NATIONAL PROGRAMME FOR PALLIATIVE CARE

OPERATIONAL GUIDELINES

Directorate General of Health Services
Ministry of Health & Family welfare
Government of India
2017

CONTENTS

1. INTRODUCTION

1.1 Background

India is home to millions of patients suffering from chronic and life limiting illnesses such as cancer, AIDS, dementia, heart, liver or renal diseases and other debilitating conditions or incapacitating injuries. Approximately 1 million people are diagnosed with cancer each year in the country. Over 80% of patients suffering from cancer present at stage III and IV when the curative treatment is much less effective and palliative care plays a dominant role. More than 1 million cancer patients are estimated to be suffering from moderate to severe pain every year. About 2.5 million people in the country are estimated to be living with HIV/AIDS and about 1.89 million suffer from pain. Overall, more than seven million people with life-limiting illnesses need pain relief in the country each year.

1.2 Definitions

1.2.1 ***Palliative care*** is an approach that improves the quality of life of patients and families who face life-threatening illness by providing pain and symptom relief, spiritual and psychosocial support from diagnosis to the end of life and bereavement.

Palliative care:

(a) Provides relief from pain and other distressing symptoms;
(b) Affirms life and regards dying as a normal process;
(c) Intends neither to hasten or postpone death;
(d) Integrates the psychological and spiritual aspects of patient care;
(e) Offers a support system to help patient's live as actively as possible until death;
(f) Offers a support system to help the family cope during the patients
(g) Illness and in their own bereavement;
(h) Uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated;
(i) Will enhance quality of life, and may also positively influence the course of illness; and
(j) 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.

1.2.2 Palliative care for children is the active total care of the child's body, mind and spirit, and also involves giving support to the family.

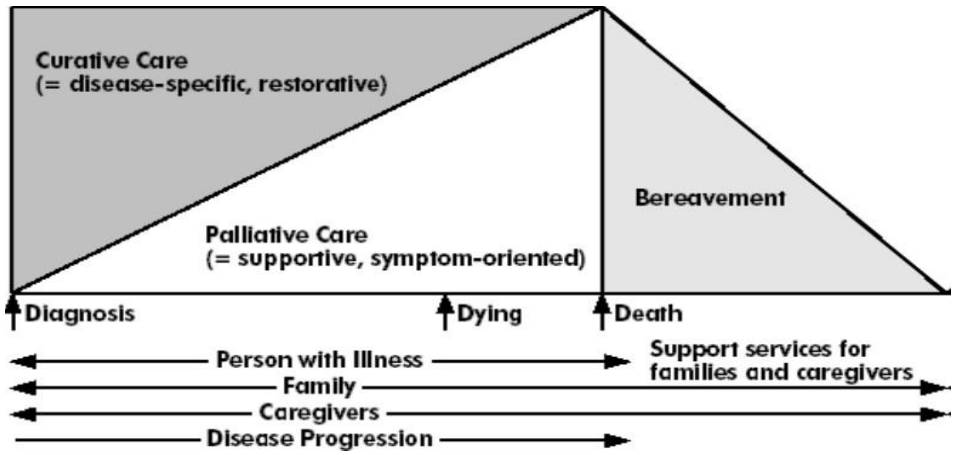
(a) It begins when illness is diagnosed, and continues regardless of whether or not a child receives treatment directed at the disease.

(b) Health providers must evaluate and alleviate a child's physical, psychological, and social distress.
(c) Effective palliative care requires a broad multidisciplinary approach that includes the family and makes use of available community resources; it can be successfully implemented even if resources are limited.
(d) It can be provided in tertiary care facilities, in community health centres and even in children's homes.

1.2.3. ***Hospice Care*** is the end-of-life care provided by health professionals and volunteers. The goal of the care is to help people, who are dying, have peace, comfort and dignity. However, sometimes the hospice care is equated synonymously with palliative care.

1.3 Principles of Palliative Care

Palliative Care, when indicated, is fundamental to improving the quality of life, well-being, comfort and human dignity for individuals. It is an ethical responsibility of health system and health care professionals to alleviate pain and suffering, whether physical, psychosocial or spiritual, irrespective of whether the disease or condition can be cured. If cure is not possible, palliative care provides essential care to provide pain relief, control symptoms, and minimize suffering. Figure below illustrates a "continuum of care" for cancer, HIV/AIDS, and other life-limiting diseases:



The principles of palliative care need to be applied starting from the time of diagnosis in chronic ailments like cancer. This is commonly referred to as supportive care and needs to be incorporated into disease specific treatment program. As the disease progresses and the curative treatment decreases, the role of palliative care increases. At the end of life, palliative care is provided as terminal care extending as bereavement counseling and support for grieving family after the patient's death.

1.4 Palliative Care approaches

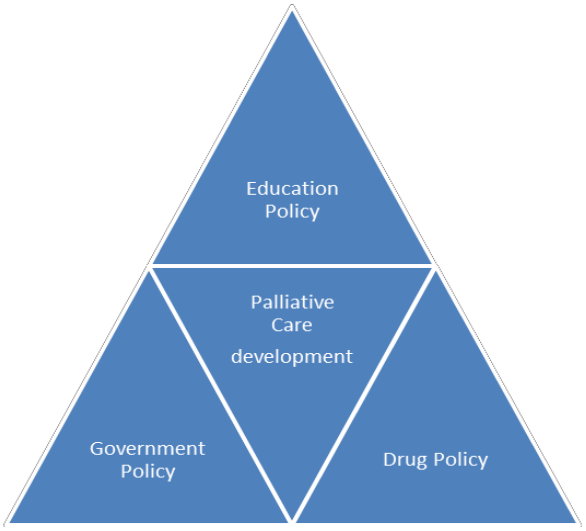
Public health approach in palliative care: To integrate evidence-based, cost-effective and equitable palliative care services in the continuum of care, across all levels, with emphasis on primary care, community and home-based care, and universal coverage schemes. WHO recommends the following three measures as a foundation for developing palliative care through the public health approach (WHO, 1996):

(a) A Government policy to ensure the integration of palliative care services into the structure and financing of the national health-care system;

(b) An educational policy to provide support for the training of health-care professionals, volunteers and the public; and

(c) A drug policy to ensure the availability of essential drugs for the management of pain and other symptoms and psychological distress, in particular, opioid analgesics for pain relief.

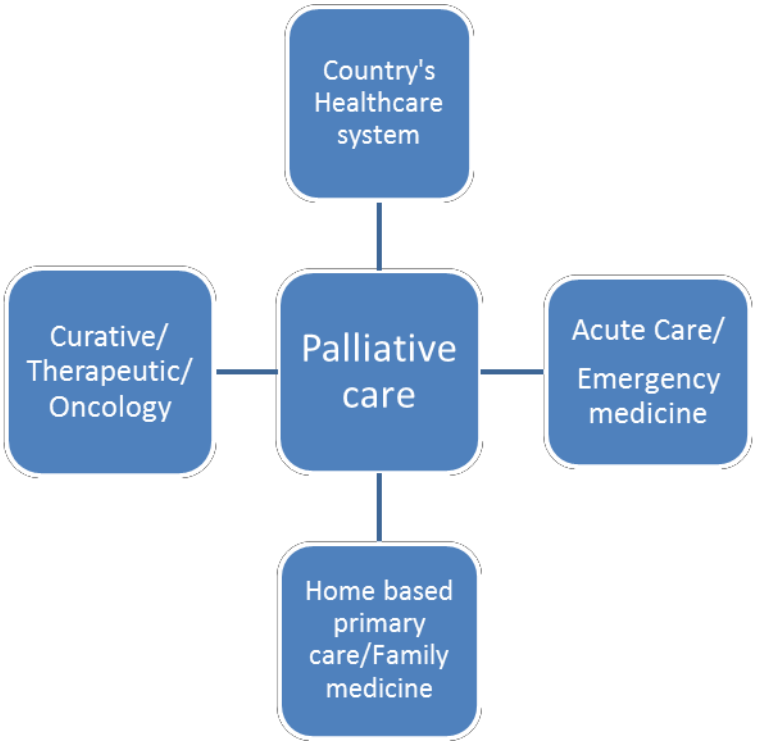
Figure: Foundation measures for developing Palliative Care



All these three measures are necessary, along with committed leadership, to achieve an effective palliative care programme. For India, all the components are relevant, including supportive policies, drug availability and strategies on education and capacity building.

Palliative care should be integrated into the structure and financing of a nation's healthcare system. It should be regarded as a part of National Health Programs aimed at reducing the overall burden of chronic illnesses.

Figure: Integration of Palliative Care with existent healthcare facilities



Interdisciplinary approach to Palliative Care: The contemporary palliative care definitions stress upon multi-dimensional aspect of suffering and its improvement as the goal, throughout the trajectory of the illness. Specialized and multi-disciplinary services comprising of palliative care physicians, pain specialists, occupational therapists, physiotherapists, palliative care nurses, psychiatrists, community volunteers and psychologists among others are required to meticulously meet these varying needs.

It is recommended to provide curative therapies and palliative care simultaneously i.e. an 'Integrated Curo-Palliative' instead of 'Curative vs. Palliative' approach to:

(a) Improve patient satisfaction and maintain the balance towards a holistic patient care. The focus of care will depend upon the stage, prognosis and response to therapeutic modalities with more emphasis on palliative care needs as the disease progresses.

(b) Allow pooling and capacity building of healthcare professionals, funds and other resources under one roof. The core concepts of palliative care i.e. mitigating suffering and managing symptoms forms a major component of oncology practice as well.

1.5 Palliative Care services in India

In the twelfth Five Year Plan, the government of India has launched National Program for Palliative Care (NPPC), as a new initiative, under the Mission flexipool

of National Health Mission. Under the program, the States/UTs may seek grant-in-aid from the Government of India for establishing palliative care services at the district level and for establishing state palliative care cell. The program is now part of the 'Mission Flexipool' under National Health Mission (NHM).

Palliative care in India is also provided through leading palliative care centres which are either government supported or private/NGO initiatives.

1.6 Drug policy and opioid availability

In India, the manufacture, possession, sale and availability of morphine and other narcotic drugs are governed by the Narcotic Drugs and Psychotropic Substances (NDPS) Act 1985 (61 of 1985). The Act is aimed at preventing easy availability of these substances for misuse and addiction. The historic amendment of NDPS Rules 2015 came with the aim to ensure easy and uniform availability of opioids for medicinal purposes. All the States/UTs need to revise their narcotics regulation rules as per the recommendations of the NDPS (Third Amendment) Rules 2015. This will avoid any legislative barrier hindering the access and availability of Opioids for medical and scientific purposes.

The opioid analgesics, referred to as Essential Narcotic Drugs (ENDs), included in Narcotic Drugs and Psychotropic Substances (Third amendment) Rules 2015 (NDPS) are Morphine, Codeine, Oxycodone, Hydrocodone, Fentanyl and their salts; out of these Morphine, Codeine and Fentanyl are currently available in India. Codeine, Tramadol and Pentazocine are available from pharmacies on ordinary prescription. Morphine and Fentanyl belong to controlled group of drugs and require special licensing.

As per the NDPS (Third amendment) rules 2015, a single order from the drug controller, instead of the existing practice of 4-5 licenses, would enable Recognized Medical Institutions to procure and dispense ENDs like morphine. It will be mandatory for any hospital/dispensary/medical institution to have at least one registered medical practitioner to apply as a Recognized Medical Institution for possessing, dispensing or selling of essential narcotic drugs for medical purposes:

1.7 Care-giver Support

The caregiver population is expected to increase in future. It is essential to ensure basic support, through multi-sectorial partnerships, to families, community volunteers and other individuals, acting as caregivers under the supervision of trained professionals. There is a general lack of capacity and expertise available for dealing

complex issues faced by this segment of the population. The ‘Caregiver Support’ should include, but not restricted to, the following:

- Imparting education and training to provide cost-effective care at home;
- Counseling to manage and counteract stress;
- Emotional, occupational and bereavement support and counseling;
- Arranging the financial assistance [e.g. Rashtriya Swasthya Bima Yojna (RSBY)/ Concessional rail ticket etc); and
- Sensitizing them to shift from passive to active mode by diverting them with compassion from grief and bereavement (passive mode) to active community palliative care workers (active mode).

Bereavement support should be provided to all bereaved families with special emphasis on those at high risk . Simple interventions, family meetings and brochures concerning grief for families have been found to improve bereavement outcomes and reduce post-traumatic stress disorder. All medical professionals and community workers involved with end of life care should be well accustomed with the identification of bereavement symptomatology (emotional distress and somatic manifestations), effective counseling, psychotherapy and criteria for referral to psychiatrist for intractable and complex cases.

2. POLICY & STRATEGIC FRAMEWORK FOR IMPLEMENTATION

2.1 Objectives

a) To provide basic palliative care services at district level and its integration into district healthcare delivery system.

b) To build capacity for delivery of palliative care services in terms of infrastructure, equipment and human resource.

c) To promote community awareness and participation in the delivery of palliative care services.

d) To broad-base palliative care into other related programs.

2.2 Components

a) Service provision: Provision of basic palliative care services at district level.

b) Capacity Building: Infrastructure development and manpower training in pain and palliative care.

c) Awareness generation through IEC activities: for involvement of community including the care-givers in the delivery of palliative care.

2.3 Strategies

2.3.1 Recruitment of Palliative Care team at district level and establishment of Sate Palliative Care Cell:

Keeping in view the scarcity of specialists in palliative care in the public health delivery system, one Physician, four Nurses, one Multi-task Worker will be appointed in the team on contractual basis. A Program Coordinator and a Data-Entry Operator may also be recruited to coordinate various activities under the program in different districts of the state.

2.3.2 Service provision:

a) Provision of basic palliative care services through OPD and IPD services at district hospital by qualified/trained palliative care professionals.

b) Provision of out-reach services at CHC/PHC by Palliative Care team at fixed interval for providing palliative care to the patients admitted at CHC/PHC.

2.3.3 Training

a) Training of Palliative Care team (Physician, Nurses and Multi-task Worker) in acquiring at least basic palliative care skills at the nearest Medical College/Palliative Care centre.

b) Training of non-specialist doctors, nurses and other healthcare personnel of district/CHC/ Taluk Hospital/PHC in acquiring basic palliative care skills at the nearest Medical College/Palliative Care centre.

2.3.4 Community Awareness

a) Sensitization and training of Community Health Workers and care-givers for acquiring basic nursing skills.

b) The CMHO or District Program Officer will coordinate with State Program Officer for IEC activities in the district.

c) Awareness regarding pain and palliative care and the availability of palliative care resources/centres in the community.

d) Interpersonal communication would be carried out through health care providers and grass root functionaries i.e. Community Health Workers, ASHA, AWW, SHG/ Youth Club, panchayat members etc. for which education material would be developed to facilitate IEC/BCC activities.

2.3.5 Monitoring and Supervision

Reporting will be done to report physical and financial progress made under the program by the State and the district at regular intervals to the Central Program Division. In this regard, Monitoring Performa will be developed by the Central Program Division and shared with State/District Palliative Care Cell/Team.

2.4 Activities

2.4.1 Establishment of State Palliative Care Cell:

The following manpower may be appointed on contractual basis in the State Palliative Care Cell:

Staff	Number
Program Coordinator	1
Data-Entry Operator	1

2.4.2 Recruitment of Palliative Care team at district hospital

The following manpower will be appointed on contractual basis:

Staff	Number
Physician	1
Nurse	4
Multi-task Worker	1

Note: The remuneration of staff will be as per the norms set by HR division of NHM.

*(Terms of Reference for contractual staff under the program is at **Annexe-1**)*

Process of Recruitment

A recruitment committee may be constituted under the chairmanship of Mission Director. Walk in Interview on pre-decided dates may be held for recruiting staff for contractual positions in State Palliative Care Cell and Palliative Care team in the district.

2.4.3 Service provision

(a) At District Hospital level

Outpatient Services:

Given the scarcity of the skilled manpower in palliative care in the country, the services may be provided by doctors and nurses who may be trained in providing only basic palliative care. Thus, all district hospitals covered under National Program for Palliative Care will offer an exclusive palliative care OPD. The expected patient load would determine the frequency of this OPD; it may vary from daily (i.e. on all

working days) to once/twice/thrice a week. The following services should be available in a district hospital at outpatient level:

Registration: All patients attending OPD will be registered in a dedicated register and should receive a unique registration number. This service is linked to record maintenance and thus, patient's unique registration number should be reflected in all the records of the patient. While district hospitals are expected to have a central registration system, the palliative care services should be separate from the hospital registration as this would be important for monitoring and evaluation purpose.

Assessment: All patients should undergo clinical assessment by a trained and competent doctor. The assessment should be geared at formulating a treatment / intervention plan. For the purpose, adequate infrastructure should be available ensuring comfort and privacy for the patients.

Counselling / psychosocial interventions / psycho-education: All patients (and their attendants, if available and only if the patients agree to involve them) assessed by the trained doctor, should receive counselling / psychosocial interventions / psycho-education, as per the clinical needs. For this purpose, it may be necessary to involve a trained medical social worker / counsellor / psychologist from some other National Health Program.

Treatment prescription: Every patient should receive a prescription of the treatment/ intervention plan advised to him. If the procedures for dispensing involves a dispensing slip, that may also be provided to the patient.

The outpatient services should have provisions for both – the new patients as well as for the old patients on follow-up.

Inpatient Treatment Services:

Patients, who require in-patient management, should be admitted in a dedicated ward which is exclusively meant for this purpose. Thus, each district hospital should have an exclusive, 10-bedded palliative care ward. While the duration of the in-patient treatment may vary as per the individual needs of the patients, all efforts must be made to provide in-patient treatment for an adequate length of time. During the in-patient stay, following services should be made available to the patient:

1. Assessment by the doctor(s): At least once per day during the morning rounds.
2. Availability of nursing care: round the clock.
3. Availability of emergency care (on call doctor): round the clock.
4. Psychosocial interventions.
5. Medicines: For management of symptoms/associated conditions.

6. Food.
7. Facility to meet visitors during the specified visiting hours.
8. Recreation facilities: newspapers, television (if available), indoor games.

The in-patient treatment period should be used to formulate the plans for home-based palliative care and the same must be discussed with the patient and care-givers. All admitted patients should be provided with a discharge summary with detailed plan for further care and follow-up from the OPD.

2.4.4 Availability and provision of drugs:

The following drugs for pain and palliative care may be made available at every PHC, CHC/Taluk hospital and district hospital.

Indicative list of drugs at PHC/CHC/ District hospital

S. No.	**Name of Drug**
I	**Anti-inflammatory & Analgesics**
1	T. Aceclofenac + Paracetamol
2	T.Meloxicam
3	T.Paracetamol
4	T. Mefenamic Acid
5	T.Ketorolac DT
II	**Antispasmodics**
1	T.Dicyclomine
III	**Narcotic Analgesics**
	***Weak Opioids*:**

1	T.Codiene
2	T.Tramadol
	Strong Opioids:
1	T. Buprenorphine
2	T. Morphine Sulphate
3	Buprenorphine and Fentanyl Transdermal Patches
IV	**Anti Allergic and Drugs Used In Anaphylaxis**
1	T.Dexamethasone
2	T.Prednisolone
3	Inj. Dexamethasone
4	T. Cetrizine
V	**Anti Epileptic Drugs**
1	T. Sodium Valproate
2	T.Pregabalin
3	T.Gabapentin
VI	**Anti depressents and Anxiolytic Drugs**
1	T. Clonazepam
2	T.Alprazolam

VII	**Anti Fungal Drugs**
1	T. Fluconazole
VIII	**G I T Drugs**
1	Liq. Paraffin + Milk of Magnesia
2	T. Metoclopramide
2	T.Ondonsetron
4	T.Haloperidol
5	T. Bisacodyl
6	T.Sodium Picosulphate
7	Sodium Phosphate Enema
8	Glycerine Suppository
9	Cap. Omeprazole
10	T.Pantaprozole
11	T.Domperidone
12	Liq.Mucaine Gel
13	Sucralfate Suspension
	Others
1	Inj. Nalaxone

2	Lignocane Gel and Viscous
3	Ketamine
4	Hyoscine Butyl Bromide
5	Baclofen
6	Tizanidine

The drugs should be procured through the established channels of the state government.

A system should be put in place, which allows for monitoring and auditing of the dispensing procedure. It must be remembered that some of the medicines used for treatment, like Essential Narcotic Drugs (ENDs), possess abuse liability and risk of diversion. Only authorized persons should be allowed to prescribe / dispense medicines as per the NDPS (Third amendment) rules 2015.

Psychological interventions:

All district hospitals should be equipped with facilities to provide psychosocial interventions. Family members/Care-givers must also be involved in psychosocial interventions as much as possible. While the specialized psychotherapies may be out-of-scope for most of the centres, trained manpower and other facilities must be available for the following psychosocial services:

a. Basic psycho-education about the nature of illness and importance of treatment adherence;
b. Motivation enhancement;
c. Brief Interventions; and
d. Relapse Prevention;

2.4.5 Referral / Consultation / Linkages:

While a comprehensive treatment/intervention program should address multiple needs of the patient, no single centre alone can provide all the services a patient requires. Therefore, it is imperative for the district palliative care centre to establish and maintain referral and consultation linkages with tertiary care facilities.

2.4.6 Outreach services:

The physician/nurse at the district hospital shall visit Taluk Hospital/CHC/PHC to provide pain and palliative care services to the in-patients. The districts may also consider using Tele- conferencing /Telemedicine facilities for linking up with Taluk Hospitals/CHC/PHC for providing support and supervision to general health staff in delivering palliative care.

Continuing care and support to persons requiring pain and palliative care: This includes referral to district hospital and follow up based on treatment plan drawn up by the Physician at the district hospital.

Provision of drugs: All persons requiring long term medications, as prescribed by the Physician at the district hospital, should be able to get their medicines at regular intervals at PHC/CHC for duration as specified by the Physician on its prescription at the district hospital. This is convenient for patients and their care-givers, reduces opportunity costs in continuing medication and frees the Physician at the district hospital from the task of writing routine repeat prescriptions.

2.4.8 Training

An important aspect of the program is the training of district, CHC and PHC healthcare workers (doctors, nurses, Community Health Workers and other peripheral health workers) so that basic palliative care skills are imparted to the trainees. The training may be carried out by training the master-trainers, who would further train other healthcare workers. The health workers may further impart the basic nursing skills of palliative care to the care-givers/family members of the treated persons.

In India, the manufacture, possession, sale and availability of morphine and other narcotic drugs are governed by the Narcotic Drugs and Psychotropic Substances (NDPS) Act 1985 (61 of 1985). The Act is aimed at preventing easy availability of these substances for misuse and addiction. The historic amendment of NDPS Rules 2015 came with the aim to ensure easy and uniform availability of opioids for medicinal purposes. As per NDPS (Third Amendment) Rules 2015, a hospital, dispensary or medical institution, with at least one registered medical practitioner possessing a minimum qualification of a degree in medicine or dentistry and who has undergone training in pain relief and palliative care, is eligible for Recognized

Medical Institution (RMI) under Rule 52N for possessing, dispensing or selling of ENDs for medical purpose. For this purpose, the Ministry has developed a standard 3-day short-term training program/course, after successful completion of which a Registered Medical Practitioner has comprehensive knowledge of types of pain, pain assessment and management and has the competency to safely prescribe, procure, store and dispense ENDs. The detail on 3-day short-term training program/course is at ***Annexe-2.***

Therefore, at least one doctor/registered medical practitioner (MBBS/ BDS) in an RMI should successfully complete one of the following eligibility courses before applying for RMI status:

1. A 3-days basic course in pain relief and palliative care, consisting of 21-hour sessions, developed by the Ministry of Health and Family Welfare, Government of India in consultation with Palliative Care Unit of Dr. B.R.A. Institute Rotary Cancer Hospital, All India Institute of Medical Sciences, New Delhi and other experts in the field of palliative care.

2. IAPC affiliated basic course in palliative care (successful completion of both Parts A and B is mandatory)

3. One-month Certificate Course in Pain and Palliative Medicine.

4. Six-week Basic Certificate Course in Palliative Medicine.

5. Six -week Certificate Course in Pain and Palliative Medicine.

6. One Year Fellowship in Palliative Medicine by Institute of Palliative Medicine.

7. One Year Fellowship in Palliative Medicine by Christian Medical College, Vellore.

8. MD in Palliative Medicine.

Training of doctors and Para-medical Workers

1. The Resource person for the training program may be State Nodal/Program Officer.
2. The Resource person will make a list of doctors and para-medical workers, who would be trained in palliative care.
3. Trainings should be organized in consultations with nearest/attached Medical College/hospital/Cancer Centre/hospice which has indoor palliative care services.
4. At least five doctors/para-medical workers should be posted for each training program.

5. Intimation about the training should be posted well in advance.
6. Trainees who miss the training program should be included in the next batch.
7. Arrangements for stay of the trainees should preferably be made in the Medical College/Hospital/Cancer Centre/hospice to avoid delays in commuting.
8. TA/DA should be paid to the trainees as per NHM financial guidelines.
9. NGOs may be involved in the conduction of the training program as per the guidelines, in this regard, issued by NHM.

2.4.9 Community awareness & participation:

Health can never be adequately protected by health services without the active understanding and involvement of communities whose health is at stake. IEC/BCC is an integral part of any Public Health program. The utilization of health-care services available in the district depend on the extent of awareness about the services in the community. Public awareness through various channels of communication will be organized by the State Palliative Care cell and/or District Unit to sensitize public about the services made available under the program. Mass media through Radio, Television, Print media will be used for public awareness using the most effective channels that have reach to the community. Locally prevalent folk media may also be used to reach the targeted population, particularly in rural and urban deprived population. The IEC activities may be implemented using the NGOs resources in the area.

Participation by an empowered community can address the issue of suffering at the end of life care in a big way. It can help people living and dying with dignity. Less than 15% of people die suddenly. Most of the others die after a period of illness and debility. Under the program, volunteers from the local community may be trained to identify problems of the chronically ill in their area and to intervene effectively, with active support from a network of trained professionals.

(a) Strategies

1. Promote awareness amongst public and policy decision makers regarding the scope of pain relief and palliative care services.
2. 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.
3. Empower the palliative trained staff to orient and educate care-givers/family members in providing home-based care.
4. Empower community and family participation in continued care for the patient through structured care & support educational activities.

5. Ensure involvement of the Local Self Government Institutions through sensitisation workshops for the members.
6. Ensure active support from the media.

(b) Activities

1. Plan and allocate budget to support awareness campaigns regarding the scope of pain relief and palliative care.
2. Design IEC, course modules and manuals for sensitization and training programs for general public.
3. Sensitize healthcare professionals in private and public-private health facilities.
4. Conduct awareness/sensitization programs for regulatory and administrative nodal officers.

2.4.10 Monitoring and Supervision

Reporting will be done by using format prescribed by Central Division to report physical and financial progress made under the different components of the program by the state and the district at regular intervals. (*Monitoring Performa at* ***Annexe-3)***

In addition to this, the State Program/Nodal program officer or the Co-ordinator of the program in the State Palliative Care Cell will visit the districts regularly for monitoring.

3. FINANCIAL GUIDELINES

Financial Provision for State & District under DMHP

Financial Management Groups (FMG) of Program Management support units at state and district level, which are established under NRHM, will be responsible of maintenance of accounts, release of funds, expenditure reports, utilization certificates and audit arrangements.

The funds will be released to States/UTs through the State Health Society to carry out the activities at different levels as envisaged in the operational guidelines. The States shall have the flexibility for inter-usability of funds from one component to another limited to a ceiling of 10%, in order to impart operational flexibility in implementation of this program. A separate bank account in a nationalized bank should be opened for NPPC. The Statement of Expenditure (SoE) and Utilization Certificate (UC), as per GFR 19, shall be submitted in prescribed formats**.**

Financial Assistance under NPPC

The funds will be released to Primary Health Centers (PHC), Community Health Centre (CHC) and district facilities through NRHM structure. The details are given in the guidelines as per unit cost at various levels. The total funds to be released to each state would be based on number of units to be taken up at different levels. Assistance to various facilities/units is summarized below:

Assistance at District level:

I) Recurring:

1. Manpower:

One Physician @ Rs 60,000 per month x 12 months

Four nurses @ Rs. 30,000 per month x 12 months

One Multi task worker @ Rs. 15,000 per month x 12 months

2. Training:

Rs. 2.00 lakh per annum.

3. Miscellaneous (for travel/stationary/communication/drugs etc.)**:**

Rs. 8.00 lakh per annum.

II) Non-Recurring (renovation of PC unit/OPD/beds/ miscellaneous equipments etc.):

Infrastructure strengthening

Rs. 15.00 lakh per annum.

Assistance at State level:

1. **Manpower**

One Coordinator Rs. 60,000 per month x 12 months

One Data Entry Operator Rs. 15,000 per month x 12 months

2. **Miscellaneous** (for travel/stationary/communication/workshop etc.)**:**

Up-to Rs. 0.50 to 1.00 lakh per annum.

It may be noted that the GOI:State share would be 60:40 and in NE states it would be 90:10.

4. PROCEDURE FOR INCLUSION OF PROGRAMME PROPOSAL IN STATE PIP

1. States will be required to submit a consolidated detailed proposal under the program in their NHM state Project Implementation Plan (PIP), which includes the proposed budget for envisaged activities.
2. On receiving the proposals in the Ministry of Health & Family Welfare, Govt. of India, through State PIP, these will be examined by the Central Division and comments will be sent to the states for revision of the proposal, if required. After receiving the revised, it will be examined by the National Program Coordination Committee (NPCC) and approved by the concerned Joint Secretary. Thereafter, the approval will be sent to the NHM division for its inclusion in the final ROP/approval which will be sent to the respective states.
3. The state PIPs are received in the month of February/March every year so that process of issuance of final approval gets over by the month of April. Hence, district health action plan needs to be prepared in the month of December so that the consolidation of State Health action plan (State PIP) can be prepared in the month of January and gets submitted to the Govt. of India in the months of February/March.
4. Based upon these proposals / PIPs from the states, funds will be released to the State Health Society for implementation of the Program as per the activities approved by the National Program Coordination Committee (NPCC), Department of Health and Family Welfare, Govt. of India.
5. The State program/nodal officer for the program will represent the program in the State Health Society and get the grants released to various District Health Societies as per the proposed activities in the District Health Action Plan drawn for the program as per the guidelines.
6. At the district level, the Program Officer (preferably CMO/CDHO) will represent the Program in the District Health Society and facilitate District Health Action Plan for the program. The Physician in the District Palliative Care Unit will act as resource person for preparation of District Health Action Plan for the program.

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The States may modify these guidelines as per their respective needs and circumstances and adopt for implementation of the program at district and below level, in consultation with the ministry.

Annexe-1

Terms of Reference (TORs) for Staff to be appointed at District Hospital

1. Job title: Physician - 1 (One)

Essential Qualifications:

MBBS or equivalent degree from institution recognized by Medical Council of India.

Desirable:

Diploma / Masters in Medicine/Anaesthesia/Radiotherapy from institution recognized by Medical Council of India (MCI)

Experience:

At least 1 year experience of working in a hospital.

Age Limit: up to 40 years.

Job requirements/responsibilities:

a) To examine and manage patients requiring palliative care in OPD/IPD.

b) To refer complicated case to higher care facility.

c) To provide follow up palliative care to the patients.

d) To provide home-based palliative care, if needed.

e) To impart basic palliative care skills to community health workers and other healthcare personnel of district hospital/CHC/PHC.

f) Any other job assigned by concerned officers.

2. Job title: Staff Nurse - 4 (Four)

Essential Qualifications:

General Nursing and Midwifery course from an institute recognized by Nursing Council of India.

Experience :

At least 1 year experience of working in a hospital.

Age Limit: up to 40 years.

Job requirements/responsibilities:

a) To assist Physician in management and follow-up of patients attending palliative care clinic/OPD and those admitted in ward.

b) To provide home-based palliative care, if needed.

c) To impart basic palliative care nursing skills to community health workers and other healthcare personnel of district hospital/CHC/PHC.

d) Any other job assigned by concerned officers.

3. Job title: Multi-task Worker - 1 (One)

Essential Qualifications:

Higher Secondary from a recognized education Board or equivalent.

Experience :

At least 1 year experience of working in a hospital.

Age Limit: up to 40 years.

Job requirements/responsibilities:

a) To assist Physician and nurses in management and follow-up of patients attending palliative care clinic/OPD and those admitted in ward.

b) To assist Physician and nurses in providing home-based palliative care, if needed.

c) Any other job assigned by concerned officers.

Terms of Reference (TORs) for Staff to be appointed at State Palliative Care Cell

1. Job title: State Program Coordinator - 1 (One)

Essential Qualifications:

M.B.B.S from institution recognized by Medical Council of India

Desirable:

Diploma / Masters in Public Health / CHA from institution recognized by Medical Council of India (MCI)

Experience:

a) At least one year experience of working in Health Services / Public Health Program in Non Communicable Diseases.

b) Working Knowledge of operating computers and internet usage.

Age Limit: Up to 35 years. Retired Govt./Public Sector officers up to the age of 62 years are eligible to apply.

Job requirements/responsibilities:

a) Preparing Program Implementation Plan.

b) Organizing state level review meetings and orientation workshops.

c) Organizing training programs for Physicians, Nurses and other healthcare personnel.

d) Reviewing and integrating existing training material into the program.

e) Developing training plan and strategy.

f) Visiting districts to monitor activities under the program.

g) Reviewing program implementation at state, district and below district levels.

h) Collaborating with central team, other states, medical colleges, NGOs etc.

i) Submitting quarterly Monitoring Performa under the program to the concerned officer in the Ministry of Health & Family Welfare, GoI.

j) Any other job assigned by the concerned officer(s).

2. Job title: Data Entry Operator

Essential Qualifications:

a) Graduate in any discipline from a recognized institute.
b) One year diploma in computer application.
c) Typing speed of 40 wpm in English.

Experience:

At least 1 year of relevant working experience preferably in health sector.

Age Limit: Up to 40 years.

Job requirements/responsibilities:

a) Ensure regular entry of all relevant data in the computer pertaining to various aspects of the program in a systematic manner to facilitate its analysis.

b) Analyse data and compile reports.

c) Maintenance and up keep of the computer and its accessories.

d) Any other job assigned by concerned officer(s).

Note: To implement the program effectively, qualified and dedicated personnel must be attracted and retained. The States may exercise flexibility, as per their particular needs, in terms of qualifications, experience and remuneration for the above contractual posts. Any deviation from the above TORs, however, will have to be approved by the Ministry.

Annexe-2

3-Day Short-term Training Program in Pain & Palliative Care

Learning Objectives

1. Understand philosophy and principles of pain and palliative care
2. Pain definitions, types, classification
3. Pain pathway and pathophysiological basis for pain
4. Pain pharmacology and using WHO step ladder
5. Assessment of pain and concept of Total Pain
6. Major types of pain and its management
7. Rational and safe pain prescription
8. Pain related communication
9. Difficult and special pain situations
10. Opioid licensing, procuring, storing and dispensing

At the end of training the candidate should be able to

1. Recognize pain and suffering in patients with chronic and life limiting illness
2. Exhibit interest and openness in dealing with pain and symptoms
3. Perform a thorough history and examination and detailed clinical assessment of pain
4. Identify different kinds of pain and relate pain to underlying pathophysiological mechanisms
5. Know basic pharmacology of analgesics and able to plan rational pharmacological treatment
6. Write rational comprehensive pain prescription and exhibits care while prescribing medications for pain
7. Recognize the impact of pain and physical symptoms on activities of daily living, sleep, mood, sexual activity and other social domains
8. Identify difficult and special pain situations and seek appropriate help.
9. Communicate and advice patients on using both pharmacological and non pharmacological measures for pain management
10. Have the requisite knowledge about opioid licensing, procuring, storing and dispensing of strong opioids.

Duration of training and distribution

Duration of the training is 3 days (21 hours) that has 2/3 (14 hours) of classroom teaching and 1/3 (7 hours) of practical hands on training.

Course structure and curriculum (14 hours of Theory and 7 hours of Practical Training)

THEORY
PRACTICAL TRAINING

Day 1 (7 hours)

Sl. No	Subject Topic	Activity	Duration
1	**Introduction to Palliative Care** Brief History, Concept of Illness and total suffering Principles of Palliative Care, Unmet Needs, Models and types of Palliative Care Delivery, Multi-disciplinary team, Home and Hospice Care.	Lecture	1 hour
2	**Introduction to Pain** Pain definition and Taxonomy Pain Classification (Acute/Chronic/Cancer) Why is cancer pain unique? Concept of Total Pain Pain pathway and mechanisms Breakthrough pain Pain crisis	Lecture	1 hour
3	**Practical training/Bedside teaching** (In Pain and Palliative Care OPDs/Home visits/Hospice/Palliative Care Unit) Pain history taking and examination. Learn about comprehensive pain assessment.	Outpatients Ward round Inpatient PCU Hospice	2 hours

4	**Pain Pharmacology** WHO Step Ladder Step 1 analgesics (NSAIDs and Paracetamol) Step 2 Analgesics (Weak opioids) Step 3 Analgesics (Strong opioids) Adjuvant Analgesics Detailed Pharmacology of Oral Morphine and Transdermal Fentanyl Opioid Titration	Lecture	1 hour
5	**Types of Pain** Somatic Nociceptive Pain Visceral Nociceptive Pain Neuropathic Pain Central Pain Syndromes Malignant Bone Pain	Lecture/Case based learning	2 hours

Day 2 (7 hours)

Sl. No	Subject Topic	Activity	Duration
1	**Assessment of Pain** Emphasizing the subjective nature of pain. Introducing the “OPQRSTUV” model of pain assessment. Pain assessment tools (Unidimensional/multidimensional tools) How to identify neuropathic pain (patient descriptors/tools) Assessment of pain in children, elderly	Lecture	1 hour

	and unconscious patients Evaluation of pain associated impact and disability.		
2	**Total Pain** Pain and suffering Bio psychosocial approach Components and subcomponents of Total Pain Factors that increase/decrease pain tolerance Total pain management approach	Lecture/Case based learning	1 hour
3	**Hands on training/Bedside teaching** See patients in the ward with pain and palliative care needs. Pain history taking and examination. Learn about comprehensive pain management.	Outpatients Ward rounds Hospice	2 hours
4	**Pain Communication** Meaning of pain Basic health related communication in a patient with pain and palliative care needs (Breaking bad news, Collusion, Denial) Basic health related communication in a patient with pain and palliative care needs (Discussing prognosis, goals of care, advanced care planning, end of life care discussion)	Lecture/Role Play based	1 hour
5	**Pain Management** Multimodal Pain management Management of somatic and visceral	Lecture/Case based learning	2 hours

	nociceptive pain. Management of neuropathic and central pain syndromes. Management of malignant bone pain. Principles of pain management Using WHO step ladder, titrating the doses, opioid conversions, managing breakthrough pain and pain crisis.		

Day 3 (7 hours)

Sl. No	Subject Topic	Activity	Duration
1	**Safe prescribing of opioids and managing adverse effects** Comprehensive pain prescription writing Spotting common prescription errors Safety in strong opioid prescription Common adverse effects of opioids and its management. Prevention of common opioid side-effects like nausea and constipation.	Lecture/Problem Solving Exercises	1 hour
2	**Practical aspects involved in handling strong opioids** NDPS act and amendments Opioid Licensing, Drug Controller Opioid procuring (paper work needed), storing (double locking system and safety), record keeping, dispensing, prescription procedures, and safe disposal of unused opioids.	Opioid Pharmacy	1 hour
3	**Hands on training/Bedside teaching** See patients in the ward with pain and	Outpatients	2 hours

	palliative care needs. Pain history taking and examination. Learn about comprehensive pain management.	Ward rounds	
4	**Cancer Pain Syndromes** Cancer related acute pain situations (Diagnostic/Therapeutic interventions, anti-cancer therapy, complications) Cancer related chronic pain situations (Direct tumor related, anti-cancer therapy, complications, Paraneoplastic	Lecture/Case based learning	1 hour
5	**Difficult pain situations** Refractory and Resistant pain Prescribing strong opioids in presence of renal and hepatic dysfunction Pain situations needing parenteral opioids and interventional techniques Special pain situations	Lecture/Case based learning	1 hour
6	**Non pharmacological management of pain** Role of OT/PT and other allied health professionals in pain management Integrative Medicine therapies such as relaxation, yoga, guided imagery, music therapy, acupressure etc. in pain management.	Lecture	1 hour

Assessment

At the end of 3 days, all students will have to appear in an exit MCQ examination and successful candidates with at least 60% of the total marks are eligible to receive the course completion certificate.

Certification

The competent authority of the Training Centre will issue the course completion certificate.

Annexe-3

Quarterly Monitoring Proforma for Palliative Care Activities

1. Reporting quarter & year: 1st/2nd/3rd/4th quarter _____(Year)
2. Name of the District: State/UT:
3. **Contact details of the authorities concerned with implementation of Palliative Care in the district**

District Nodal Officer	**Name & Address***	
	Telephone*	
	Mobile*	
	Fax*	
	Email id*	
	Date of joining	

4. **Status of availability of Manpower at district hospital for carrying out palliative care activities:**

Designation/Positions	**Recruited**
Physician (One)	Yes/No
Nurses (Four)	Yes/No
Multi-task Worker (One)	Yes/No

5. **Status of trainings and capacity building of the health professionals in the district**

Health Professionals	**Total no. in the district**	**Total no. of professionals trained**		**No. yet to be trained**
		In the reporting quarter	Cumulative	

Medical Officers at district hospital/CHC/PHC				
Nurses at district hospital/CHC/PHC				
Nurses				
ANMs				
Others; if any, please specify ……..				

6. **Status of Palliative Care Services available in the district**

A.	***Palliative Care Services – Out Patient Department (OPD) and referral services***		
A 1.	Total no. of new patients seen in the OPD in the reported quarter		
A 2.	Total no. of follow – up cases seen in the OPD in the reported quarter		
A 3.	Total no. of cases referred to tertiary care hospital in the reported quarter		
B.	***Palliative Care Services – In Patient Department (IPD)* at District Hospital**		
B 1.	Availability of In-patient services (Yes/No)		
B 2.	No. of beds available		
B 3.	Total No of patients admitted in IPD		
B 4.	are there any linkages with other NGOs to provide discharged patients with continuing community care		
C.	***Availability and Dispensing of Essential Narcotic Drugs***		
	Drugs	District Level	PHC/CHC Level
		Hint to fill the responses: (A=regularly available,	

		B=irregularly available and NA=not available)	
C1.	Morphine		
C2.	Codeine		
C3.	Dihydrocodeine		
C4.	Methadone		
C5.	Fentanyl		

7. **Financial status – as on ……..**

S. No.	Activity	Budget Received	Expenditure incurred	Balance	Remarks
1.	Manpower				
2.	Training				
3.	Infrastructure strengthening (renovation of PC Unit, Beds, Equipments etc)				
4.	Miscellaneous (travel, IEC, stationary, drugs, communication etc.)				
5.	Any other				
	Total				

Signature of District Nodal Officer
Dated……

(Please send the filled in proforma to Dr. Alok Mathur, Addl.DDG (AM), Room No. 351-A, Ministry of Health & FW, Nirman Bhawan, New Delhi-110011 or at alokmath29@gmail.com on 5th day of every successive quarter)

Quarterly Monitoring Proforma for State Palliative Care Cell

1. **Reporting quarter & year: 1st/2nd/3rd/4th quarter _____**(Year)
2. **Name of State/UT:**
3. **Contact details of the authorities concerned with implementation of Palliative Care in the state**

State Nodal officer	**Name & Address***	
	Telephone*	
	Mobile*	
	Fax*	
	Email id*	
	Date of joining	

4. **Status of availability of Manpower appointed under State Palliative Care Cell**

Designation/Positions	**Recruited**
Co-ordinator (One)	Yes/No
Data Entry Operator (One)	Yes/No

5. **Financial status – as on ……..**

S. No.	**Activity**	**Budget Received**	**Expenditure incurred**	**Balance**	**Remarks**
1.	Manpower				
2.	Miscellaneous (travel, IEC, stationary, workshops, communication etc.)				
5.	Any other				
	Total				

Signature of State Nodal Officer

Dated……

(Please send the filled in proforma to Dr. Alok Mathur, Addl.DDG (AM), Room No. 351-A, Ministry of Health & FW, Nirman Bhawan, New Delhi-110011 or at alokmath29@gmail.com on 5th day of every successive quarter)