National Strategic Framework for Palliative Care Development in Sri Lanka 2018 – 2022

Introduction to Palliative Care

Palliative care is an approach that improves the quality of life of patients (adults & children) and their families who are facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. (WHO)

Palliative care begins at the time of diagnosis of a life-threatening disease (eg. cancer) and continues throughout the disease process until death and into the family's bereavement period as shown in Figure -1.

Fig. 1 Old concept & current concept of spectrum of palliative care

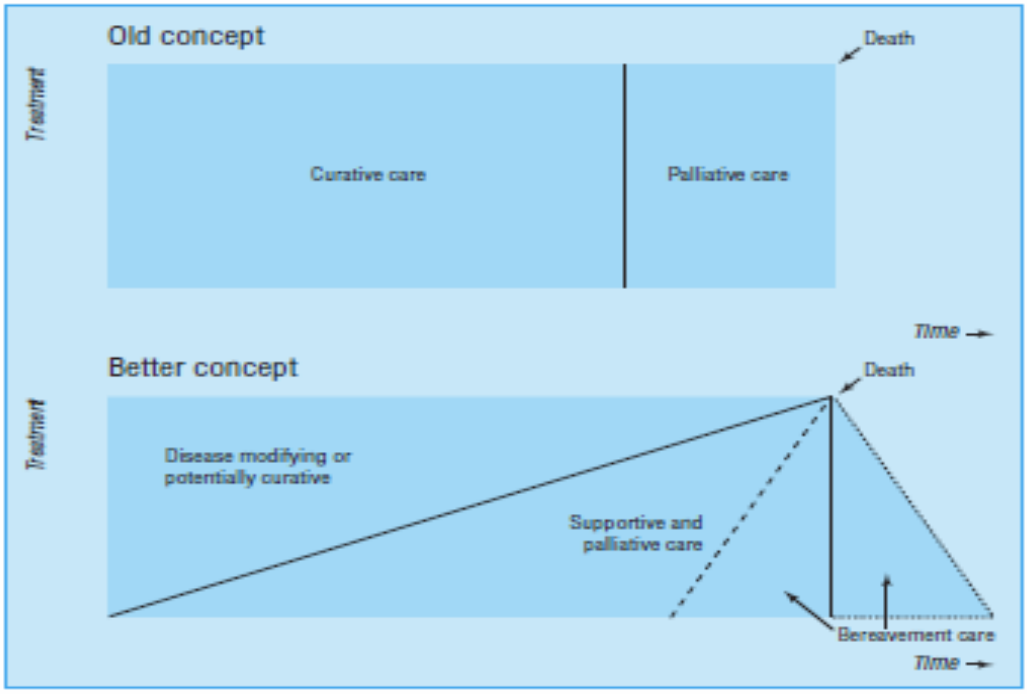


Fig 2 Appropriate care near the end of life. Adapted from Lynn and Adamson, 2003.[7] With permission from RAND Corporation, Santa Monica, California, USA

Ref. Murray, S. A et al. BMJ 2005;330:1007-1011

Palliative care is a right of the every person with life threatening illness to receive appropriate palliative care wherever they are. It is also a responsibility of every health care professional to practice palliative care according to the need irrespective of the illness or its stage and any other characteristic of the patient including age, sex, ethnicity, religion or the income status.

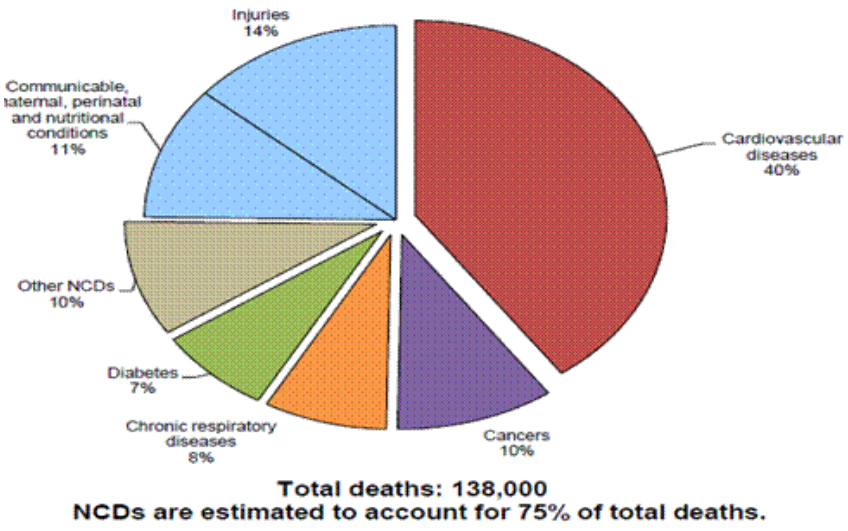
It is estimated that palliative care is needed for 40%-60% of deaths annually. The leading disease conditions which require palliative care for adults and children in global context are listed in table 1.

Table 1: Disease conditions which need palliative care in global context.

Diseases among Adults	Diseases among Children
Cardio vascular diseases (38.5%)	Congenital anomalies (25.0%)
Cancer (34%)	Neonatal conditions (14.6%)
Chronic respiratory diseases (10.3%)	Protein energy malnutrition (14.1%0
AIDS (5.7%)	Meningitis (12.6%)
Diabetes (4.6%)	HIV/AIDS (10.2%)
Chronic kidney disease	Cardio vascular diseases (6.1%)
Chronic liver disease	Endocrine, blood & immune disorders (5.8%)
Dementia.	Cancer (5.6%)
Chronic neurological diseases	Neurological conditions (2.3%)
Congenital anomalies	Kidney diseases (2.2%)
Drug resistant tuberculosis	Cirrhosis of the liver (1.0%)

With the demographic and epidemiological transition, deaths due to chronic non communicable diseases are increasing and it has led to the increasing demand for palliative care services worldwide. According to the cause of death data of year 2014 in Sri Lanka too it is shown that about 75% deaths are occurred due to the chronic non communicable diseases as shown in figure 2.

Fig. 2 Cause of death data of Sri Lanka – Year 2014



Palliative care in Sri Lankan context

Palliative care has been identified under the broad strategic direction of 'Promotion of equitable access to quality rehabilitation care' at the '*Sri Lanka National Health Policy 2016 – 2025*'. It is mentioned that 'The mainstream health system should provide Palliative Care to all patients who are in need of such care for them to live and die with dignity.' In addition palliative care is identified as continuum of care of several other policy documents in Sri Lanka including National Policy & Strategic Framework for Prevention and Control of Chronic Non-communicable diseases (2010), National Policy & Strategic Framework of Prevention & Control of Cancers (2015) and National Elderly Health Policy (2017).

Palliative care has been identified at the Health Master Plan 2016 – 2025. Also palliative care is a prioritized activity of National Multi Sectoral Action Plan for the Prevention & Control of Non Communicable Diseases of year 2016 – 2020.

Overall Goal

Promote quality of life, respect dignity & life style and ensure holistic support system to patients with life threatening illnesses and their families through evidence-based, multi-disciplinary and cost effective approaches.

Strategies

1. Include palliative care as an essential component of comprehensive health care
2. Integrate palliative care services at all levels of care: tertiary, secondary, primary and at community level.
3. Ensure availability of skilled multi disciplinary human resources for delivery of palliative care services at institutional and at community levels.
4. Ensure availability & adherence of protocols & guidelines in palliative care
5. Ensure availability of essential drugs & technologies for provision of palliative care at all levels: tertiary, secondary, primary and community level
6. Build partnerships with government and non-governmental organizations for delivery of palliative care
7. Empower family members, care givers for the provision of palliative care
8. Encourage research related to palliative care
9. Ensure adequate financing & resource allocation for cost effective delivery of palliative care
10. Facilitate strengthening legislative framework for delivery of palliative care
11. Ensure availability of management information system to monitor palliative care services

Strategies & Major activities

1. Include palliative care as an essential component of comprehensive health care

Major Activity	Expected output	Indicator	Means of Verification	Time Frame	Responsibility
1. Include policies related to palliative care in the national health policy	Palliative care is prioritized in delivery of health care	Inclusion of palliative care in the national health policy	National health policy document	2018-2019	Secretary /Health DGHS D/Policy Analysis & Development
2. Develop national palliative care policy linking national health policy & other related health & non health policies	Comprehensive approach to palliative care is facilitated.	Availability of national palliative care policy (Stand alone policy)	National palliative care policy document	2018-2019	DGHS D/Policy Analysis & Development
3. Identify palliative care as a component of other related health policies & non health policies	Palliative care is included in continuum of care linking primary prevention, early detection & treatment programmes	Inclusion of palliative care in other health related policies	Other health related policy documents Eg. 1.NCD Policy 2.Cancer control policy 3.Primary care policy 4.Elderly health care policy 5. HIV/AIDS policy 6. Medicinal Drug Policy 7. Social Services Policy	2018-2019	D/Policy Analysis & Development D/NCD D/NCCP D/Primary Care D/YEDD D/NSACP Ministry of Social Services
4. Establish a National Steering Committee on Palliative Care	Availability of functioning committee to coordinate activities at national level.	No. of meetings conducted per year	Reports & minutes of the steering committee meeting	2018-2019	DGHS

Major Activity	Expected output	Indicator	Means of Verification	Time Frame	Responsibility
5. Incorporate palliative care at the national & regional health development agenda	All stake-holders are actively involved in delivery of palliative care	No. of meetings palliative care is discussed per year	Minutes of health development committee (HDC) meetings, Minutes of Provincial committee meetings.	2018 - 2020	DGHS PDHS RDHS
6. Conduct advocacy programmes to obtain support from all stakeholders	All stake-holders are actively involved in delivery of palliative care	No. of advocacy programmes	Report of advocacy programmes	2018- 2020	Nat. Steering Comm. on Palliative Care D/NCCP D/Primary Care D/NCD Palliative Care & End of Life Care Task Force of SLMA Palliative Care Association Professional Colleges

2. Integrate palliative care services at all levels of care: tertiary, secondary, primary and community level

Major Activity	Expected output	Indicator	Means of Verification	Time Frame	Responsibility
1. Establish designated palliative care team within the hospital setting.	Team members of the designated palliative team are aware about their key tasks.	No. of hospitals with palliative care teams	Reports	2018- 2020	DGHS Nat. Steering Comm. on Palliative Care DDG (MS 1) Director /MS of the hospital
2. Commence *'Palliative care consult services'* at the tertiary & secondary care level to deliver all aspects of palliative care (*Annex 1 & 1.1)* '	Palliative care consult services are available with the participation of Consultants, medical officers, nursing officers, physiotherapists, occupational therapists, pharmacists, social workers etc at tertiary & secondary care.	No. of palliative care consult services	Reports	2018- 2020	DGHS Nat. Steering Comm. on Palliative Care DDG (MS 1) DDG (NCD) PDHS/RDHS Director /MS of the hospital D/NCCP Director /NCD
3. Link palliative care centres / hospices with palliative care consult services	Palliative care centres / hospices are linked with closest palliative care consult service	No. of palliative care centres / hospices with direct links with palliative care consult services	Reports	2018- 2020	DGHS DDG (MS 1) DDG (NCD) Nat. Steering Comm. on Palliative Care
4. Integrate palliative care at primary care institutions & general practitioners	Palliative care is delivered for those who need at the closest health setting	No. of patients received palliative care at the primary care	Survey report	2018- 2020	DDG (MS II) D/Primary Care D/NCCP D/NCD Professional colleges

Major Activity	Expected output	Indicator	Means of Verification	Time Frame	Responsibility
5.Conduct pilot projects on home based palliative care including involvement of primary care institutions & general practitioners and scale up	Experience is gained to scale up the home based palliative care	No. of Projects; No. of patients received home based palliative care	Project evaluation reports	2018-2020	DDG (NCD), DDG (MS II) DDG (PHS I & II) PDHS; RDHS D/NCCP; D/Primary care SLMA Palliative Care Association Other NGO
6. Advocate for appointing a 'community nurse' and ensure her role in palliative care at home based setting.	Community nurse is actively involved in delivery of palliative care at family level	No. of Community nurses involved in palliative care	Report	2018-2020	DGHS DDG (PHS II) PDHS; RDHS Director/Nursing (Public Health)

3. Ensure availability of skilled multi disciplinary human resources for delivery of palliative care services at institutional and at community levels.

Major Activity	Expected output	Indicator	Means of Verification	Time Frame	Responsibility
1. Develop human resource deployment plan for palliative care (Annex 1 & 2)	Human resource requirement in different categories and different levels of care is identified.	Availability of human resource deployment plan for palliative care	Report	2018-2019	DDG (Planning) Director (Planning)
2. Commence specialist training programme for palliative medicine (MD in Palliative Medicine)	Consultants in Palliative medicine are available in Sri Lanka	No. of trainees enrolled for MD palliative medicine	Reports of PGIM	2018- 2021	Secretary / Health; DGHS, DDG (Planning) DDG (MS 1), DDG (ET & R) Director / PGIM
3. Include module on palliative care in relevant specialist training programmes	Palliative care services are delivered at the different specialist health settings.	No. of specialist training programmes containing palliative care module	Reports of PGIM	2018-2020	Director / PGIM DDG (MS 1), DDG (ET & R) Boards of Studies at PGIM Professional colleges
4. Commence a Post Graduate Diploma in Palliative Medicine for medical officers	Medical officers are specially trained on palliative medicine	Availability of Post Graduate Diploma Programme in Palliative medicine	Report of Post Graduate Inst. of Med. (PGIM)	2018-2019	Director / PGIM DDG (MS II), DDG (ET & R)
5. Commence a post basic diploma programme in palliative nursing for nursing officers	Nursing officers are specially trained in palliative care	Availability of post basic diploma programme in palliative care for nurses.	Report of Post Basic School of Nursing	2018 -2019	DDG (ET & R) Director (Nursing Education) Principal (Post basic Nursing School)

Major Activity	Expected output	Indicator	Means of Verification	Time Frame	Responsibility
6. Include aspects of palliative care in basic / under graduate training programmes of Medicine, Nursing and other relevant health related disciplines	Health care workers are trained in palliative care at their initial training	No. of study hours / length of course in palliative care in each training programmes	Reports of teaching programmes & audits	2018 – 2020	DDG (ET & R) DDG (MS 1) Director – Nursing (Training) Dean / Faculty of Medicine, Nursing or Allied Health Sciences Professional Associations
7. Develop and conduct in service training programmes in palliative care for medical officers, nursing officers, pharmacists etc.	Health care workers are trained regularly in palliative care	No. of study hours / length of course in palliative care in each training programmes	Reports of teaching programmes & audits	2018 – 2020	DDG (ET & R) DDG (NCD), DDG (MS II) D/NCCP, D/Nursing (Medical Services) Professional Associations

4. Ensure availability & adherence of protocols & guidelines in palliative care

Major Activity	Expected output	Indicator	Means of Verification	Time Frame	Responsibility
1. Develop protocols & guidelines for delivery of palliative care	Palliative care protocols & guidelines are developed for health care staff.	Availability of protocols & guidelines	Reports on protocols & guideline	2018 – 2020	DDG MS I & II D/NCCP D/NCD D/Primary care SLMA, Professional colleges
2. Facilitate availability of protocols & guidelines in palliative care at the service delivery points	Palliative care protocols & guidelines are available for health care staff.	% of units guidelines are available	Survey reports	2018 -2020	DDG MS I & II Director /MS of the hospital PDHS/RDHS Consultants
3. Review the adherence of guideline at palliative care setting through clinical audits	Best possible care is offered with the use of existing resources	Proportion of patients received care according to guideline	Audit reports	2018 -2020	Director /MS of the hospital PDHS/RDHS Consultants
4.Include aspects of palliative care to the quality assessment tools and quality improvement projects	Quality assurance is ensured at every level of care	Proportion of palliative care settings introduce quality assessment tools	Quality assurance report	2018 -2020	DDG MS I & II Director/ Health Care Quality Director /MS of the hospital PDHS/RDHS Consultants

5. Ensure availability of drugs & technologies for provision of palliative at all levels of care: tertiary, secondary, primary and community level

Major Activity	Expected output	Indicator	Means of Verification	Time Frame	Responsibility
1. Attend to the relevant amendments to the existing legislation regarding availability & prescription practices of controlled drugs especially Morphine	Pain relieving medications are adequately prescribed	Availability of amendments	Amendments to Dangerous drug control act	2018 – 2019	Legal Draftsmen Dept. National Dangerous Drug Control Board; Legal Officer, Ministry of Health
2. Include WHO model list of essential medicines (adult & children) for palliative care in national list of essential medicines	Essential medicines for palliative care are available at health care settings	Availability of palliative care drugs at the list of essential medicines	National list of essential medicines	2018 – 2019	DGHS NMRA DDG/ MSD, D/MSD Professional colleges
3. Prepare list of drugs need for palliative care for each level of health facility	Palliative care drugs are available at each level.	Availability of list of palliative care drugs at each level	Report	2018- 2019	DDG/ MSD, D/MSD Professional colleges
4. Ensure continuous supply & availability of palliative care drugs at all levels of care	Adequate amounts of palliative care drugs are available throughout the year.	Proportion of hospitals of each district where morphine is available	Reports & returns	2018- 2020	D/MSD Director/ MS of TH,PGH,DGH, BH
5. Determine & obtain medical technologies required for palliative care according to the need at each level	Necessary medical technologies (eg. Syringe drivers for pain management, PEG tube) are available	Proportion of hospitals of each district where specific medical technologies for palliative care are available	Report	2018-2020	DDG (MSD) DDG (BME) D/MSD Director/ MS of TH,PGH,DGH, Professional colleges BH

6. Build partnerships with government and non-governmental organizations for delivery of palliative care

Major Activity	Expected output	Indicator	Means of Verification	Time Frame	Responsibility
1. Identify government and non-government organizations involved in palliative care	Facilitate networking among palliative providers & understanding of their roles and areas of work	Availability of list of organizations at national & sub national level	Reports	2018 – 2020	National Steering Committee DGHS PDHS RDHS
2. Develop networks nationally & regionally among organizations coordinating or providing palliative care	Coordinated service provision is ensured	No. of functional coordinated services.	Reports	2018– 2020	Ministry of Health Dept. of Social Services D/NCCP, D/Primary care SLMA Palliative Care Association of Sri Lanka NGOs
3. Advocate to obtain support of community and religious based organizations in the delivery of palliative care	Aspects of palliative care are delivered at home level by the volunteers.	No. of patients received palliative care	Survey Reports	2018 – 2020	Ministry of Health Dept. of Social Services Religious leaders
4. Expand networking with international organizations to strengthen palliative care	International experience & support is received to strengthen palliative care	No. of international organizations	Reports	2018 – 2020	National Steering Committee DGHS Professional Colleges WHO Country office

7. Empower family members, care givers for the provision of palliative care

Major Activity	Expected output	Indicator	Means of Verification	Time Frame	Responsibility
1. Create awareness & their responsibility amongst general public on palliative care and service availability	General public is aware about palliative care needs, services & their responsibility	No. of programmes conducted	Survey	2018 - 2020	D/NCCP D/Primary Care D/NCD PDHS; RDHS Palliative Care & End of Life Care Task Force of SLMA Palliative Care Association Professional Colleges
2. Empower family members & care givers for delivery of palliative care	Family members are empowered.	No. of programmes conducted. No. of educational materials developed.	Reports	2018- 2020	D/NCCP D/Primary care D/NCD D/YEDD NGOs
3. Facilitate establishment of self-help / support groups for palliative patients	Community organizations are formed.	No. of groups	Reports	2018- 2020	PDHS; RDHS Dept. of Social Services, NGO; Civil Society;

8. Encourage research & clinical audit related to palliative care

Major Activity	Expected output	Indicator	Means of Verification	Time Frame	Responsibility
1. Identify research needs on palliative care	Priority research needs on palliative care are identified.	Availability of list of research needs in palliative care	Reports of palliative care research needs	2018 – 2020	Nat. Steering Comm. on Palliative Care DDG/ET & R D/ Research
2.Facilitate research related to palliative care	Palliative care research is conducted at different levels	No. of research related to palliative care	Reports of research related to palliative care	2018– 2022	DDG/ET & R D/ Research Universities
3. Disseminate findings of research related to palliative care	Palliative care services are improved based on research evidence	No. of published research related to palliative care in Sri Lanka	Published research reports	2018-2022	DDG/ET & R D/ Research Universities
4.Apply research findings related to palliative care	Research evidence is applied to improve the palliative care practice.	No. of research evidence used for palliative care practice	Reports	2018-2022	Nat. Steering Comm. on Palliative Care Professional colleges
5.Conduct clinical audits at palliative care setting	Palliative care services are improved based on clinical audit	No. of clinical audits related to palliative care conducted.	Report of clinical audit	2018-2022	Directors/ MS of the hospital Professional colleges

9. Ensure adequate financing & resource allocation for cost effective delivery of palliative care

Major Activity	Expected output	Indicator	Means of Verification	Time Frame	Responsibility
1. Advocate for regular budgetary allocations for the sustainable delivery of palliative care at national & provincial level.	Financing mechanism is available for the cost effective delivery of palliative care	Financial allocation for palliative care	Reports of annual action plan	2018-2022	DGHS DDG (Planning) DDG (MS I), DDG (MS II), DDG (NCD) DDG (Finance) Hospital Directors / MS PDHS /RDHS
2. Encourage private sector to allocate finances to expand palliative care services at the private sector.	Palliative care services are available at the private sector	Financial allocation for palliative care at Private sector	Reports	2018-2022	DGHS D/PHSD Private Medical Institutions Regulatory Council

10. Facilitate strengthening legislative framework for delivery of palliative care

Major Activity	Expected output	Indicator	Means of Verification	Time Frame	Responsibility
1.Identify existing legislative provisions and utilize those for delivery of palliative care	Patients with palliative care needs and palliative care service providers are protected legally.	Availability of legislative framework	Legislative Reports	2018-2022	Nat. Steering Comm. on Palliative Care DGHS Legal officer / Ministry of Health
2. Identify legislative needs for provision of palliative care & develop new legislative procedures	Patients with palliative care needs and palliative care service providers are protected legally.	Availability of new legislative framework	Legislative Reports	2018-2020	Secretary /Health DGHS Nat. Steering Comm. on Palliative Care Legal officer / Ministry of Health Attorney General Department

11. Ensure availability of management information system to monitor palliative care services

Major Activity	Expected output	Indicator	Means of Verification	Time Frame	Responsibility
1. Develop & introduce indicators to monitor palliative care in consultation with stakeholders	Palliative care service delivery is monitored at all levels	No. of M & E indicators	Report	2018-2020	Nat. Steering Comm. on Palliative Care DGHS DDG (Planning) Director (Information) PDHS /RDHS
2.Incorporate palliative care monitoring indicators at the management information system (MIS)	Standard palliative care services are being evolved.	No. of M & E indicators at the MIS	management information system (MIS)	2018-2020	Nat. Steering Comm. on Palliative Care DDG (Planning) Director (Information) PDHS /RDHS Hospital Directors / MS

References

1. Planning & implementing palliative care services : A guide for Programme Managers, WHO 2016
2. 'Palliative care in Sri Lanka' – Mission Report submitted to International Atomic Energy Agency (IAEA), October 2012
3. National Policy & Strategic Framework on Prevention & Control of Cancers in Sri Lanka - 2015
4. Recommendations of Sri Lanka College of Oncologists on Palliative care of cancer patients in Sri Lanka, 21.03.2017
5. Letter on 'Development of Palliative care services in Sri Lanka' send by Asia Pacific Hospice Palliative care Network 03.05.2017
6. Concept paper of the Palliative care & End of Life care Task Force of Sri Lanka Medical Association
7. Proposal on Palliative care submitted by Palliative care Association of Sri Lanka to the National Health Strategic Master Plan 2016 – 2025
8. Murray, S. A et al. ' Illness trajectories & palliative care', BMJ 2005;330:1007-1011

27.03.2018

ANNEX 1

Strategic Objective 2 :- Integrate palliative care services at all levels of care: tertiary, secondary up to base hospital level, primary and community level

2.1 Palliative Care Services at the tertiary & secondary care level

These services can be developed in phased out manner according to the need, institutional preparedness to develop the services and availability of human resources at tertiary & secondary care.

Director or the Medical Superintendent of the hospital should coordinate with all stakeholders when commencing the formal palliative care services at the hospital.

Human Resource

(i) Consultant - Team leader

Consultant Palliative care physician will be the team leader of the palliative care service. Until Consultant Palliative Care Physician is available, any other specialist board certified in the PGIM as a specialist to the relevant hospital or serving as an honorary capacity (Eg. University) can be appointed as the team leader.

Every patient that qualifies for palliative care must be identified only by a referral from specialist consultant in the relevant field and the name of referring consultant should be mentioned in the registration. Referring consultants at the hospital will need to liaise with the team leader of the Palliative Care Consult Service (PCCS), for arranging the optimal palliative care for the patients. The referring consultant may work in partnership with the PCCS team leader or may hand over the entire patient care to the team leader.

(ii) Medical Officers

At least one Medical Officer needs to be available on a full time basis under the supervision of the PCCS team leader. When medical officers with post graduate diploma in palliative medicine are passed out, those medical officers are preferred to be appointed to the PCCS.

(iii) Nursing Officers

When nursing officers with post basic certification in palliative nursing are available those officers need to be appointed to the PCCS. Until then, experienced and committed nursing officers having trained on the basics of palliative care can be appointed.

At least one nursing officer needs to be available on a full-time basis for PCCS

(iv) Allocate a Social Service Officer – After communicating with district social services officer, social services officers can be arranged.
These Social service officers need training in the basic concepts of Palliative care and the role of the social worker in Palliative care

(V) Counsellor – If available in the hospital

(VI) Pharmacist – One of the hospital pharmacists should be part of the PCCS team

(vii) Health Assistants – Male & Female

In addition to above mentioned officers, Physiotherapists, speech therapists, occupational therapists, psychologists, counselors, nutritionist etc. are ideally needed for optimal service delivery (Establishing extended 'Palliative care team').

Space & Equipment
Space for consultations for consultant, medical officers, nursing officers
Equipment – 1 desktop computer, Printer, portable hard disk,
Filing cabinet

Necessary medicines & equipment for patient management
Eg. Essential medicines
Equipment - Wheelchair, home oxygen, folder beds

Every Palliative Patient must have an identity to fast tract services in the hospital as well as other public institutions preventing them waiting in the queue.

Services
1. Outpatient clinic sessions
Initially one clinic session per week can be conducted, later the number of sessions to be increased as per institutional need.

2. Palliative care in- patient consult service
This consult service should receive and accept referrals from any unit of the hospital. The patient remains under the care and in the ward of the referring consultant. The palliative care team needs to visit each patient and provide advice and inputs on a daily basis or as needed basis.

3. Linking with Palliative care services at primary care

Shared care plan arising from palliative care consult service, need to be utilized to communicate with the responsible primary care (Divisional Hospitals/Primary Medical Care Units/General Practitioners).
The goals of care need to be communicated to the primary care. This should be communicated in a common structured format, preferably as an e-document.

4. Linking up with other government & non-government institutions
Coordinate with hospices, Social Service officers attached to Divisional Secretariat Offices, Non-governmental organizations etc.

2.2 Palliative care services at the Primary Medical Care Institutions (PMCI)

Provision of care for the patients who need palliative care services will be the responsibility of the primary medical care institution. Those patients are registered at the primary medical care institutions (Divisional hospitals & Primary medical care units) as part of the shared care plan.

All medical officers and nursing officers at the PMCI need to be trained on palliative care.

Patients have to be sent to the primary care with a shared care plan from the palliative care consult service. Patients can be referred back for complex care if needed.

The services at primary care need to be linked with the patient's General practitioner, local MOH office, local religious leaders, community based organizations & volunteers etc according to the need and wishes of the patient.

Guidelines on palliative care at primary care level for medical officers and nursing officers need to be available.

All care givers need to be educated and empowered by regular multi disciplinary team (MDT) meetings and family discussions.

2.3 Palliative care services at the home-based level

Home-based palliative care must be headed by the primary medical care institution where the patient is registered or with the patient's General Practitioner, as a part of shared care plan of the specialist consult service. This service should link up with the nearest primary care medical institutions and the secondary care hospital for specified advanced care if needed.

A uniform training should be given to all the General Practitioners on caring for palliative patients.
With the appointment of community nurse (Public Health Nursing Officer), delivery of home-based palliative care can be initiated and linked with the closest primary health care institution. Until then existing initiatives mainly coordinated by hospitals and non-governmental organizations (NGO) need to be supported.

Relevant Primary medical care institutions require to coordinate with the patient's General Practitioner and/or patient & family members to provide necessary supportive care. Area MOH office can further help the primary medical care institution with its field staff. Family members can be educated and empowered to provide supportive care for the palliative patients.

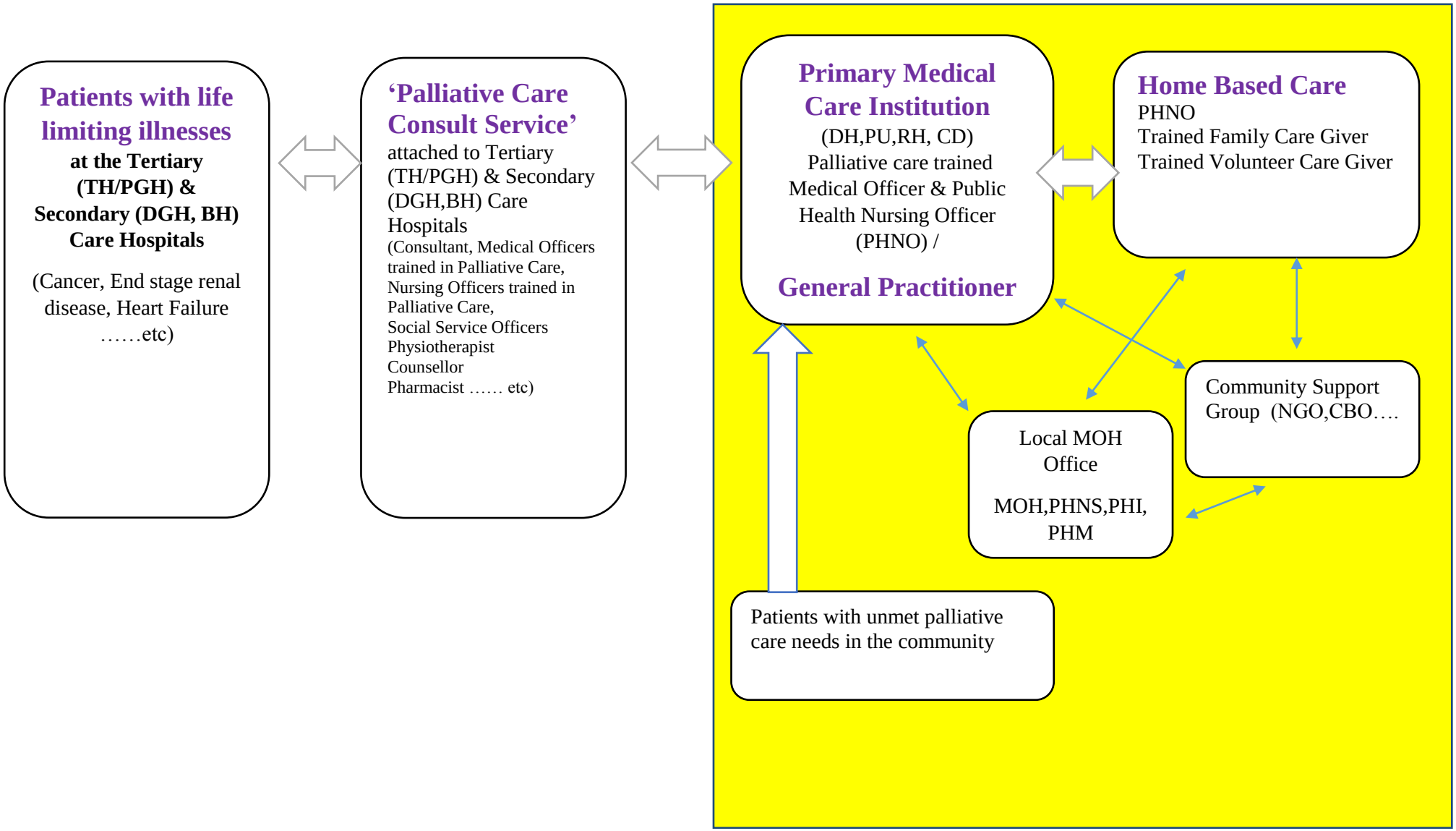
A palliative care consultation helpline could be established to support all primary care doctors including General Practitioners.

Regular audits ad reviews, with patient and public feedback, are recommended to improve on the service delivery

ANNEX 1.1

Proposed Model for Delivery of Palliative Care

(Institutional Care to Community Based Care)



JOB DESCRIPTION

MEDICAL OFFICER (PALLIATIVE MEDICINE)

1	**Post Number:**	
2	**Job Title:**	Medical Officer (Palliative Medicine)
3	**Grade:**	Medical Officer (Grade I /II)
4	**Accountable To:**	DGHS, PDHS
5	**Reports to:**	Director of TH or PGH, Medical Superintendent of DGH or BH These officers will be appointed to **Teaching Hospitals (10), Provincial General Hospital (3)**, **District General Hospital** (**18**), **Base Hospital Type – A** (**22**), **Base Hospital Type –B** (**46**) in phased out manner.
6	**Responsible For:**	Provision of palliative care for the patients whom are referred from specialist units (Oncology, Nephrology, Neurology, Chest Medicine, Rheumatology, General Medicine, Paediatrics etc.) Coordination of palliative care activities up to the community level in coordination with both curative & public health institutions and with other organizations.
7	**Key Relationships:**	This officer will be appointed to the palliative care consult service at the hospital. Until Consultant Palliative Care Physicians are available, a consultant at the hospital will be in-charge of the palliative care consult service.
8	**Key Purpose:**	To provide palliative care under the guidance of the consultant in-charge of the palliative care consult service.
9	**Key Tasks**	Provision of **clinical palliative care** for patients whom are referred from specialist units under the guidance of consultant in charge. Maintain the **palliative care registry** of the hospital **Training** health staff and community volunteers in palliative care **Coordination** of palliative care up to the community in

		coordination with curative and public health institutions and with other organizations • **Coordination** with Primary medical care institutions (Divisional Hospitals and primary medical care units) • **Coordination** with MO/NCD, MO / Mental Health, RSPHNO,HEO of the district and Medical Officers of Health (MOH) • **Liasing** with other provincial & district government officials (eg. Government Agent, Social Services Officer etc) • **Liasing** with non governmental organizations (NGO) and Community Based Organizations (CBO) in relation to provision of palliative care **Monitor prescription** & **utilization pattern of Morphine** for palliative care patients **Participate** in-service training programmes on palliative care at district level as a resource person Encourage & facilitate **research** related to palliative care **<u>Palliative care for cancer patients</u>** Coordinate palliative care for the cancer patients and their care givers with the guidance of Consultant Oncologists at the Provincial or District Cancer Treatment Centres & Director – National Cancer Control Programme Attend to District Cancer Control Committee Meetings conducted at the RDHS office.
10	**Person Specification.**	MBBS or equivalent qualification with Post Graduate Diploma in Palliative Medicine Till medical officer with above qualification is available, experienced medical officers can be appointed.

11	**Officers reporting to Medical Officer /Palliative Medicine**	Nursing officer with training in palliative nursing Programme & Planning Assistant (PPA)
12	**Responsibility of Facilities & Resources**	
13	**Facilities entitled**	Working space at the Out Patient Department of the hospital for palliative care consult service Arrangement of transport facilities when needed from the hospital or RDHS Office to attend to out-reach activities and coordination of work
14	**Special circumstances affecting the job**	Need to collaborate with other health units of the district and other organizations and agencies in the district including Non Governmental Organizations.