Agartala, Tripura, February

Tripura is situated in the far northeast of India, surrounded on 3 sides by the country of Bangladesh. Historically, the population is made up of many tribes and 90% of the approx. 4 million population live in rural areas. The State is considered very poor and the overall literacy rate is 88%. Tripura consists of 8 Districts, which are locally governed. The society remains very traditional and male-oriented with family relations and structures seen to be very important. Children are strongly encouraged to study and families who are able, often send them away to pursue educational opportunities elsewhere. The combination of these factors makes care of the elderly and ill very challenging, regardless of the site of care.

<table>
<tr><td colspan="2">Site
Agartala Regional Cancer Centre (ARCC)
ARCC is the only public cancer centre in Tripura and it cares for the poor. Patients travel great distances to access treatments and family members provide all personal care in the wards. All types of staff are very limited and struggle with huge workloads. Professional roles are strictly delineated. There are 100 inpatient beds: 4x25 bed wards, 2 male and 2 female. The great majority of patients present with Stage 4 cancer.</td></tr>
<tr><td>Year of Visit
2013 (first visit)</td><td>Year of Visit
2018 (fourth visit)</td></tr>
<tr><td>Participants from APLI
Dr Christine Drummond, Senior Palliative Medicine Consultant, Northern Adelaide Specialist Palliative Care Service, South Australia
Mrs Valerie Hughes, Clinical Practice Consultant, Northern Adelaide Specialist Palliative Care Service, South Australia.</td><td>Participants from APLI
Dr Christine Drummond, Senior Palliative Medicine Consultant, Central Adelaide Local Health Network, South Australia
Ms Maite Uribe, Nurse Practitioner Candidate, Southern Adelaide Palliative Services, South Australia.
Shalini AJ, Project Officer, Pallium India</td></tr>
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Agartala Palliative Care Team:
• Dr Gautum Majumdar, Medical Superintendent and Medical Oncologist
• Dr Amit Kumar Datta, Deputy Medical Superintendent and Medical Oncologist
• Dr Badhan Janapathy (completed 6 week TIPS training)
• Ms Laxsmi Sengupta, Community Nurse
• Ms Rita Saha, Community Nurse (completed 6 weeks TIPS training)
• Social worker in community as needed
• Soon to join:
  ○ Dr Bijan Saha
  ○ 2 male nurses: Tapash Chakraborty, Manohar Ali
	Agartala Palliative Care Team:
	• Dr Gautum Majumdar, Medical Superintendent and Radiation Oncologist
	• Dr Amit Debburman
	• Dr Badhan Janapathy (6 weeks TIPS training)
	• Ms Rita Saha, Nurse (6 weeks TIPS training)

Objectives of the visit: • To begin to develop an understanding of the culture, politics, economics and geography of Tripura and how this relates to development of palliative care. • To demonstrate flexibility in approach to supporting the palliative care service, rather than presenting a prescriptive approach; we were prepared to do what was requested of us and keep open minds. • To focus on developing friendly, open and respectful professional relationships with all staff. • To take advantage of any reciprocal educational opportunity that presented.	**Aims of the visit:** • To strengthen supportive, professional relationships with the staff of the Regional Cancer Centre in Agartala, especially the palliative care team, in order to enhance reciprocal learning opportunities. • To promote the development of the palliative care service in Tripura, especially through support of Dr Majumdar. • To build international friendships between palliative care colleagues and improve cultural awareness.

• To plan for our second visit in conjunction with the Tripura team.	
Potential threats to achieving objectives: • State election preventing exposure to community • Presenting an arrogant or inflexible approach • Either of us becoming ill or being emotionally overwhelmed	**Potential threats to achieving aims:** • A lack of opportunity to truly support Dr Majumdar from a political perspective • A lack of initiative from many of the staff members including senior officers in RCC • Illness, especially through contact with food or water we are unable to tolerate • Lack of resources – for example, RCC did not have simple dressing material to do dressings for affected patients.
Summary: • The team spent time in the in-patient setting of the RCC to gain first impressions of the working of the center and also assisted with the care of several patients • The team provided significant interactive educational opportunities to a variety of staff. • Many practices were questioned to understand their origins, to provoke thought about them and confront practices which the mentors considered required improvement. • The APLI team visited the Agartala Medical School and meet the Principal and CEO. The team also visited the Spiritual Centre of the Brahma Kumaris, who provide regular meditation sessions at the RCC for the spiritual care of patients and their families. • Dr Majumdar organized a media interview during which we discussed the concept of palliative care, which was broadcast on a	**Summary:** • Dr Majumdar has continued to worked tirelessly to significantly bring in improvements and upgrading of facilities at the RCC in recent years. Eg. purchasing several wheelchairs between 2014 and 2015 along with supervising the construction of a multi-story, surgical centre alongside the existing hospital for 4 years. Several factors have resulted in this being a protracted project, which is frustrating the State Government, but over which Dr Majumdar has only limited influence. • There were education sessions for the nurses and bedside teaching, which made a significant difference to the care of several patients. Practices were questioned as much to understand as to provoke thoughtful reflection. The APLI team was able to directly confront practices considered required improvement, as a result of having developed a long-term relationship.

30 minute health programme on television the week after the team's visit. • Dr Majumdar heads a small team of local champions dedicated to the progression of palliative care in Tripura. Discussion occurred regarding options for identifying and enhancing clinical leadership skills amongst key RCC staff. • Key RCC staff members require significant ongoing education in palliative care principles and practice to ensure best clinical practice within the RCC and opportunities for teaching and modeling practice to other staff members. o Some palliative care team members had had no basic education in palliative care – attending the 6 week course in Pallium India was difficult due to financial and logistic constraints, participants instead attended a course offered in Kolkata. o Dr Naveen Salins, agreed to provide assistance with the possibility of conducting a clinical education course during our next visit o The APLI team committed to providing on site, case-based clinical training to empower healthcare workers to translate knowledge into practice. • Tripura currently has only one small team to cater to the needs of the population. Both teams have decided to develop a 10 year plan to achieve Dr Majumdar's dream of having 1 PC team per district. The APLI team suggested that the RCC work towards this	• The team visited 2 regional hospitals, to deliver basic education about palliative care, with both visits successful from a teaching perspective, with a multi-disciplinary group of participants. Though the responses have been encouraging but their commitment to the cause is debatable. • There was another teaching session for nurses in Agartala Medical College, the connected hospital to the RCC. The response was lukewarm, mainly pertaining to the hierarchical challenge of nurses having negligible say in leadership decisions. • During the 2016 visit, the APLI team collaborated to facilitate a 10-day intensive course for future community teams. It was a concern that no community visits had taken place since mid-2016. • In Aug 2017, a refresher course of 5 days (3 days for home care) was organized by Pallium India, where Pallium India, RCC and National Health Mission collaborated to train approx. 40 doctors, nurses, Pharmacists and Multipurpose workers from all the 8 districts. • A major obstacle to the development of community palliative care in the state - responsibility for the development of these teams was incorporated under the auspices of the State National Health Mission, with governance and funding for these services devolved to the National Program for Palliative Care (NPPC) and community palliative care teams were therefore no longer funded. • The disbanding of community teams is a great disappointment, especially given the work that was done to develop them. If

through education and mentoring of current and new staff, with considerable support from all key team members and government. • Though staff appeared keen to learn and improve their clinical skills, the concept of holistic care for patients was challenging due to the strict delineation of roles which prevented individuals from responding to patient needs. The APLI team gently challenged this with actions and willingness to perform duties traditionally outside the easily accepted area of our roles, demonstrating humanity. • An immediate focus on improvements in the inpatient setting for patients, families and staff is required, and seems manageable over the next 2 years. Issues range from – low staff nurse numbers, lack of basic clinical equipment, lack of Universal Infection Control measures and accurate documentation of clinical notes and medication records, lack of emergency pain relief medication, lack of facilities for families etc. • Patients present to the RCC at late stage of the disease - RCC must have a role in cancer prevention strategies and initiatives such as community awareness and education campaigns; consideration regarding the true value of expensive treatments, community engagement strategies etc. • Establish a volunteer program to enhance community capacity and support in inpatient settings. • The Brahma Kumaris have expressed a keen interest in assisting further with the spiritual care of patients, families and staff of the RCC. This may be a suitable starting point in the development of	community care is to be re-established, a major effort to recruit and train workers will be required, as many of the previous workers have left • A senior medical officer at the Cancer Centre has not been very supportive of the Hamrahi program and is reluctant towards many assigned actions. Unfortunately, his influence in political spheres is significant and Dr Majumdar's progress and plans has been restricted and made so much harder. • The ARCC and the APLI team met the Health Minister who was open to the idea of implementing a State Palliative Care Policy, aligned with the National Strategy. Dr Majumdar presented him with a draft policy for consideration while the APLI team expressed interest to help advocate for this in any way possible. • A change in the political landscape in Tripura has resulted in a slowing down of progress. The crucial roles and positions must be occupied by individuals focused on the objective of having a state policy rather than personal agendas. Continued political difficulties are disheartening, are diverting activity from service improvement to playing politics and are causing fatigue in champions, like Dr Majumdar. • Dr Majumdar has identified 2 doctors with leadership skills and a passion for palliative care, and has commenced succession planning for his retirement. These leaders require clinical governance and managerial responsibilities, in order to influence the practices of their colleagues, several of whom have no interest.

the role of volunteers. • An audit of the palliative care service using Pallium India's 'Standards Audit Tool for Palliative Care Programs' may be useful.	• The RCC still has no capacity for wound dressings, which is extraordinary when head and neck cancers are very common. Patients travel to the surgical hospital for dressings, a very inefficient practice, which is extremely cumbersome for patients and their families. This is expected to change once the new facility opens. • Some clinical practices remain below standard, which is difficult to understand since the APLI team was informed that funding was not the problem. Eg metal cannulas being used for IV infusions, poor hand hygiene and poor chemotherapy handling techniques (although some gloves are now being used). • The doctors have reasonable knowledge of palliative care, although only 2 have done any formal training. However, their advocacy for the needs of patients is limited, almost with a resigned attitude that nothing can be done. • The nursing role is limited, underutilized, poorly skilled and poorly respected with many nurses uninterested to learn about communication and other clinical skills and preferring to stick with the few activities they are used to, even when Maite demonstrated how much more a nurse could do. • The nursing role requires upgrading and 2 nurses, namely Rita and Monohar, should be given specific leadership roles with clinical governance responsibilities and powers to improve practice on the wards, including hand hygiene practices, wound management, basic patient and family education.

	• There has been no social worker assigned to palliative care • Spiritual care is limited to the Brahma Kumaris visiting on Sundays. There is no spiritual care provided as a part of everyday practice. The embedding of spiritual care and social work practice within the inpatient units needs much consideration
	Impressions • Probably future efforts to be digressed to another Medical institute to pick the role of a champion. Clinical Champions were identified at the Tripura Medical College and an ongoing relationship with these physicians and nurses should be actively nurtured. An invitation for these senior clinicians to attend a Pallium India course may be a critical step in advocating for morphine at the Medical College, so that palliative care provision can truly progress. • Overall, in spite of being one of the literate states in India, Tripura society is greatly impacted by political and hierarchical leadership, gender (male & female) & role inequality (doctor & nurse) and the conflict of powers hinders the progress of a good cause. Any future attempts should be targeted with a more neutral medical institute • We look forward to an ongoing relationship with the RCC and have great respect for Dr Majumdar. However, we are concerned that this may not be viable unless significant improvement in political relationships and clinical care in the RCC can occur. We recognize

	that we are also a limited resource and there are many places in which our input can make a significant difference; we need to ensure we put our efforts into the right ones.