.3. Identify barriers to uninterrupted supply of affordable opioids and develop solutions | Consultative committee, State steering committees, PC experts | August 2013 - ongoing |
| 2.3.4. Have systems in place at the office of the Drug controller within state<br>- To grant RMI status to health care institutions based on procedure defined in the Central Regulations<br>- Develop policies and procedures to prevent dispensing units to be out-of-stock for opioids, especially immediate release oral Morphine tablets<br>- Periodically check records of existing RMIs and all their transactions to prevent misuse. | Drug Controller | July 2013 – March 2014 |

## C. Institute measures for community education about concepts, safety aspects and access to pain relief measures (through development of IEC materials)

| | | |
|---|---|---|
| 2.4.1. Prepare and disseminate IEC materials in both public and private health care delivery sectors on<br>- WHO Ladder/drugs<br>- Clarifications on misconceptions<br>- Support innovative concepts (e.g. door-step education as per medical representative model)<br>- Information on training opportunity in usage of strong opioids<br>a. Web-based education programs through MoH, IAPC, & WHO CCs' websites<br>b. Links with FAQs on opioid usage, interactive discussion group, helpline on issues related to morphine, etc.<br>c. Utilise the platforms and academic meetings or CME programs of healthcare associations to disseminate awareness and safe practices regarding pain relief through opioids | DCGI and state Drug Controllers; with support of palliative care experts and CSOs | August 2013 – April 2017 |
| 2.4.2. Create and disseminate IEC materials to improve public awareness on principles of pain relief and oral opioids | State Health and Public Relations Departments, with support from CSOs | August 2013 –April 2017 |

| | | |
|---|---|---|
| | and in collaboration with offices of mass media | |

**D. Improve awareness and ensure acceptance of WHO method of pain relief and assure making available essential medicines within the private health sector.**

| **Activities** | **Who – Accountable/ Responsible** | **Timeline** |
|---|---|---|
| 2.5.1. Meeting with MOH, MOF, and NABH to discuss necessitating RMI status and availability of adequate pain relief services as a condition for accreditation | **MOH, MOF, NABH, palliative experts, CSOs** | September 2013 |
| 2.5.2. Inclusion of access to essential medicines for pain relief as mandatory as per clinical establishment act and for accreditation. | **NABH** | November 2013 |

# Objective 3

## Encourage attitudinal shifts amongst healthcare professionals by strengthening and incorporating principles of long term care and palliative care into the educational curricula (of undergraduate/postgraduate medical, nursing, pharmacy and social work courses)

**Strategies to achieve Objective 3 include:**

A. Work with the Medical, Nursing, Dental, and Pharmacy Councils of India to incorporate palliative care into the respective curricula
B. Work at the State and university level to implement the outcomes from strategy A.

### A. Work with the Medical, Nursing, Dental, and Pharmacy Councils of India to incorporate palliative care into the respective curricula

| Activities | Who – Authority/Responsibility | Due Date |
|---|---|---|
| **3.1. Integrate palliative care content into medical and nursing curricula** | **MOH** | **November 2013** |
| 3.1.1. Hire expert agency/consultant (EA/C) to manage and coordinate PC curriculum development and implementation | MOH | April 2013 |
| 3.1.2. Formation of working group of palliative care experts and faculty from universities for developing educational programs. Members include MOH P.C. cell, palliative care experts, and 1 representative from MCI and NCI | MoH | April 2013 |
| 3.1.3. Conduct first working group meeting of experts to review action steps and to form 2 sub-groups with terms of references | MOH, Working group, EA/C | May 2013 |
| 3.1.4. Conduct 2-day meeting of MBBS curriculum sub-group to<br>(1) Study existing curriculum contents and prepare PC curriculum for integration within MBBS course. (A list of topics for MBBS curriculum is included in the MOH strategy document) and<br>(2) prepare action plan for creating transactional tools for training of trainers (ToT) course | MOH, MBBS working group | May 2013 |
| 3.1.5. develop training contents, transactional tools, facilitator guide and handbook / manual and evaluation systems to empower medical college faculty to impart learning in concepts of palliative care<br>Prepare feedback methodology for faculty and students to understand and improve effectiveness of the program | MOH, MBBS sub-group | May-August 2013 |

| | | |
|---|---|---|
| 3.1.6. Conduct 2-day meeting of Nursing curriculum sub-group to<br>(1) Study existing curriculum contents and prepare PC curriculum for integration within nursing courses.<br>(2) develop training contents, transactional tools, facilitator guide and handbook / manual and evaluation systems to empower medical college faculty to impart learning in concepts of palliative care<br>Prepare feedback methodology for faculty and students to understand and improve effectiveness of the program | MOH, Nursing sub-group | June 2013 |
| 3.1.7. Conduct meeting of MBBS and Nursing sub-groups to develop implementation plan | MBBS and Nursing subgroups, additional representatives from MCI and INC, | September 2013 |
| 3.1.8. Field test ToT in identified institutions | Selected institution, EA/C | September 2013 |
| 3.1.9. Modify ToT tool based on feedback | MBBS and Nursing sub-groups, EA/C | October 2013 |
| 3.1.10. MCI and INC disseminate revised curriculum to all universities<br>- Universities to organise Faculty Board meetings for developing further action plan to reach students | MCI, INC | November 2013 |
| **3.2. Integrate palliative care content into dental and pharmacy curricula** | **MOH** | **November 2014** |
| 3.2.1. Conduct 2-day meeting of dental curriculum sub-group to<br>(a) prepare PC curriculum for integration within BDS course.<br>(b) prepare action plan for creating a tool for training of trainers (ToT) course | MOH, Dental sub-group | May 2014 |
| 3.2.2. Conduct 2-day meeting of pharmacy curriculum sub-group to<br>(a) prepare PC curriculum for integration within pharmacy courses.<br>(b) prepare action plan for creating a tool for training of trainers (ToT) course | MOH, pharmacy sub-group | June 2014 |
| 3.2.3. Conduct a workshop to review progress of PC integration within MBBS and nursing courses. Modify curricula and implementation plan as needed | MOH; MBBS, nursing, pharmacy, and dental sub-groups with representatives from MCI, INC, pharmacy and dental councils. PC TRG representative | October 2014 |

| | | |
|---|---|---|
| 3.2.4. Dental and Pharmacy Councils disseminate revised curriculum to all schools and universities | Dental and Pharmacy Council | November 2014 |
| **3.3. Review meeting of MCI, INC, IDC & PCI for reviewing progress and redefine strategy** | **MOH, Universities** | **May 2015** |

## B. Activity at State/University level to implement outcomes from strategy A

| **3.4. Implement revised curricula in medical, nursing, dental and pharmacy schools** | **MOH** | |
|---|---|---|
| 3.4.1.<br>- Meeting of Faculty Board for Need and situation analysis and define Objectives, Principles, strategies and action plan to facilitate incorporation of proposed contents<br>- Identify medical and nursing colleges andrecruit faculty member(s) from each centre. Involve medical education units (MEU), medical education technology centers (METC), and continuing nursing education departments (CNED) | University registrar with the State steering committee, EA/C | December 2013 |
| 3.4.2. Develop faculty pools for four regions (North, Northeast, West, and South) | EA/C | |
| 3.4.3. Launch Training of Trainers (TOT) program for a faculty pool for four regions (North, North-east, West and South) | State steering committee & PC experts, EA/C | May-June 2014 |
| 3.4.4. Launch palliative care education in medical and nursing teaching institutions. Target 1 medical and 1 nursing institution in each region | Individual teaching institutions | July 2014 |
| 3.4.5. Launch palliative care education in pharmacy and dental teaching institutions. Target 1 pharmacy and 1 dental institution in each state. | Individual teaching institutions | 3rd year |
| 3.4.6. Expand medical and nursing education. Roll out to as many institutions as possible. | Individual teaching institutions | 3rd year |
| 3.4.7. Expand the program as many pharmacy, dental, medical and nursing institutions as possible. | Individual teaching institutions | 4th year |

# Objective 4

**Promote behaviour change in the community through increasing public awareness and improved skills and knowledge regarding pain relief and palliative care leading to community initiatives supporting health care system**

**Strategies to achieve Objective 4 include:**

1. Incorporate palliative care within the community health care and the primary health care system by the state government to bring it close to people
2. Establish a mechanism to link the peripheral units with higher centres of palliative care (palliative care wings in the CHC, district hospitals and cancer centres)
3. Promote awareness amongst public and policy decision makers regarding the scope of pain relief and palliative care services
4. Collaborate with NGOs to act as technical advisory agencies for the process of community awareness, mobilisation and empowerment in the field of palliative care programs (e.g. WHOCC – Calicut and WHO CC – Thiruvananthapuram, among others)
5. Empower the palliative trained staff at the CHC and 'senior health assistant' at PHC in selected districts to orient and educate the family carer in providing home based care
6. Empower community and family participation in continued care for the patient through structured care & support educational activities
7. Support community empowered initiatives in identified regions in the country which fulfil following criteria
    a. a state government and the community acknowledging unmet need and willing to develop the services for palliative care as a priority
    b. presence of adequate service providers and leadership in the field
    c. community already participating actively in policy matters as reflected in the on-going civil society activity in health / development
8. Ensure involvement of the Local Self Government Institutions through sensitisation workshops for the members
9. Ensure active support from the media

| Action | Responsibility | Timeline |
|---|---|---|
| **4.1. Activities at the national Level** | | |
| 4.1.1. Budget for awareness/ sensitisation campaign through visual media at national level | MoH | April 2013 |
| 4.1.2. Budget for generating education and training material for primary health care workers and lay person carers on how to care for the bedridden and dying patients | MoH | April 2013 |
| 4.1.3. Create core awareness/ sensitisation material for health care professionals and general public with key messages | MoH, Department of Public Relations, Consortium of Palliative Care initiatives | May 2013 – August 2013 |

| | | |
|---|---|---|
| 4.1.4. Develop details of basic courses, core training material, training modules in palliative care for health care professionals | MoH, Consortium of Palliative Care initiatives | May 2013 – November 2013 |
| 4.1.5. Create sensitisation campaign through print, visual and social media | MoH, Department of Public Relations, NRHM, Consortium of Palliative Care initiatives | May 2013 – March 2017 |
| **4.2 Activities at the state level** | | |
| 4.2.1. Adapt centrally prepared core awareness/ sensitisation material for health care professionals and general public to local language and local culture | Dept H&FW, State H&FW Society (NRHM), Public Relations Department, Institutions/ Civil Society Organizations (CSOs) in palliative care, Consortium of Palliative Initiatives | September 2013 – March 2014 |
| 4.2.2. Adapt centrally prepared basic courses, core training material, training modules in palliative care for health care professionals to local situation | Dept H&FW, State H&FW Society (NRHM), Public Relations Department, Institutions/ CSOs in palliative care, Consortium of Palliative Initiatives | December 2013 – June 2014 |
| 4.2.3. Launch sensitisation campaign in local language through print, visual and social media | Dept H&FW, Department of Public Relations, State H&FW Society (NRHM), Consortium of Palliative Care initiatives | July 2013 – March 2017 |
| 4.2.4. Develop a action plan/time line at the Senior Medical Officers' meeting for establishment of palliative care programs | Dept H&FW, State H&FW Society (NRHM), District H&FW Society (NRHM), District Administration (Health) | December 2013 |
| 4.2.5. Develop a reporting and referral system for the program and fix responsibilities at the state, district and institution level | Dept H&FW, State H&FW Society (NRHM), District | December 2013 – March 2014 |

| | | |
|---|---|---|
| | H&FW Society (NRHM), District Administration (Health) | |
| **4.3 Activities for the community level** | | |
| 4.3.1. Launch sensitisation/training programs in the community for lay person carers and general public | CSOs, Self help groups, District H&FW Society (NRHM), District Administration (Health), Local Self Government Institutions | April 2014 March 2017 |
| 4.3.2. Conduct training programs for primary health care workers including doctors | District H&FW Society (NRHM), District Administration (Health), faculty support by health care professionals | July 2014 – March 2017 |
| 4.3.3. Establishing palliative care programs with mandatory home care in district hospitals and CHCs | Dept H&FW, District H&FW Society (NRHM), District Administration (Health), CSOs in Palliative Care (involvement defined by state policy) | April 2014 – March 2017 |
| 4.3.4. Form a supporting network of trained volunteers in the community | District H&FW Society (NRHM), Hospital Management Committee of each hospital, CSOs | April 2014 March 2017 |

# Objective 5

## Encourage and facilitate delivery of quality palliative care services within the private health centres[7] of the country.

Strategies to achieve objective 5 include:

A. Strengthen policies, guidance, and accreditation processes for assuring quality palliative care services
B. Strengthen public and private health insurance policies to encourage delivery and use of palliative care services
C. Collaborate with national bodies of health care specialities and providers to improve awareness and delivery of palliative care
D. encourage public-private partnerships (PPPs) at state level to improve access to palliative care
E. Improve capacity of NGO sector to provide palliative care
F. Conduct activities at state level for health care professionals through awareness and trainings

### A. Strengthen policies, guidance, and accreditation processes for assuring quality palliative care services

| Activities | Who | Timeline |
|---|---|---|
| 5.1.1. Half day meeting of MOH PC cell and TRG, followed by email consultations with palliative care experts to work on 5.1 with a view to achieving establishment of policies, guidance, and accreditation processes. | MOH PC cell, TRG | May 2015 |
| 5.1.2. Draft and submit to National Council for Clinical Establishment Act minimum standards for care, inclusive of palliative care, through strengthening of the Clinical Establishment Act | MOH PC cell, TRG | May 2016 |
| 5.1.3. Declare policy that availability of essential medications such as morphine (including training of staff in their use) is mandatory within all public and private health care delivery as a legal obligation under the U.N. Single Convention on Narcotic Drugs, 1961 | MoH | |
| 5.1.4. Disseminate policy on the availability of essential medications such as morphine | State health departments | |
| 5.1.5. Prepare draft and submit to the National Accreditation Board of Hospitals and Healthcare Providers (NABH) recommendations to improve quality of care, pain policy, end of life care policy.<br>• Recommend that RMI status be part of the NABH accreditation process. | MOH PC cell, NABH, TRG | May 2015 |
| 5.1.6. Conduct working group meeting of TRG to create | MoH PC Cell, TRG | 2013 – 2014 |

[7] Private Health Sector: Hospitals, Nursing Homes, GPs, Family Physicians, Insurance, NGOs, amongst other institutions and providers

| | | |
|---|---|---|
| criteria and compliance parameters for Centers of Excellences to demonstrate best practices. Utilize WHO benchmark standards. | | |
| 5.1.7. Liaise with legal experts and CSOs to define terminologies and decision making processes related to chronic advanced progressive diseases[8] for GoI, Medical Council of India, and other bodies | MOH PC cell, TRG | **2013 – 2015** |

### B. Strengthen public and private health insurance policies to encourage delivery and use of palliative care services

| | | |
|---|---|---|
| 5.2.1. Recommend policy changes in the central & state government/ private / NGO run insurance companies to ensure coverage of palliative services within their healthcare delivery reimbursement plans.<br>• Facilitate inclusion of home health care as an extension of in-patient services | MoH PC cell, TRG, insurance bodies representatives | 2014 |
| 5.2.2. Explore "Pay for Performance" mechanisms to incentivize health care institutions to provide appropriate palliative care services | | |
| 5.2.3. Encourage private insurance or work place sponsored reimbursement plans to cover palliative care services | | |

### C. Collaborate with national bodies of health care specialties and providers to improve awareness and delivery of palliative care

| | | |
|---|---|---|
| 5.3.1. Create and operationalize plan to sensitise and collaborate with professional associations to work towards integration of PC concepts in their academic meets and service delivery | MOH PC cell, TRG, national associations/bodies of health care providers | 2013 - 2014 |
| 5.3.2. Educate hospitals on the need for quality palliative care service delivery | National Accreditation Board of Hospitals and Healthcare Providers (NABH), Association of Healthcare Providers India (AHPI), state hospital associations, PC experts | |
| 5.3.3. Facilitate PC sensitization workshops across the country for interested professionals from all sectors | MoH PC Cell, TRG, national | |

[8] Definition of a Terminal illness, Advance directives/ anticipatory decision making on choice of interventions, Right to dignity in life and death, Right to Information, Empowered Informed consent, Autonomy, Futile Care, Allowing natural Death, EOL Care bill by Parliament, Clarity on withholding & withdrawing life support for terminally ill patients with irreversible conditions

| | | |
|---|---|---|
| 5.3.4. through national and state health care associations/bodies | associations/bodies of health care providers | |
| 5.3.5. Organise and present concepts during private sector CEOs meet (North zone & South zone) | MoH PC cell, PC experts | |
| 5.3.6. Meet with Indian Nursing Council and Trained Nursing Association of India for initiating in-service training of nursing professionals | NSC with Palliative Care Expert Group | |
| 5.3.7. Meet with Pharmacy Council of India, Clinical Pharmacists for capacity building workshops on narcotic usage and strengthening practice policies | NSC with Palliative Care Expert Group | |

**D. Innovate at state-level to encourage public-private partnerships (PPPs) to improve access to palliative care**

| | | |
|---|---|---|
| 5.4.1. Establish policies, orientation and financial assistance for NGOs and other private providers to improve access to palliative care across the state | State PC Cell, State health department, PC experts | 2013-2017 |
| 5.4.2. Develop systems and monitoring mechanisms for appropriate functioning and utilisation of PPP | State PC Cell, State health department, PC experts | |
| 5.4.3. Monitor the availability and accessibility of essential medicines at all levels of health care delivery in all sectors including private / NGO through Common Review Mission program | State health Department | |
| 5.4.4. Assuring availability and accessibility of training for professionals in appropriate usage of oral opioids as part of the process of making essential medications available. | State health Department, PC experts | |

**E. Improve capacity of NGOs to provider PC services**

| | | |
|---|---|---|
| 5.5.1. Map of existing NGOs providing either health care services and/or palliative care or related care [home visits for elderly, hospices etc.] in the state | State health Department, PC Experts | 2013-2017 |
| 5.5.2. Analyze and evaluate NGOs to ability to begin or increase availability of palliative care out-, in-, and home care services | State health Department, PC Experts | |
| 5.5.3. Disseminate information on SOPs for PPP activities to the identified NGOs | State health Department | |

**F. Conduct activities for health care professionals from all sectors through awareness and training**

| | | |
|---|---|---|
| 5.6.1. Improve capacity of General Practitioners/Family Physicians/Specialists to incorporate PC principles within | NSC, State health Department with | 2013-2017 |

| | | |
|---|---|---|
| their practice<br>• Prepare Comprehensive Modules with handbook [9]<br>• Identify training centers and trainers within the state | Palliative Care Expert Group, professional bodies | |
| 5.6.2. Conduct training for Doctors, and paramedical professionals | State health Department with Palliative Care Expert Group | |
| 5.6.3. Monitor impact by maintaining list of all GPs / FPs/ Specialists who underwent training | State health Department with Palliative Care Expert Group | |
| 5.6.4. Facilitate training opportunities on WHO method of pain relief as required for stocking oral opioids | Department of Revenue and state health department | |
| 5.6.5. Liaise with respective state health care institutions and professional associations to sensitize health care professionals to improve capacity for PC services | State PC cell, state steering committee, PC experts | 2013-2017 |
| 5.6.6. Organise meetings on concepts of Palliative care (1 per state); and establish relevance for practice | State PC cell, PC experts | |

[9] Principles of PC, applied ethics of managing advanced disease, Pain management, other symptom management, EOL Care etc.

# Objective 6

**Develop Standards for Palliative Care services and continuously evolve the design, and implementation of the activities**

Strategies to achieve objective 6 include:

A. Establishing minimum standards for palliative care delivery
B. Establish minimum standards for palliative care education
C. Establish system for monitoring progress.
D. Evolve and conduct relevant need-based research.
E. Secure funding to ensure successful implementation of the 12th plan strategies for palliative care
F. Establish strategic partnership across international government and non-governmental organizations

In addition, strategies **1.7.** Conduct baseline assessment for PC services in India and identify program monitoring mechanisms and **1.11.** Create and have a functioning national steering committee, also support Objective 6.

**A. Establish minimum standards for palliative care delivery**

| **Activities** | **Who – Authority/Responsibility** | **Timeline** |
|---|---|---|
| 6.1.1. Hire the services of an independent autonomous body to monitor implementation of the palliative care strategy (MB = monitoring body) | MoH | October 2013 |
| 6.1.2. Appoint 4-6-member working group for development of minimum standards for palliative care. | MoH, EA/C | November 2013 |
| 6.1.3. Examine available "standards" documents and prepare separate drafts for standards for primary, secondary and tertiary palliative care services. | Working group | Dec 2013 – March 2014 |
| 6.1.4. Work with Central Drugs Standard Control Organisation [CDSCO][10] ensuring quality, safety, efficacy, criteria for import, manufacture, distribution, sale and standards of palliative care medicines | EA/C, Working group | April-Dec 2014 |
| 6.1.5. Conduct working group meeting to finalize standards documents | EA/C, Working group | April 2014 |
| 6.1.6. Develop tools for field-testing the standards for palliative care services | Working group | May 2014 |
| 6.1.7. Field-test the standards documents in one state and analyze results | Working group | June-Aug 2014 |
| 6.1.8. Make use of the results of field testing to modify the "standards" | Working group | Sept-Oct 2014 |
| 6.1.9. Roll out evaluation of palliative care services using evolved "standards" | Monitoring Body | Nov2014 – March 2015 |
| 6.1.10. Analyze results and present the findings to MoH | Monitoring Body | August 2015 |

[10] headed by the Drug controller General in the Directorate of Director general of Health Services [DGHS] office and State Drug Control Organisation headed by the Drug Controllers

| | | |
|---|---|---|
| and to TRG | | |

**B. Establishing minimum standards for palliative care education.**

| | | |
|---|---|---|
| 6.2.1. Organize 2 day meeting of working group to prepare framework for "minimum standards" for palliative care education at different levels | Monitoring Body | September 2015 |
| 6.2.2. Prepare draft documents for standards for palliative care education at different levels | Working group | Oct-Dec 2015 |
| 6.2.3. Develop tools for field-testing the standards for palliative care education | Working group | Jan-March 2016 |
| 6.2.4. Field-test the standards documents in four institutions in 4 different zones and analyze results | Working group | April-July 2016 |
| 6.2.5. Make use of the results of field testing to modify the "standards" for palliative care education | Working group | September 2016 |
| 6.2.6. Roll out evaluation of palliative care education centers using evolved "standards" | Monitoring Body | Oct 2016-<br>Feb 2017 |
| 6.2.7. Analyze results and present the findings to MoH and to TRG | Monitoring Body | March 2017 |

**C. Evolving system for monitoring progress of implemented palliative care strategy**

| | | |
|---|---|---|
| 6.3.1. Develop tools for monitoring process and outcome measures of various components of palliative care strategy | Monitoring Body | Oct-Dec 2013 |
| 6.3.2. Develop evaluation and monitoring frame-work for various components of the palliative care strategy | Monitoring Body | Oct-Dec 2013 |
| 6.3.3. Field-testing of monitoring tool in sample population in each of four zones | Monitoring Body | Jan-March 2014 |
| 6.3.4. Refining monitoring tool based on the results in the sample population | Monitoring Body | April 2014 |
| 6.3.5. Rolling out monitoring of process and outcome measures in sample population in each state | Monitoring Body | May-August 2014 |
| 6.3.6. Prepare report on monitoring and recommendations and submit to MoH | | Sept-Oct 2014 |

**E. Evolve and conduct relevant need-based research**

| | | |
|---|---|---|
| 6.4.1. Liaison with the 'National Family Health Survey' [NFHS] and the District Family Health Survey [DFHS] of India to incorporate "number of bedridden patients per family" as one of the survey information to be collected. | EA/C; Monitoring Body | Sept 2013<br>March 2014 |
| 6.4.2. Liaison with Health Management Information System [HMIS] for reorientation of the system for long term care that allows collation of data without loss to follow-up | EA/C; Working group | Sept 2013<br>March 2014 |
| 6.4.3. Identify critical research questions to conduct | Working group, ICMR, | Sept 2013 |

| | | |
|---|---|---|
| research into palliative care needs, nature of suffering and value of interventions. | With support from CSOs | March 2014 |
| 6.4.4. Liaison with palliative care institutions and CSOs to identify those that are willing to take up research projects and have the capacity to do so, and initiate two such research projects every year. | Working group, ICMR | February 2014-February 2017 |
| 6.4.5. Collate results annually and encourage publication in free access journals | Working group, ICMR | March 2015, 2016 and 2017 |

**E. Secure funding to ensure successful implementation of the 12th plan strategies for palliative care**

| **Activities** | **Who – Authority/Responsibility** | **Timeline** |
|---|---|---|
| 6.5.1. Identify funding and resource gaps within the overall implementation framework for the 12th plan strategies for palliative care | WCO-India | Sept 2013 – Feb 2014 |
| 6.5.2. Fundraise for additional resources | WCO-India, PC organizations | ongoing |

**F. Establish strategic partnerships across international government and non-governmental agencies to support "balance" within India's narcotic law and regulations and overall integration of palliative care within the government health system**

| **Activities** | **Who – Authority/Responsibility** | **Timeline** |
|---|---|---|
| 6.6.1. Support attendance of key MoH and DoR policymakers and administrative officials for global palliative care meetings and conferences | Working group; Global palliative care organizations | ongoing |
| 6.6.2. Identify and create strategic partnerships to improve efforts for translation research. | Working group; ICMR | Ongoing |