Evaluation report of Project Hamrahi

Prepared for Australasian Palliative Link International

Review Team:
Dr Odette Spruijt
Ms Archana Ganesh
Dr Anil Tandon
Ms Rachel Coghlan

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1. Executive Summary

Background

Palliative Care in India began in 1980's with the first hospice, Shanti Avedna Sadan, opening in Mumbai in 1986. The Indian Association of Palliative Care (IAPC) was established in 1994, with the first annual conference held in Varanasi, Uttar Pradesh that year. To date, there are over 200 services registered with the IAPC. However, the scope and reach of these services is limited, and integration into health care is minimal across all medical specialties and settings of care. The overall quality of dying in India is ranked poorly against other countries according to the Quality of Death index[1]. Patients in India, as in 127 other countries, lack access to essential medications for pain relief (immediate release and injectable morphine) (hospicecare). It is estimated that only 4% of serious health-related suffering in India (as measured by DOME[1]*) is met by currently available medications and services (hospicecare)[2]

Overview of Project Hamrahi

Project Hamrahi is an international, collaborative, mentorship project between Australasian Palliative Link International (APLI) and Pallium India. APLI is an Australian registered charity established in 1996 to raise awareness of the need for further palliative care development across the Asia Pacific region. The Trivandrum Institute of Palliative Sciences, Pallium India, is a World Health Organization Collaborating Centre for Training and Policy on Access to Pain Relief.

Project Hamrahi aims to help sustain developing palliative care centres in India through the establishment of long-term relationships between Australian and New Zealand clinicians (mentors) and Indian palliative care providers (mentees). Mentors are linked to an Indian palliative care organisation, and conduct week-long visits annually, for three years, teaching, observing and sharing skills and knowledge. Cultural awareness is enhanced through the support of Pallium India Project Officers who accompany the mentors whenever possible.

Over the ten-year course of the Project, there have been 50 mentoring visits to 20 different palliative care services in India. A total of 32 mentors from Australia and New Zealand, including 14 doctors, 15 nurses and three other professions (pharmacist, counsellor, project officer) have participated in the Project.

Evaluation of Project Hamrahi

Since Project Hamrahi began in 2010, the palliative care landscape in India has changed considerably giving rise to a need to evaluate the impact of this Project with a view to planning future development and directions. This evaluation involved a mixed methods enquiry to

[1] **DOME - Distributed Opioid Morphine Equivalent*

analyze the benefits and challenges of the Project, and the key learnings which emerged for all participants. This report provides conclusions and recommendations to inform the future of the Project, and strategies to adapt to the changing environment, strengthen engagement and increase capacity of the Project.

The evaluation used online surveys of mentors, mentees and Project Officers, followed by semi-structured interviews of selected mentees, and analysis of mentors' submitted reports after their annual Hamrahi visits.

In total, 83 clinicians (28 mentors, 49 mentees and 6 Project Officers) were surveyed, with a different survey created for each group, eight mentees were interviewed and 24 Hamrahi reports were analysed.

Summary of Key Learnings

Highlights and achievements

Project Hamrahi provided an important means for shared learning for all participants, facilitated by the collaboration in direct patient care during the week-long visits. Mentors were exposed to new expressions of palliative care practice in different populations (diagnoses, stage of illness) and at times, to extremes of suffering, which challenged and expanded their clinical experience and humanity. Mentors spoke of the humbling experience of seeing the compassionate practice of palliative care in such difficult circumstances, and often, with so few resources.

There was beneficial sharing of practical skills and techniques between the partnering teams. Mentors often expressed deep appreciation for the work of their Indian colleagues in very demanding circumstances, working with large populations and limited time. Learning to adapt the principles of palliative care in these new environments was a key learning for mentors.

Mentees appreciated the new knowledge and skills obtained through the relational learning of this mentoring Project, and the opportunity to observe the demonstration of empathic listening and communication by mentors. Mentees benefited from the teaching and support provided over the course of the Project; for example, one mentee felt that this assistance helped to gain their international diploma of palliative medicine.

At many participating sites, palliative care development occurred over the course of the Project. At several sites, funding and encouragement for more staff to attend foundational training in palliative care was facilitated. Intensive workshops and opioid availability workshops were conducted and advocacy with senior executives and government officials lead to greater awareness and expressed support for palliative care development at that site and beyond, in other institutions in those cities. Community sensitization to palliative care was another highlight and patients benefited from the attention and expertise of the visiting teams.

Further opportunities included research and quality improvement discussions. Many visits included completion of the Indian Palliative Care Standards to assess progress against those

indicators and to plan the focus for development for the coming year. Practical support in the form of educational materials, books, equipment such as syringe drivers for continuous infusions, and dressing supplies, were all valued.

The establishment of a mutually respectful relationship created a space for mentors to explore in depth the issues that faced the linked organisation and for mentees to be more open and confide in the mentors about key challenges or doubts. Mentees appreciated the recommendations for service development.

Challenges and lessons

There were many practical challenges associated with planning and conducting the Project Hamrahi visits. Participants needed better advance planning, including establishing clearer goals and aims for each site and visit. Importantly, mentees preferred a more intensive engagement with the mentors, finding the one week per year to be too little to advance their service adequately.

The inclusion of a Pallium India Project Officer on the visits wherever possible, from 2014 onwards, was a key lesson for the Project. This enhanced the quality of the interaction between mentors and mentees, through facilitation of cultural understanding and translation during education sessions and clinical interactions. The Project Officers maintained contact with and often visited these sites throughout the year, which helped the mentors to keep up with the progress and challenges at their linked organisation, when they returned the following year. Project Officers became an essential part of the Project and a valuable resource for mentors when planning their visits.

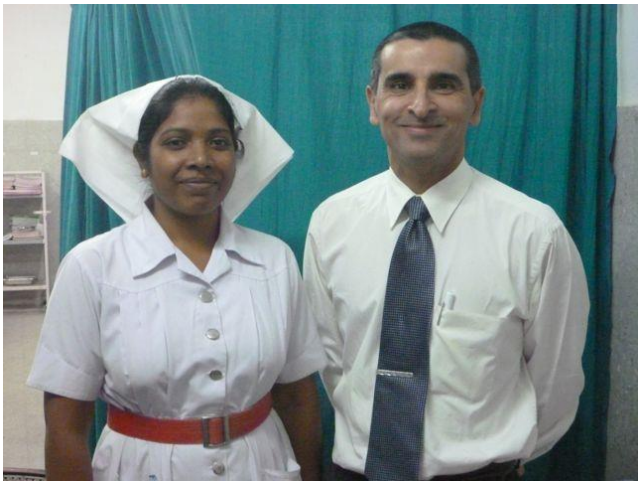
Recommendations for APLI and Pallium India

1. **Improve project planning and management – before, during and after visits:**
    a. Agree a Memorandum of Understanding between APLI and the linked partner organisation at the commencement of the relationship.
    b. Agree visit objectives by partner organisations prior to each visit.
    c. Agree ongoing support requirements of all partners at the conclusion of each visit.
    d. Ensure visit reports are written by mentors and shared with the linked partner organisation within two months of returning from the visit and with a follow-up videoconference discussion of recommendations.
    e. Standardise debriefing practices for all mentors and ensure avenues for debriefing following visits are available and clear.
    f. Allocate a dedicated program manager to oversee and develop the Project collaboration. This position may be shared across both organisations. An alternative would be to employ administrative support at APLI to assist with program project planning and management, given PI may have existing capacity to support this Project.
    g. Ensure the inclusion of a Pallium India Project Officer at each Project Hamrahi site to facilitate visit planning, provide mentor orientation, and facilitate communication between Pallium India and APLI Project Hamrahi Coordinators.

2. **Scale up the intensity and specificity of the Project to strengthen relationships and outcomes:**
    a. Establish a mechanism for better identifying the specific needs of all sites and the intensity of visits/duration of the relationship required to achieve best outcomes.
    b. Where appropriate, increase the number of visits to sites e.g., from annual to visits to two/three times per year.
    c. Where appropriate, increase the duration of each visit e.g., from x days to 15 days per visit.

3. **Strengthen engagement and supportive education for mentees and linked organisations:**
    a. Establish additional forms of education such as tele-mentoring to strengthen engagement between mentors and mentees throughout the duration of the Project at each site.
    b. Develop strategies to increase nursing mentor capacity in the Project and facilitate links to nurse leaders and educators in India.

4. **Establish clear modes for orientation, training and education of mentors:**
    a. Draw on experienced APLI mentors to provide orientation for new mentors.
    b. Establish attendance at the IAPC mandatory for mentorship eligibility.
    c. Ensure mentors have signed an agreement to participate in the Project and are aware of their duties to fulfil Project requirements concerning preparation, visits, follow-up and travel costs.
    d. Develop dedicated resources for mentors including: training material in key topics (pain and symptom management, palliative care emergencies, prognostication, communication, end of life care); and local language resources.
    e. Develop the teaching pedagogy for the Project, with emphasis on teaching at the bedside, in outpatients, and on community visits rather than didactic lectures. When given, lectures should be small group and interactive, aiming for case-based learning and discussion.
    f. Develop advocacy and service development training for mentors including: training module on challenges of opioid availability in India; and global advocacy preparation.




MILE STONES
MTMH
LION BAHADURJI CANCER DETECTION CLINIC ESTABLISHED - 1968
INDIAN CANCER SOCIETY ESTABLISHED - 1968
RADIOTHERAPY STARTED (OLD COBALT) - 1972
MTMH ESTABLISHED - 1975
X- RAY - 1975
SELECTRON (ICRT) - 1980
DIAGNOSTIC CENTRE - CT SCAN, USG, - 1988
MAMMOGRAPHY INAUGURATED - 1995
SIMULATION & TREATMENT PLANNING SYSTEM STARTED - 1997
M R I INAUGURATED - 2000
SPIRAL CT INTRODUCED IN PLACE OF CAT SCAN 2002
NEW COBALT (REPLACED) - 2002
RADIO FREQUENCY ABLATION (RFA) STARTED - 2007
SELECTRON (ICRT) HDR INTRODUCED - 2007
LINEAR ACCELATOR - 2010
PALLIATIVE CARE - 2010
DIGITAL X- RAY - 2012

2. Background

Palliative care in India began in the mid-1980s with the first hospice opening in New Delhi. The Indian Association of Palliative Care (IAPC) was established in 1994, with the first annual conference held in Varanasi, Uttar Pradesh. To date, there are over 200 services registered with the IAPC. However, the scope and reach of these services is limited, integration into health care is minimal across all medical specialties and settings of care, and the overall quality of dying in India is ranked poorly against other countries according to the Quality of Death index.

2.1 Overview of APLI, Pallium India and Project Hamrahi

APLI is an Australian registered charity which began as an NGO in 1996, aiming to raise awareness within Australia and New Zealand of the need for further palliative care development within the Asia Pacific region. Specific aims are to develop links between palliative care providers and organisations in Australia and New Zealand, and the Asia-Pacific region; and to provide a forum for the exchange of information and ideas across the region[3,4].

Pallium India is a national registered charitable trust formed in 2003. Pallium India provides training and clinical services through the Trivandrum Institute of Palliative Sciences (TIPS), a World Health Organization Collaborating Centre (WHOCC) for Training and Policy on Access to Pain Relief [5].

In 2010, APLI and Pallium India collaborated to establish Project Hamrahi (Hamrahi means 'Fellow Travelers' in Hindi). Project Hamrahi is an international mentorship project which aims to help sustain new and developing palliative care centres in India through the establishment of long-term relationships between Australian and New Zealand clinicians (mentors) and Indian palliative care providers (mentees). Mentors are linked to a particular Indian palliative care organisation hereafter 'link organisation', and conduct week-long visits annually, for at least three years, teaching, observing and sharing skills and knowledge. APLI provides financial support for airline travel, up to $1500 per mentor. Those who can self-fund are encouraged to do so. Each mentor group writes a summary report of their visit on their return. This report is shared with Pallium India, the APLI Project Hamrahi coordinator, and with the mentee link organisation. Mentors are encouraged to discuss their reports with the link organisation, and to arrive at a series of recommendations for that organisation to work on in the intervening year between visits.

2.2 The changing palliative care environment in India

Since Project Hamrahi's commencement in 2010, the palliative care landscape in India has changed considerably. Changes include the amendment of the Narcotic Drugs and Psychotropic Substances Act in 2014[6]; growth in training programs and centres through the Indian Association of Palliative Care (IAPC)[6]; the creation of the National Programme for Palliative Care within the Non Communicable Diseases Action Plan of the Health and Family Welfare Department, National Health Mission, India[7] and the promotion of palliative care training for primary care physicians[7];the development of Doctor of Medicine specialist palliative caretraining[8]; an international collaboration to establish a national quality improvement training programme (Palliative Care-Promoting Assessment and Improvement of Cancer Experience (PC- PAICE))[9]; adoption of tele-mentoring programs such as the Extension for Community Healthcare Outcomes (ECHO)Palliative caretraining[10]; and the introduction of communication and ethics modules in undergraduate medical training[11].

However, there is ongoing need for palliative care development in India as in other low-and middle-income countries. The Economist Intelligence Unit evaluation of the quality and availability of care for the dying (Quality of Death Index) ranked India 67 out of 80 countries[1]. This same report also identified that India's human resources capacity, and capacity to deliver palliative care ranked very low at 67/80 and 60/79 respectively. The global scale of serious health-related suffering due to lack of access to pain and palliative care expertise was detailed in the Lancet Commission Study Group in 2018 and created an imperative for heightened international efforts and collaboration in global palliative care education, advocacy for opioid availability, and universal health coverage which includes palliative careservices[12].

2.3 Project Hamrahi activities

Over the past ten years, there have been 50 mentoring visits to 20 different palliative care services and hospitals in India. There have been 32 mentors from Australia and New Zealand, including 14 doctors, 15 nurses and three other professions (pharmacist, counsellor, project officer) (Table 1).

The Project has focused efforts in the north eastern region of India, where at the commencement of Project Hamrahi, palliative care services were still in the early stages of development.

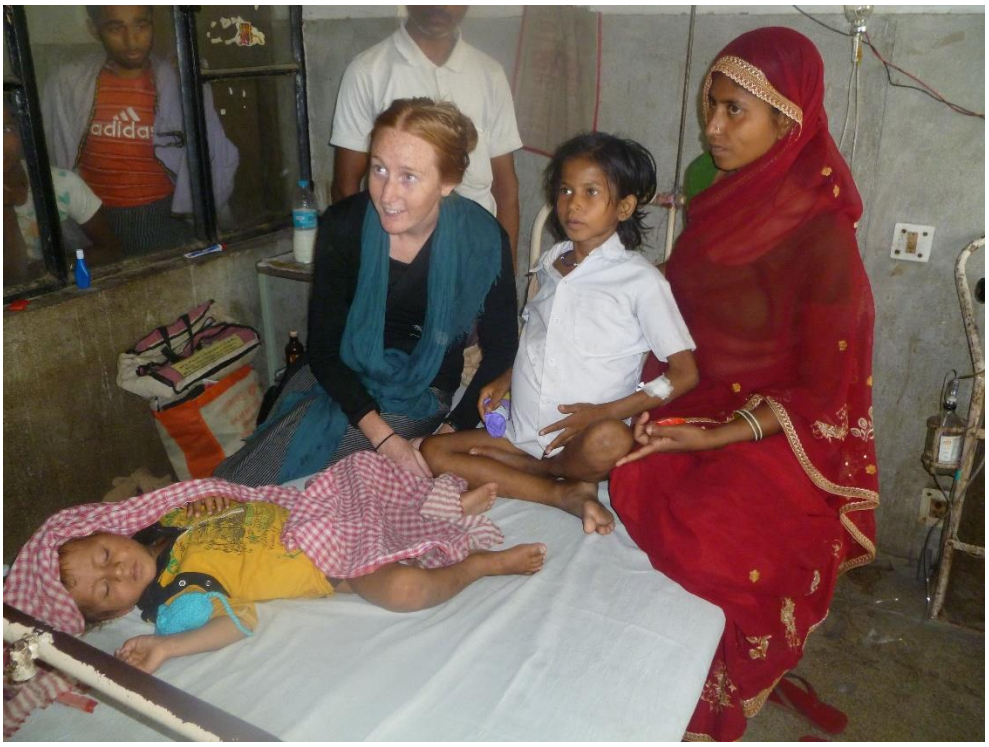
Table 1: Consolidated details of Project Hamrahi visits

	Name of Link Organisation	Visit details (number / year)	No. of mentors associated	Project Officer involved
1	Cachar Cancer Hospital Society, Silchar, Assam	*7 visits: 2012, 2013, 2015, 2016, 2018, 2019, 2020*	10: David Brumley, Oliver Haisken, Sarah Corfe, Ofra Fried, Niamh O'Connor, Lisa King, Joan Ryan, Penny Tuffin, Liese Groot Frank Brennan	No
2	Indira Gandhi Institute Medical Sciences, Patna, Bihar	5 visits: *2010, 2012, 2015, 2018 (Feb and Nov)*	4: Odette Spruijt, Sarah Begley, Anne Adams, Mary Duffy	Yes
3	All India Institute of Medical Sciences, Patna, Bihar	2 visits: 2018*(Feb and Nov)*	2: Odette Spruijt, Mary Duffy	Yes
4	Mahavir Cancer Centre, Patna, Bihar	2 visits: 2018*(Feb and Nov)*	2: Odette Spruijt, Mary Duffy	Yes
5	Paras Hospital, Patna, Bihar	2 visits: 2018*(Feb and Nov)*	2: Odette Spruijt, Mary Duffy	No
6	Gujarat Cancer Research Institute, Ahmedabad, Gujarat	3 visits: 2012, 2019, 2020	4: Sarah Begley, John Haberecht, Sandy Hawkins,	Yes

			Toni Coleman	
7	Rotary Ambala Cancer and General Hospital – Sneh Sparsh, Ambala Cantt, Haryana	2 visits: 2016, 2018	2: David MacKintosh, Jane MacKintosh	No
8	Bhagwan Mahaveer Cancer Hospital & Research Centre, Jaipur, Rajasthan	2 visits: 2013, 2015	3: Odette Spruijt, Mary Duffy, Anil Tandon	No
9	Meherbai Tata Memorial Hospital (MTMH) Jamshedpur, Jharkand	4 visits: 2010, 2011, 2012, 2014	2: Anil Tandon, Wendy Scott	No
10	Tata Main Hospital (TMH), Jamshedpur, Jharkand	4 visits: 2010, 2011, 2012, 2014	2: Anil Tandon, Wendy Scott	No
11	The Pain and Palliative Care Society, Pushpagiri, Kerala	1 visit: 2010	1: Sok Hui Goh,	No
12	Thanal Charitable Society/ Lakshadweep Institute of Palliative Care, Kavaratty and Amini, Lakshadweep	3 visits: 2013, 2014, 2016	2: Sophia Lam, Sarah Begley	Yes
13	Synod Hospital / Grace Hospital, Aizawal, Mizoram	1 visit: 2019	2: Anil Tandon Ed Gaudoin	Yes
14	Maharaja Krishna Chandra Gajapati Medical College & Hospital, Berhampur, Odisha	1 visit: 2012	1: Meera Agar	No
15	Asha Kiran Society, Lamtaput, Odisha	1 visit: 2020	2: Kath Savona, Davinia Seah	No
16	PAHAL, Jalandhar, Punjab	1 visit: 2016	2: David MacKintosh, Jane MacKintosh	No
17	Agartala Regional Cancer Centre, Agartala, Tripura	4 visits: 2013, 2014, 2016, 2018	6: Christine Drummond, Valerie Hughes, Wendy Salmon, David MacKintosh, Jane MacKintosh, Maite Uribe	Yes
18	Sneha Sandyha Age Care Foundation, Vizag, Andhra Pradesh	3 visits: 2018, 2019, 2020	3: Maite Uribe, Christine Drummond Dr Seshu Boda	Yes
19	Ruma Abedona Hospice, Kolkata, West Bengal	1 visit: 2015	2: Anil Tandon Ed Gaudoin	No
20	Minimal Access Surgery (MAS) Clinic and Kolkata Medical College Hospital, Kolkata, West Bengal	1 visit: 2017	2: Anil Tandon Ed Gaudoin	No

Over time, the Project evolved to include participation in palliative care introductory course as faculty (Jaipur, Vizag and Agartala), and included a number of shorter day-only visits (Mahavir Cancer Centre Patna, Paras Hospital, Patna, AIIMS Patna, Kolkata Medical College, Ruma Abedona Hospice, Kolkata) to introduce the concept of palliative care and support its development at those sites.

The introduction of the Pallium India Project Officer into Project Hamrahi began in 2014, with the Hamrahi visit to Lakshadweep. Mentors on that Hamrahi visit reported benefits in communication, cultural awareness and a much-improved ability to provide education to the mentees and to interact with patients. Subsequently, Project Officers were incorporated into Hamrahi visits whenever possible.



2.4 Project Hamrahi Evaluation

Project Hamrahi was developed to help sustain new palliative care providers in India. However, there has been no formal evaluation of the outcomes of Project Hamrahi to date. In light of this and of the changed landscape of palliative care in India over this period, there was a clear need to review the outcomes and learnings from Project Hamrahi to date and evaluate the impact of this Project with a view to planning future development and directions.

This evaluation aimed to inform the future development of the Project, through exploration of its achievements to date, exploring the challenges associated with the Project, consideration of how the Project has evolved over the duration of its operations, and identification of current needs, opportunities and priorities for both mentors and mentees involved in the Project.

Objectives of the Evaluation

The objectives of the evaluation were to:

- Understand the benefits and challenges of Project Hamrahi for mentees and for the sites in which they work.
- Understand the benefits and challenges of Project Hamrahi for mentors and Pallium India's Project Officers.
- Explore the impact of Project Hamrahi on the sustainability of palliative care activities and development at the link organisations in India.
- Identify key learnings for mentees, mentors and Pallium India Project Officers.
- Explore mentee, mentor and Project Officer perspectives on the future vision and strategic direction for Project Hamrahi.

Evaluation governance structure

The study governance consisted of the Core Project Team (Odette Spruijt (Principal Investigator – PI), Archana Ganesh (Research Assistant – RA) Rachel Coghlan and Anil Tandon) and an Advisory Committee (members of the APLI Executive Committee and Pallium India representatives).

2.5 Ethical approval

The evaluation was approved by the ethics committee of the Western Health Office for Research as a Quality Assurance project [ID: QA2020.61]. The evaluation was conducted in compliance with the conditions of Western Health Low Risk Ethics Panel approval, the Western Health Research Code of Conduct (2018 and updates), NHMRC National Statement on Ethical Conduct in Human Research (2007 and updates) and the ICH Guidelines for Good Clinical Practice.

3. Methodology

3.1 Evaluation design

A mixed methods approach was adopted which included a combination of surveys involving mentors, mentees and Project Officers, and semi-structured interviews with selected mentees. A qualitative synthesis of the Hamrahi visits' reports which were submitted by mentors after their visits, was also conducted.

The evaluation drew on the Consolidated Framework for Implementation guidance documents, to help develop both the survey and the interview instruments (12).The survey and interviews were conducted sequentially, with the interview instrument being informed by the results of the surveys.

3.2 Participant information and Data Collection

Surveys

In total, 83 clinicians were surveyed (28 mentors, 49 mentees and 6 Project Officers). Three different surveys were developed and administered to these three groups of respondents. The mentors were identified through the APLI membership database (all mentors are members of the APLI) and the Project Hamrahi database.

Mentees were the lead clinicians (doctors, nurses and allied health) and administrators of the palliative care services which had received a minimum of one Project Hamrahi visit between 2010 and February 2020. The mentees were identified through the Project Hamrahi database and by connecting with the mentors linked to each organisation.

The Project Officers from Pallium India included those who had participated in at least one Project Hamrahi visit since the project began in 2010.

The surveys were administered using Survey Monkey, an online survey software.

Each response was allocated a project reference number and responses were de-identified. The results were then pooled and presented in aggregate form.

The survey response rates and completion rates across categories were as follows:

Table 2: Survey participation rates

Particulars	Total Response Rate (in %)	Completion Rate of responders (in %)
Mentors	61	88
Mentees	45	73

Project Officers	100	71

The survey questions are outlined in Appendix 1 (Mentor Survey), Appendix 2 (Mentee Survey) and Appendix 3 (Project Officer Survey).

Fifty-seven responses were received; several mentors and Project Officers completed multiple surveys, one for each site they were linked to. The response rates are shown in Table 2.

Semi-structured interviews

Semi-structured interviews were conducted with a purposive sample of mentees. The interviews provided a platform to gain in-depth understanding of mentees' experiences with Project Hamrahi, the relationship established with the mentors, and the impact of Project Hamrahi on the development of their palliative care services.

Mentors were not interviewed as extensive feedback from the mentors were received throughout the project, including through debriefing, report generation and discussion, an APLI annual forum and informal contact with the APLI Project Lead. Therefore, the views of mentors had significantly shaped the Project over the 10-years duration.

A sampling frame (see Table 3) guided the purposive sampling of mentees across variables including length of time with Project Hamrahi, site location and number of Project Hamrahi visits.

Table 3: Sampling frame

Sampling Variables			
Discipline	Medical	Nursing	Other
Length of time with Project Hamrahi	<2 years	>2 years	
Location in India	North East region*	North India** and East India***	South India ****
Number of Project Hamrahi visits	1	2-3	>3

*Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland and Tripura, Sikkim. https://en.wikipedia.org/wiki/Northeast_India

** Haryana, Himachal Pradesh, Jammu and Kashmir, Punjab, Rajasthan and Union Territories of Delhi, Chandigarh, Bihar, Gujarat, Madhya Pradesh and West Bengal.https://en.wikipedia.org/wiki/North_India

*** Andaman and Nicobar, Bihar, Jharkand, Odisha, West Bengal https://en.wikipedia.org/wiki/East_India

**** Andhra Pradesh, Karnataka, Kerala, Tamil Nadu and Telangana and the union territories of Andaman and Nicobar, Lakshadweep and Puducherry. https://en.wikipedia.org/wiki/South_India

Selected mentees were approached by an email sent by the RA and signed by the PI inviting participation in the interviews. The interviews were conducted by the RA by videoconference using the Zoom platform. Appendix 4 details the semi-structured interview guide.

A total of eight interviews were conducted which included four doctors, one nurse and three others (administrators, social workers). The average time of interviews was 32 minutes. Details of the interview and de-identified interviewee information can be found in Appendix 5. Interviews were conducted between late October and early December 2020.

Qualitative Synthesis of Project Hamrahi reports

There was a total of 13 site summary reports included in this synthesis, derived from a total of 24 Project Hamrahi visit reports. A summary for each site was collated which included the following data:

- Background to the location/ state of the Indian palliative care service/background to the palliative care service.
- Year of visits and participants in each visit (mentees, mentors and Project Officers).
- Objectives of each visit.
- Threats identified for achieving these objectives.
- Summary of the outcomes of each visit.
- Recommendations made by mentor team.

An example summary report (Jamshedpur, Jharkhand) is included in Appendix 6.

All summary reports were then thematically analyzed. The findings of this analysis were incorporated into the results section, along with the survey and interview analyses.

3.3 Data analysis

A coding framework was developed and data extracted using this framework by AG, and verified by OS. Data analysis involved an iterative process of independent coding, review, discussion and interpretation of data by two researchers (AG, OS).

4. Results

Four key themes emerged from data analysis:

1. ***Education:*** Project Hamrahi facilitated ongoing and mutual education and development for all participants.

2. ***Advocacy*****:** Project Hamrahi provided opportunities for promotion of palliative care development in India.

3. ***Relationship building*****:** Project Hamrahi created a space for deeper engagement and sharing of challenges and expertise.

4. ***Project management requirements*****:** There was a need to improve the clarity of purpose and processes of engagement between project partners through better planning and monitoring of outcomes.

4.1 Education: Project Hamrahi facilitated ongoing and mutual education and knowledge

All participants agreed that participation in Project Hamrahi led to gaining greater insights into palliative care and its various components. Mentors and mentees both recognised the mutual learning which took place during visits. There were overt improvements in the overall knowledge, attitudes, and skills in palliative care of participating mentees, with reciprocal learning, attitudinal change and development of cultural understanding and appreciation for the challenges of working in low-and middle-income countries for mentors.

4.1.1 Mutuality:

Both mentors and mentees reported shared learning as a result of their participation in the Project. Mentees and Project Officers highlighted that the discussions which took place with mentors during home visits and ward rounds facilitated mutual learning and sharing of perspectives:

"Home visits and ward rounds are very important. It enhances the learning at both ends. The visiting mentors also learn new ways of doing things which might not be very popular in their country" POQ19_2

"Definitely a two-way learning process – we learn as much from them as they from us" MentorQ29_1

"80% of our patients are head and neck patients.. and most of them come with maggots and very foul-smelling wound.. so for them maggots and all such things were very fascinating which they might not have handled.. such patients.. they also wanted to learn that how our nurses are taking out maggots boldly.. so they took lots of interest in

everything, in every procedure of the patient.. they used to go for home visit along with our nurses" PH_D_002

Several mentors shared examples describing how their participation in the Project taught them of the need to be culturally sensitive, to comprehend working respectfully in different cultures, to appreciate the impact of local legislation and their corresponding implementation challenges, to understand the impacts of varying levels of medication availability, and to be respectful of mentees workload.

"The importance of cultural sensitivity and working within a different culture with respect.. But also, being able to say what you need as a visitor, in a respectful way. We have more in common than we have differences" MentorQ29_6

"The difficulty in implementing amendments to opioid law.. and impact on people suffering with cancer pain.. I have been very impressed at the efforts and hard work of colleagues trying to make a difference.. I realize that change takes a great deal of time and perseverance" MentorQ29_15

"Be respectful of the very demanding workload of the doctors" MentorQ29_24

4.1.2 Knowledge:

All participants noticed an increase in palliative care knowledge levels among mentees.

Mentors highlighted that knowledge transfer was a continuous process occurring during home visits, outpatient clinics, grand rounds, focused educational sessions and informal rounds / small tutorials with the healthcare teams at the link centres.

"They provided useful tips.. practical tips.. they imparted knowledge to us.. they demonstrated that knowledge.. it was not bookish knowledge only" PH_O_002

Participants described knowledge transfer in both technical and specialist topics and more general topics. Examples of technical specialist topics included information about the specific components of palliative care, opioid usage, subcutaneous route of drug delivery, wound management techniques, usage of syringe drivers, communication skills, exposure to end-of-life care and pain management, the importance of spiritual and psychological assistance, and different treatment modalities. General topic discussions included the adoption of universal (standard) precautions to minimise the risk of transmission of blood-borne pathogens from patients to clinical staff, understanding different healthcare systems, sharing best practice guidelines or ideas, prevention of staff burn-out, and quality assurance measures.

"We learnt about new wound care methods.. learnt about pain management.. learnt about how to educate the family members of patients having end stage diseases" MenteeQ25_2

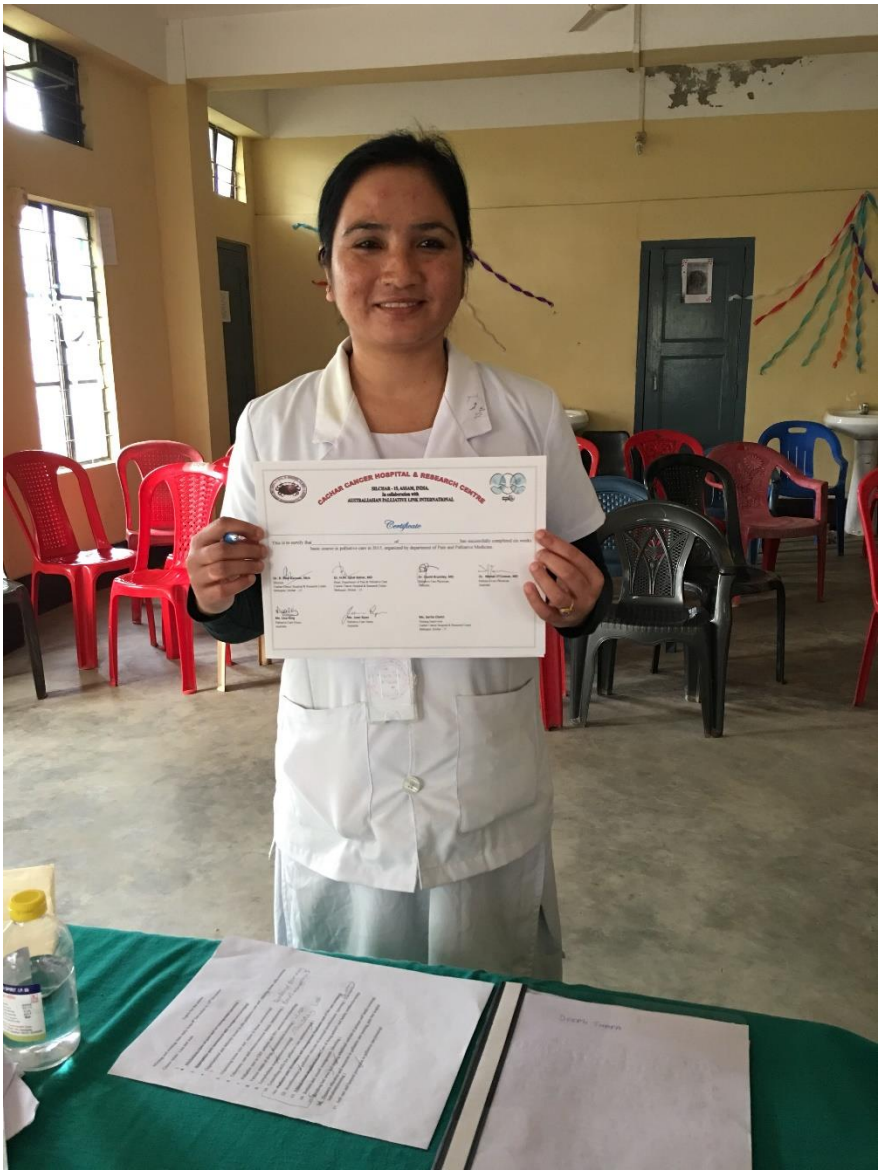
"Many staff rotating through the unit, then go on with more confidence into other roles" MentorQ28_17

"Project Hamrahi was a greater motivation in the patient care and an opportunity to understand the different modes of treatment.. it also influenced our organization in reaching out the public" MenteeQ23_8

"Their recommendations helped us in ensuring judicious use of morphine and improved documentation of morphine use within the ward, helped in adopting universal precautions for hospital staff and self-care, improved discharge systems with better documentation, helped in bettering communication skills and confidence of the nurses and lessened the representation through the education of the family/attendants, implementing the of subcutaneous route of drug delivery" MenteeQ23_17

Participants noted that increasing specialist knowledge was important in enabling improved availability of opioids, improved patient comfort at link centres and at satellite treatment centres, and an overall improvement in documentation and general practices of mentees. Changes in documentation practices were reflected in effort to improve the efficiency of scheduling of home care visits, and the adoption of flowcharts for pain management and bowel charts. Improvement in mentees' general practices involved improved hand hygiene, more utilisation of locally available resources, and the initiation of dispensing morphine tablets to outpatients, proper labelling and dispensing of drugs in the ward and pharmacy, and the avoidance of polypharmacy.

"Some of the patient care aspects being taught by Hamrahi teams was introduced into routine practice by Site 1 healthcare providers like dressing technique, use of syringe drivers, better communication with patient and family etc." POQ18_4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SILCHAR - 15, ASSAM, INDIA
In collaboration with
AUSTRALASIAN PALLIATIVE CARE INTERNATIONAL
Certificate

4.1.3 Attitudes:

Participants discussed that a host of factors contributed towards positively impacting the attitudes of both mentors and mentees towards palliative care.

Mentors shared that they recognised the need for humility in this role, as they accepted and appreciated local culture and challenges, and were impressed by the adaptability of mentees to provide quality care despite resource constraints.

"Humility.. Observing how hospitals can do very useful palliative care with little money" MentorQ29_26

"Some appreciation of the cultural differences in approach to caring and death.. the ability to give good care despite not having the wide range of available therapies and therapists.. admiration of staff to provide compassionate care in difficult circumstances" MentorQ29_17

They also observed that being able to explain the theory of practice improved the observed actual practice of nursing mentees.

"I could see an improvement in the link between nursing staff theory and practice. I contributed more to the WHY than the HOW in their service" MentorQ27_18

Mentees reported favourable changes both personally and professionally.

"I think so, because they made a positive impact on my colleague and made us a better care provider" MenteeQ23_10

Mentees were validated in their practices and reassured that their challenges were consistent with international experience. They also shared that they believed that they were now more tolerant, compassionate, empathetic and humane in their interactions.

"The most useful part was the validation of some of our procedures" MenteeQ13_20

"We have compassion in us because of Hamrahi which had made us do that" PH_D_003

"Part of our service after the first contact with Project Hamrahi took into consideration the greater tolerance and more humane treatment than the patient and the constant help and attention" MenteeQ24_12

"Working with them, I learned how humane the last stage cancer patient is, and how much intimacy he has created" MenteeQ13_12

Interestingly, participants from all three categories suggested that mentees were more confident and empowered due to Hamrahi, as they gained new knowledge and a deeper appreciation of the philosophy and practice of palliative care within their local context.

"Because of their project.. our nurses' confidence levels have increased.. yeah.. I have seen changes I want to tell that makes a lot of difference.. because in medical profession or nursing profession, we need very much confidence to work with the patients.. like before they came, I also did not have so much of confidence.. and now including me also, we have lots of confidence.. like doing so many visits with them.. going with them.. and working with them.. they have given us lot of development" PH_N_001

"Appreciation of the philosophy of Palliative Care within the local context" MentorQ28_2

4.1.4 Skills:

Most mentees reported an increase in their skill set due to their involvement in the Project in three main spheres:

a) Management skills (planning, accountability, leadership and report writing skills).
b) Technical skills (communication skills, provision of counselling and bereavement support, psychosocial, symptom and pain assessment, wound management techniques, drug titrations, usage of syringe drivers and nasogastric tubes).
c) General patient care (oral care, patient hygiene practices).

"Learnt planning, leadership skills, accountability" MenteeQ25_1

"Mentor 9 was very good in presenting reporting about whatever he did here.. he filed a very good report.. and that report was also a specimen to be shown to our people, 'look here, this is the way how the work is reported'.." PH_O_002

"A thorough clinical examination.. Use of sub cut route of drug delivery...Palliative care in ESRD... Drug titration" MenteeQ25_17

"We learnt many new procedures from Hamrahi nurses. e.g. Syringe driver" MenteeQ23_13

"Like wound dressing, pain management.. like how to give the counseling and how to do bereavement visits and all.. how to handle the patients and their families.. they have practically given us some knowledge on how to do the new things.. since separate palliative care unit was not seen in our hospital before that.. so it is a new thing.. and it also gives an encouragement to the doctors and the patients" PH_O_003

4.1.5 Preferred learning Pedagogy:

Mentors shared that teaching needed to be less didactic, and more flexible and interactive, for example, in small group workshops rather than grand rounds. Undergraduate teaching sessions were also felt to be less effective. Participants discussed that bed-side teaching was a useful approach as it not only provided mentees with an opportunity to share queries and concerns, but also for mentors to demonstrate good communication, and to model empathy, enthusiasm and expression of humanity within the therapeutic relationship. Adopting a blend of theory alongside practical skills was described as most successful in furthering knowledge, attitudes and skills.

"Bedside and bedside indoor management of patients real time was really helpful and it enthused them.. and that really picked up at Site 8a.. Palliative picked up.. and it was a big help to those people" PH_D_004

"The blend of theory and practical hands-on training was the best part" POQ15_5

"Bedside teaching and modeling communication and patient assessment spending time with colleagues in India allowed more open sharing of concerns and questions" MentorQ18_16

"The best thing was definitely the bedside teaching (for multiple doctors and nurses to learn together) followed by the outpatient clinic (for the palliative care doctor to have one-on-one teaching)" MentorQ18_25

One comment was that training include non-palliative care topics but did not specify what topics. In addition, mentees requested be more frequent and in-depth education.

"They gave training only in palliative care.. they focus on mainly on palliative care.. I want them to do more you know like more content.. not only in palliative care.. but in other aspects also" PH_N_001

They suggested mentors might collaborate with local teams to develop educational and awareness-raising material in local languages.

"If you can do the training materials, the study materials, if we can translate it into our local language, because see if it is a doctor, only then having all the materials in English is very good.. but if you come to the nurse and paramedical staff, to be honest, we do need in our local language rather than in English.. not even in Hindi.. most of them can't even read Hindi.. when it comes to literature or if something were given in the hand to read, they are only comfortable with our local language. that is only suggestion.. so if we can get the materials for further training or whatever, we will be really happy to do the translation work.. but if we do something.. local language would be the most effective thing" PH_O_001

Most mentee participants noted that collaborating alongside mentors enriched the role of nurses and improved their confidence, image within the link organisation, and morale. This arose through development of better understanding of the scope of their role and responsibilities, and through their gains in new knowledge and skills. The key role of nurse mentors was evident in connecting with nurses at the linked organisations.

"Since involvement with Project Hamrahi, the nurses' morale has come up.. that is the first and most important thing... they now have confidence.. they feel accountable, responsible and feel that they now have better knowledge.. they feel that it is now their duty to teach the students and caregivers.. it improved the nurses behaviour and their communication with the patient.. they feel that even if I am not there, they can definitely look after the patient well.. they can do wonderful things you know.. that is the biggest change I can feel" PH_D_002

This was evident in the mentor reports from several centres also. For example, in Cachar Cancer Centre, mentors reported on an observed increase in nursing confidence and role recognition over the seven years of the Project at that organisation. At the Community Oncology Centre, Ahmedabad, the Project's focus was specifically on mentoring the nursing workforce, in order to increase their confidence and expertise. A nurse was identified for ongoing tele-mentoring between in person visits, although this did not eventuate.

"Their own image is lift up you know.. they feel that "now we are important", "we can".. so by arranging Hamrahi it is made wonderful things you know.. really wonderful.. "they feel that we are important".. because she madam has arranged all such things, and "all these people have come all the way from Australia because we are important.. because if we learn, we will be able to serve our patients better".. so that has helped a lot.." PH_D_002


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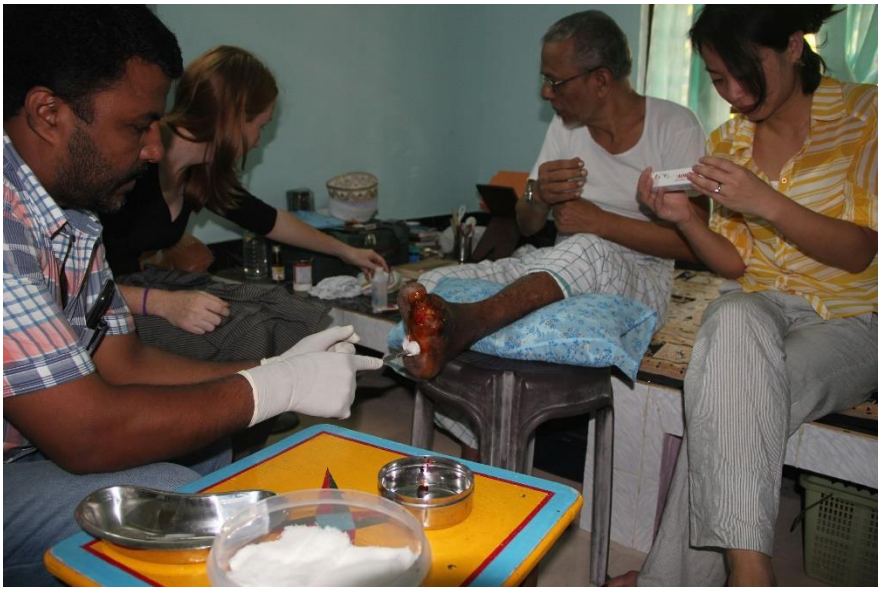

4.2 Advocacy: Project Hamrahi provided opportunities for promotion of palliative care development in India

Advocacy and palliative care awareness-raising was a specific aim of the Project and a recognised objective and activity of many visits as reported by mentors.

Participants across categories described that the Project had a positive impact on advocacy efforts led by the mentees to raise awareness for palliative care among various stakeholders (healthcare staff, hospital administrators, local government officials, patients, their families and the community at large).

> *"It made a huge impact on social systems, people started to think more about palliative care. The visits opened the eyes of administration and health care professionals… and more enthusiasm poured into our palliative care services." MenteeQ23_21*

> *"Communication Skill, Psychosocial and Spiritual aspects of Palliative Care Services, basic concepts of Palliative Care among health staffs and community level health worker were learnt throughout the subsequent visits" MenteeQ23_3*

The impact of advocacy efforts could be broadly grouped as impacting on the internal environment of the hospital or the external environment of the hospital. Participants described that regular advocacy efforts impacted a hospital's internal environment in terms of non-palliative care staff appreciating the importance of palliative care, establishment of key relationships with hospital administrators, improved inter- and intra-team communication, improved allocation of resources/facilities towards palliative care, motivated mentees who expanded services to include day care, inpatient care, outpatient clinics, bereavement support, and improvements in the availability of morphine.

> *"Because of the Project and the media coverage of the visit of the mentors from APLI, the sensitization took place. Today Site8a has been modernized and a full-fledged palliative care unit is working under a palliative care specialist" MenteeQ23_15*

Advocacy directed towards the external environment included meetings with local politicians/government officials to influence palliative care development outside the hospital environment. For example, the team linked to the Agartala Cancer Centre met with the Health Minister to discuss state-wide policy for palliative care. The Lakshadweep mentors reported meeting with the Administrative Head of Lakshadweep islands, Mr Khan, in 2016, who pledged support for the work of Thanal Lakshadweep in expanding their centres across the group of islands. These efforts emerged in the survey responses where the influence on the development of state-based palliative care policies, enabling government health centres to achieve Recognised Medical Institution status, and influencing palliative care integration into the health system were all documented.

"Significant increase in sites and reach.. Was only on one island and expanded to multiple sites over the years with increased funding support from local government" MentorQ28_1

"Project Hamrahi visit created a big impact on the progress of palliative care in State4. Both Mentor 7 and Mentor 8 visited couple of district hospitals to ensure palliative care in integrated in the overall government health infrastructure. Their involvement during home visits with Site 9 doctors left a lasting impression on the patients and other government doctors and nurses." POQ18_2

Further impacts included the expansion of service coverage beyond the physical boundaries of a hospital (spread of services to other islands, initiation of community level palliative care services, opportunity to partner with other hospitals and local or regional cancer centres), and the creation of opportunities for local sites to partner with State Governments to provide training to doctors and nurses.

"junior staff later left Site 10 and were appointed to other hospitals in City 3. This lead to new connections with Site 3. From grand round at Site 10, senior surgeon invited visit and connection at other hospitals in City 3, Non-project Hospital 11 and also Non-project Hospital 12" MentorQ25_15

Interestingly, participants also recognised that the physical presence of mentors during the visits yielded some unforeseen positive impacts. Improved patient satisfaction due to *"a foreign doctor visiting the patient's home*", boosting the image of the hospital as local media often reported on the visits, an increase in the enrolment of mentees into various palliative care certificate courses, and the creation of other opportunities for training were some of the examples highlighted by participants.

"The patients who got visited by them were also encouraged.. 'somebody from such far-off places have come to us' which they never dreamed off.. so in that way our association was quite useful" PH_O_002

"Whenever there has been a visit, what we saw was that the patients were I mean they felt better.. in the sense that that outsiders have also come to see them and meet them and be with them in these trying times.. so there is a psychological impact.. so that is there" PH_D_003

"It was a huge impact on the patients, as well as the doctors and the whole community... Especially, the community again sensitized by this visit Project Hamrahi.. because foreign doctors are coming to the Islands.. it was a first time in the history of India Union Territory 1, foreign doctors are coming to our Island and visiting homes.. not hospitals.. but visiting homes and providing and looking at their fingernails, and feet, their bed, they are providing diet advice... It was a huge impact and highly admired by our government and our health department.. everybody.. so much inspired by this visit and Project Hamrahi was a great success" PH_D_001


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4.3 Relationship building: Creating a space for deeper engagement and sharing of challenges and expertise

4.3.1 Building a community of practice

Mentors and mentees agreed that a community of practice was developed and nurtured due to participation in the Project.

Mentors were able to both contribute towards improving patient care and the development of the various link organisations, as well as towards extending support and a guiding hand to mentees who were striving to establish palliative care services in resource-limited environments.

"Improved patient comfort practices.. Improved appreciation of non-palliative care staff of the place of palliative care.. the use of opioids.. Improved satellite treatment centres.. Improved pharmacy support.. Improved patient drug documentation" MentorQ27_26

Mentees were supported by gaining knowledge, networking with global palliative care experts which provided them with opportunities to engage in collaborative research, access to international articles and global protocols, and validating their practices and procedures. They also gained opportunities to attend international conferences.

"The visit of APLI members at our hospital had definitely made a positive impact. Each visit was unique and it opened avenues for mutual academic learning, fostering relations, capacity building and collaborative research across cultural, resource and other barriers" MenteeQ13_17

Mentees reported that the support from mentors not only made them feel encouraged, motivated and recognised, but also helped to improve their skills, adopt new approaches of care for non-palliative care patients, develop roadmaps for service development and gave them important opportunities for experiential learning. It was interesting to note that the mentees helped to increase the coverage of Project Hamrahi as they joined new centres. For example, Dr Pritanjali Singh participated in the Project when a radiation oncology registrar at Indira Gandhi Institute of Medical Sciences. On her appointment at the newly established All India Institute of Medical Sciences, Patna, in 2015, she worked to establish the development of palliative care services there also and invited the mentor team to participate in advocacy and education at that site.

"I mean Hamrahi project as such, has been very instrumental in not only I mean my sensitization but also the sensitization of so many people.. and to think of that, we have sat down after the visits and we have worked out about how to go about it.. we have drawn down the road maps amongst our team.. it is a small team which is slowly and slowly growing.. so what Hamrahi has actually done for us is that have been very instrumental in this.. like we were all knowing each other, but then sitting together and putting down a road map.. and being instrumental in making of course morphine available.." PH_D_003

Project Officers and mentees also described that establishing team meetings as a learning from participation in the Project enabled them to improve team work which they felt also increased their engagement with the mentors.

While these positive benefits of participation and relationship building were reported by many participants, some also questioned whether it was possible to establish depth of relationship given the limitations of the Project. These included the short, generally one week, duration of the annual visit, the small scale of the Project and the recognition that developing service integration and capacity was a slow process requiring perseverance and buy-in from the hospital executive. Local politics were highly influential in facilitating or obstructing development.

"Nurses change completely during visits.. so relationship building was hard" MentorQ25_7

"Internal politics in organizations influences outcomes and as visitors, little opportunity for ongoing integration" MentorQ29_14

"Our program is small and most of the initiatives have been local.. so I am not sure really how much Hamrahi has actually contributed to the development of our work.. but then again, I have only been serving here for 1 year so far" MenteeQ23_19

Establishing and maintaining relationships therefore involved time and commitment and it was not easy to assign specific outcomes or successes to this Project alone, taking place as it does, within a complex and rapidly changing environment.

4.3.2 Evolution of participants' relationship

In general, participants agreed that over time they had developed positive, trusted and friendly relationships between mentors and mentees, resulting in them becoming comrades or colleagues. A few of the attributes reported to describe their current relationship were:

'professional', 'cordial', 'beautiful', 'inspiring' and *'motivating'*.

"The single most important aspect of this relationship is in the establishment of trust and rapport strengthened by continuity of the visiting team even when there was change within the team. Also maintaining contact between visits also helped develop the relationship of ongoing collegiality with the setting of goals" MentorQ25_2

Over time, this mutually respectful relationship created a space for mentors to explore in-depth the issues facing the link organisation, which would not have otherwise been seen or appreciated, while also providing mentees with the freedom and opportunity to seek informal advice from their Project partners.

Mentees discussed that they valued the accessibility of mentors, their readiness to provide guidance at each step, and their willingness to provide access to knowledge and other resources (educational material, dressings, equipment such as syringe drivers for continuous infusions).

"The mentors are always very helpful and they ready to clear our doubts at any time anywhere during the time of visit" MenteeQ21_2

"I am very thankful to my mentors. They guided and taught me a lot.. without their help I could not have passed my examination of Cardiff Diploma in Palliative Medicine" MenteeQ21_10

"They had brought lots of material you know.. dressing material.. something which they use in their set up.. so that also enlighten our people.. they were so open.. they shared the link of their therapeutic guidelines for nurses.. like whatever their documents, education material is there.. that material was also very very useful you know, to teach our nurses.. whenever the nurses find any problems, they can go through the book and refer the things.." PH_D_002

"I have been in touch with mentors on this project and others for advice for patients, for their input in other issues. Mentor 1 and Mentor 12 organised the donation of some books to our library too. On my request Mentor 7 gave us a comprehensive report on the functioning of our Out-patient and In-patient which was very useful… Both have helped in access to new publications. Mentor 1 has always been a great resource" MenteeQ21_23

Mentors suggested ways to improve the relationship they had with the Project and with APLI. This included making the submission of post-visit reports mandatory as these are a valuable resource for the Project. These reports provide important reflections and summaries of the individual partnership development, outcome information and can be drawn upon for presentations and grant applications. Through the reports, which are shared between partnered mentors and mentees, and the Project collaborating organisations, APLI and Pallium India, partners in the Project learn from each other's experiences.

"All mentors must write a report, if they wish to be funded for next visit.. Feedback from mentee sites after every visit" MentorQ42_15

Other suggestions were to provide mentors with India-specific training through sharing role plays or video recordings of Project mentors interacting with Indian patients/relatives, and providing structured pre-visit support in terms of preventive health measures, general travel information and other specific site details. Necessary site details are the main contact people, the linguistic and cultural background of the setting, and a pre-visit review of the link organisation.

Project Officers described the mentors and mentees as:

'fun to be with and doesn't seem like work'.

They reported that this association provided them with an enriching opportunity to experience new cultures, people and places.

4.3.3 Strengthening mentor-mentee engagement

Mentors and mentees shared several strategies towards strengthening engagement with each other.

Mentees suggested that their engagement with mentors could be improved by increasing the opportunities for role-modelling activities in outpatient clinics and bed-side interactions and by providing periodic online education sessions between Project visits, to share new methods and techniques in palliative care delivery and maintain and grow the connection between partners.

"Periodical visits and suggestion from there end for betterment of delivering services.. Organizing CMEs/ discussions for up gradation of knowledge among health staff" MenteeQ33_3

"More time in the clinics and bed side.. More time on learning research methodologies in palliative care" MenteeQ33_16

Mentors described their pre-visit or post-visit engagement strategies. Pre-visit strategies which were reported or suggested included the valuable role of the Pallium India Project Officer in initiating and facilitating contact with the identified link organisation; organising pre-arrival interactions by video-conference, email or other social media; ensuring that a formal agreement is established with mentee sites; engaging with the same doctor-nurse pair over the years of the Project; and ensuring periodic monitoring with anonymous and pooled feedback from mentees after each visit.

"Pre arrival agreement with site hosts to provide a program / plan, engaged nurse/doctor and contact details of mentees" MentorQ42_5

"At the onset a stronger sense of the role and expectations of both the mentors and mentee… A more realistic approach to what is possible within the time frame of each visit to facilitate preparation of educational content and resources" MentorQ11_1

Suggestions towards improving after-visit engagement included facilitating ongoing online sessions with mentees aimed at identifying and working toward future goals; developing better understanding between mentors and mentees; and communicating openly about obstacles encountered by mentees in goal realisation. Such periodic multi-group sessions would allow Project participants to discuss shared learnings, review the outcomes of each visit and plan future visits together, and to identify the challenges faced by both mentors and mentees in sustaining the Project relationship and service developments, and enable shared problem solving. Such sessions might also include periodic online training sessions.

"Sharing (reports) between groups would be useful - what has been useful, not useful, difficulties, problem solving. Although every site will be very different I think there would be some good learnings. A zoom meeting (e.g. every quarter) for an open discussion about the visits including successes and difficulties for a brain storming about things that have worked for other sites" MentorQ43_17

Challenges to relationship development

Several challenges were identified by Project participants. A key challenge was the difficulty in obtaining and sustaining commitment from key stakeholders. The trained palliative care staff from several link organizations, was redeployed by the government or took up new positions in different organisations. Senior administrative staff changed. This sometimes worked in favour of palliative care development, if the new executive were more supportive of this area of care. Government officials also changed frequently or had many competing priorities beyond palliative care. Mentors identified the inability to visit mentees more than once annually was a significant barrier to forming productive relationship.

"The previous CEO of the hospital, he was of the view that palliative care is not needed.. he said that since we had our different pressures, even the 1000 beds are falling short..

so his contention was that palliative care would occupy a lot of bed days and also he was unwilling to give me palliative care.. plus there are other issues also.. so he did not want to take up another area of concern.. so he said that we will continue as a curative hospital, palliative as a standalone separate thing.. and then it went into a cold storage" PH_D_004

The changing /reducing need for Project Hamrahi due to input from parallel programs at their sites also was also recognised as reducing the need for ongoing mentee engagement. For example, the IAPC and Lien Foundation-sponsored training in Patna provided valuable education from 2018 on, which reduced the need for Project Hamrahi engagement at the four sites in Patna. Mentees also recognised that language barriers and the lack of access to technology were important barriers towards effective engagement.

"Site 3 radiation oncologist, Doctor 6, Site 3, was very enthusiastic. However, the relationship has not continued.. Palliative care development appeared to move to the head of department of anesthetics, Doctor 7, Site 3.. In addition, Non-project Hospital 1 began to provide education in City 3, making the role of Hamrahi less clear/invited" MentorQ25_14

"There was.. even communication also, only I have to do.. the nurses cannot operate email and everything.. I have to do.. so that was a lacking on my part frankly speaking.. but it can be done" PH_D_002

"The biggest challenge was language.. even I cannot follow their pronunciation.. I am very poor in foreign languages pronunciation and all such things.. but fortunately Pallium India had arranged Project Officer 1, their project officer, to be there along with these nurses.. and our physician Doctor 1, Site 1.. he has come back from US and throughout his career he was there in the US, so he was also able to communicate with them better.. so that was the biggest challenge" PH_D_002

4.4 Project Management: the need to improve the clarity of purpose and engagement between project partners at each site.

4.4.1 Planning of Visits:

Some participants felt that the visits by the mentor team were well planned. However, several mentors and mentees, identified opportunities towards improving the visit planning.

Almost all participants highlighted the need to ensure that the visits were realistic in aim and well-structured. They suggested ensuring that agendas for the visit were pre-planned, as a collaborative exercise between all partners involved, including the Project Officers, so that the mentors' and mentees' aims and objectives were well aligned. There needed to be more clarity on respective roles and responsibilities during the visits. Goals for each visit should be clearly articulated. Participants needed more understanding of the linked organisation's current stage of development at the time of each visit, keeping up with the local developments and priorities.

"I think there needs to be clarity on what exactly the deliverables are in this project" MenteeQ32_18

"Better advance planning and clarity of goals for each link site.. mentors and mentees to identify what they hope to achieve.. collaborating with Pallium India project officers is very important" MentorQ42_15

Mentors and Project Officers highlighted that having a cohesive and effective team, open to challenge and dedicated to palliative care, in the linked organisation, was a key factor in ensuring successful visits. Similarly, having a cohesive and multidisciplinary mentor team who were experienced and enthusiastic, and respectful of each others' skills was important.

Project Officers who helped manage logistics and other day-to-day issues were essential components of an effective Project Hamrahi visit.

"Out of all of my PH visits, this was the most successful - due to the presence of the Pallium India PO. Her presence was invaluable - both in terms of organizing the logistics but also day to day issues, helping us be aware of cultural sensitivities etc." MentorQ18_20

Most participants across all three groups felt that the visits needed to be regular, more frequent, and for longer than one week. Two weeks would allow more time for organising and conducting the educational sessions, home visits, advocacy meetings and general interactions. Some respondents suggested a minimum of three visits per annum to enable rapport development.

"I believe the number of visits should be increased to have a good follow up on the progress of the project" POQ19_2

"I am not sure why the visits are limited to 3.. I feel it takes at least 2 visits to start to develop the rapport that will allow more open and robust discussion with mentees." MentorQ42_17

"The nurse's visits should be planned every 4 to 6 months, total 3 visits in year. Each visit should have agenda, and should be followed up during next visit. Each visit should be of two weeks duration" MenteeQ32_7

Mentees particularly highlighted that the likelihood of translating Project Hamrahi visit recommendations into actual service developments were higher when the recommendations were given directly by the visiting mentors to the management of the link organisations.

Other suggestions for improvement included enabling mentors to be better prepared for visits by more systematically providing them with access to general information about travel to India. Mentors new to India felt uncertain about arranging a taxi, details about internal flight requirements in India such as the need to carry physical ticket copies, and accommodation information. The Project currently encourages staying on site at the linked organisation if suitable accommodation is available there. If not, mentors needed assistance arranging accommodation. They also requested prior orientation to the linked organisation, including knowledge of the level of spoken English at the site, and the level of palliative care knowledge and practice in place. The importance of the assistance of the Pallium India Project Officer was emphasised.

"Some basic information about what to expect when travelling in India – e.g. needing paper copies of internal airline ticket to get into airport.. some information about activities we were likely to be expected when visiting a program.. information about the level of English spoken.. information about accommodation when visiting" MentorQ11_3

4.4.2 Monitoring and Feedback:

The importance of effective monitoring and feedback was articulated by a participant when they mentioned that:

"Monitoring can accelerate positive outcomes and curb negatives before it is too late" POQ19_3

Monitoring

Several Project Officers and mentees identified the need for stronger monitoring mechanisms. Post-visit follow-up and periodic monitoring in the form of quarterly or bi-annual visits by Project Hamrahi teams with in-between follow-up by Indian partners were suggested as ways to provide ongoing encouragement and motivation to mentees. They also described that improved monitoring helped instil more accountability for the quality of service provided, and facilitated teamwork.

"Improving post training follow ups and ongoing mentoring till next visit. May be assigning faculty to small groups" POQ26_5

"Quarterly visits by APLI team and monthly follow ups by the India partner" POQ29_1

"we can follow it up, like 'last time this many things we had taught, this we wanted to implement..' so during next visit, they can check whether this was implemented or not?.. what was the problem?.. so this whole thing.. if you had planned properly, it could have worked much better, I feel now" PH_D_002

Mentors highlighted that challenges such as changing clinical practices at the link sites, cross-cultural differences, frequent staff turnovers, short visits, limited visits by mentors to accurately gauge change, and the impact of COVID-19 on mentee's activities were some of the factors limiting effective monitoring at the link organisations.

"Because we had only very short periods of time with each of the three sites, there was too little time at each one to make any meaningful difference" MentorQ27_20

"Clinical practices difficult to change" MentorQ28_10

Feedback

Participants mentioned that the visits by the mentors allowed for mentors to provide mentees with individual and critical feedback on service delivery. Additionally, a few participants also highlighted that mentors were needed to ensure that the feedback provided was realistic (sensitive to local legislations and conscious of mentee limitations), culturally appropriate and therefore feasible to integrate into daily practice and thereby ensure sustainability.

"Mentors to understand the challenges of the visiting country, the state and the local organizations and accordingly make suggestions" POQ26_2

"you see they recommended to us again and again, that without palliative care trained physician, the services can't be really beneficial to the patients.. we agree.. but in view of our limitations, our paucity of funds, we do not find it possible to hire a palliative care trained physician.. so how to bridge this gap more effectively? we are trying.. but if some ways can be suggested, we will be very happy.." PH_O_002

While most participants were happy with the way Project Hamrahi was designed and delivered, a few of them identified opportunities for improving the design and delivery of the existing model.

"The advantage of this model is that it distinguishes Hamrahi from a one-off teaching tour, it encourages ongoing relationship" MentorQ45_2

Suggestions towards improving the design and delivery of Project Hamrahi were captured mainly from two perspectives; the mentors' perspective and the mentees' perspective.

Mentors feedback towards improving the design and delivery of the program included increasing resources (fundraising strategy and mentor enrolments) towards the program and developing a memorandum of understanding with the link organisation to guide visit preparation, agenda development, embed mandatory periodic monitoring mechanisms, provide clarity on the purpose of the visit and clearly articulate the mentors' roles.

"A Memorandum of understanding before site has Hamrahi visits.. In particular the same nurses and also the doctor for engagement. Sites to agree to arrange suitable accommodation (safe and to an adequate standard) prior to visit" MentorQ42_2

"A little more structure around the purpose of the visits and what is expected of the mentors while considering their individual skills" I am not sure why the visits are limited to 3 (or is it just the minimum? - this is something that needs to be made clearer). I feel it takes at least 2 visits to start to develop the rapport that will allow more open and robust discussion with mentees." MentorQ42_17

Mentees shared that ensuring periodic training and feedback would give them an opportunity to share their concerns and receive assurance that they are being supported. They also suggested that assigning the Hamrahi faculty to small manageable groups during visits, adopting dynamic pedagogies relevant to changing times, adopting a time-bound research-

oriented process to document evidence and ensure accountability, would improve the design and delivery of the program.

"Time bound research-oriented processes would add to accountability and evidence" MenteeQ32_17

Mentees also requested that mentors provide specific advice regarding ways in which APLI can extend support, ways to establish new services including infrastructural advice, an offer to assess current practices and thereafter assist in identifying ways to improve current services.

"A note on the areas where the organization is doing well and areas that could do with improvement with suggestions and how to improve" MenteeQ30_1

Suggested modifications to the current model of Project Hamrahi included: accommodating customised models tailored to suit mentee needs according to their palliative care experience; enabling mentors to adjust the duration of the relationship with their site according to the achievements and outcomes at that site, rather than the current timeframe based model; ensuring active engagement in publications and research activities; providing more resources to mentors (creating an education portfolio, organising train the trainer workshops); and clarifying the mentors' expectations regarding fundraising and funding disbursement policies.

"Clear goals for the next year for starters.. Realistic goals.. Review of our policy and guidelines.. If we are not going to do fundraising as a group then take it off the agenda and work within the limits.. Consolidation and the formation of a strong leadership role in this area through publication and research.. Education portfolio as a resource, and a train the trainer workshop" MentorQ45_1

"I think a clear message of commitment is needed but perhaps could be around achievements / outcomes rather than it being time frame based" MentorQ45_2

4.4.3 Debriefing:

Debriefing within the Project was practised only among Mentors and the Project Officers.

Mentors highlighted the importance of debriefing under three dimensions.

Firstly, debriefing assisted most mentors to normalise, understand and share experiences. It provided the opportunity to reflect on the purpose of the visit, identify the nuances of the visit, connect outcome to process, facilitate planning of future visits or develop agendas, and brainstorm for solutions to overcome challenges experienced during the visits.

"An opportunity to discuss the details of our visits and possible strategies for future visits" MentorQ37_4

"Helpful to touch base post visit and make meaning of experiences" MentorQ34_4

Secondly, respondents noticed that debriefing facilitated the identification of existing gaps in services at link organisations while also acknowledging the excellence of service delivered.

"Opportunity to reflect on interactions and to see some more of the positives, rather than just focus on the negatives." Mentors Q34_10

Thirdly, mentors shared that debriefing presented them with an opportunity for self-learning, to gain clarity of their role as mentors, to strengthen their mentor teams and to solidify their commitment towards Project Hamrahi by building harmony, trust, respect and openness within the mentor group.

"Our team always spend a few days together in India on our way home to reflect on the visit as we are geographically scattered back home. This is a great team building exercise and very productive in the ongoing energy of the group and the commitment to the Project Hamrahi. it is also beneficial for future planning, creativity and collegiality. It is a shared experience that builds respect within the team and promotes harmony as a group through discussion, openness, trust and humor." Mentors Q34_2

"To be guided as to how to avoid making mistakes in the future" MentorQ34_17

However, a very small section of the mentors surveyed reported an absence of experienced personal benefits. Several mentors reported non-participation in debriefing, saying that they were either unaware of its availability or, as Project coordinator, was responsible for providing debriefing for others and did not have this opportunity themselves. Some mentors felt that participation in debriefing should be voluntary with the option of having the choice to debrief with a person of their choosing.

"As project lead of Hamrahi, I have been debriefing others, and had not set up an opportunity for my own debriefing" MentorQ35_4

"Should be optional and with someone an individual mentor chooses" MentorQ38_2

Mentors and Project Officers reported that face-to-face debriefing was the most successful mode as it allowed for structured conversations and better reflection. Participants mentioned that leveraging technology using telephone or video-conferencing should only be considered when in-person communication was not possible.

"Physical interview and detailed story presentations if possible, electronic only if the former is not possible." PO23Q_3

"We found face to face debriefing valuable. Could occur via video link or in person.. Just written communication is unsatisfactory." MentorQ37_11

Mentors also appeared to confuse the reporting at the APLI executive with debriefing and indicated that such reporting was not adequate for debriefing. There was support for sharing of mentors' experiences at the annual APLI forum.

"I find presenting at the APLI meetings less valuable as there is an agenda to proceed with.. Our visit presentations at our conference days provide a richer platform to debrief and an opportunity for a shared experience with other mentors… Perhaps a joint mentor presentation on zoom would be beneficial and for discussion to flow from that It may also be of interest to wider members not on the executive" MentorsQ37_2


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4.4.4 Site summary analysis

The focus of the education and mentoring in the Project differed across link organisations, according to each organisation's stage of development and needs. These are summarised in Table 4.

Table 4: Areas of particular focus in Project Hamrahi sites

	Particulars
1	Establishing palliative care
2	Sustaining the service
3	Training of palliative care staff
4	Education of non-palliative care stakeholders
5	Nursing development
6	Service expansion
7	Workflow
8	Continuous quality improvement
9	Statewide service development
10	Home care

5. Recommendations

These recommendations are based on the evaluation of the Project over the past ten years, and present possible improvements and ways to build on the strengths of the Project if it were to continue in its current form. The recommendations are mainly targeted towards APLI but some involve Pallium India's role in the Project.

However, with the impact of the COVID19 pandemic on preventing international travel, there is little prospect of in-person Hamrahi visits for 2021, and into 2022, possibly beyond. APLI and Pallium India will need to consider whether online mentoring is possible and useful in the absence of at least an initial in-person visit of mentors to Indian linked organisations.

1. **Improve project planning and management – before, during and after visits:**
    a. Agree a Memorandum of Understanding between APLI and the linked partner organisation at the commencement of the relationship.
    b. Agree visit objectives by partner organisations prior to each visit.
    c. Agree ongoing support requirements of all partners at the conclusion of each visit.
    d. Ensure visit reports are written by mentors and shared with the linked partner organisation within two months of returning from the visit and with a follow-up videoconference discussion of recommendations.
    e. Standardise debriefing practices for all mentors and ensure avenues for debriefing following visits are available and clear.
    f. Allocate a dedicated program manager to oversee and develop the Project collaboration. This position may be shared across both organisations. An alternative would be to employ administrative support at APLI to assist with program project planning and management, given PI may have existing capacity to support this Project.
    g. Ensure the inclusion of a Pallium India Project Officer at each Project Hamrahi site to facilitate visit planning, provide mentor orientation, and facilitate communication between Pallium India and APLI Project Hamrahi Coordinators.

2. **Scale up the intensity and specificity of the Project to strengthen relationships and outcomes:**
    a. Establish a mechanism for better identifying the specific needs of all sites and the intensity of visits/duration of the relationship required to achieve best outcomes.
    b. Where appropriate, increase the number of visits to sites e.g., from annual to visits to two/three times per year.
    c. Increase the duration of each visit to 15 days per visit.

3. **Strengthen engagement and supportive education for mentees and linked organisations:**
    a. Establish additional forms of education such as tele-mentoring to strengthen engagement between mentors and mentees throughout the duration of the Project at each site.

b. Develop strategies to increase nursing mentor capacity in the Project and facilitate links to nurse leaders and educators in India.

4. Establish clear modes for orientation, training and education of mentors:

a. Draw on experienced APLI mentors to provide orientation for new mentors.
b. Establish the attending at least one IAPC conference as mandatory for mentorship eligibility.
c. Ensure mentors are members of APLI and have signed an agreement to participate in the Project and are aware of their duties to fulfil Project requirements concerning preparation, visits, follow-up and travel costs.
d. Develop dedicated resources for mentors including: training material in key topics (pain and symptom management, palliative care emergencies, prognostication, communication, end of life care); and local language resources.
e. Develop the teaching pedagogy for the Project, with emphasis on teaching at the bedside, in outpatients, and on community visits rather than didactic lectures. When given, lectures should be small group and interactive, aiming for case-based learning and discussion.
f. Develop advocacy and service development training for mentors including: training module on challenges of opioid availability in India; and global advocacy preparation.

Appendix 1: Survey guide for Mentors

- Name (Optional):

  Free text.
- Age:

  Dropdown options: 21-30, 31-40, 41-50, 51-60, 61-70, over 70
- Participant Discipline:

  Dropdown options: Doctor, Nurse, Pharmacist, Counselor, Project Officer, Other (please specify)
- How did you hear about Project Hamrahi?

  Drop down options: From Pallium India staff, From Australasian Palliative Link International (APLI) staff, Cannot remember, Other (please specify)
- What link organization have you been linked to?

  Dropdown option: List all Project Hamrahi sites
- When was the first visit that you were a part of?

  Dropdown option: 2010-2011……2020.
- How many Project Hamrahi visits have you participated in (in total)?

  Dropdown options: 1, 2, 3 etc.…
- Are you currently involved as a Project Hamrahi Mentor?

  Dropdown options: Yes / No
- Did you receive the mentor pack for Project Hamrahi?

  Dropdown options: Yes /No/Unsure
- Did you receive adequate advice and information from APLI when preparing for your Project Hamrahi visit in India?

  Dropdown options: Yes/No
    - If no, what would have helped you to be better prepared?

      Free text
- Were you able to connect with your link organisation before the visit and plan your visit together?

  Dropdown options: Yes/No
    - If no, what problems did you encounter in connecting with your link organisation?

      Dropdown options: poor communication/ unsure what to do/ plans fell through/ other

- Did you have contact with Pallium India's regional project officer (PO) for your link organisation region before the visit?

  Dropdown options: Yes /No /Unsure

  - If yes,
    - Who was your PO?

      Dropdown options: List all the PO's
    - Did you conduct any Project Hamrahi visit with this PO?

      Dropdown options: Yes/No

- What activities did you undertake during your Project Hamrahi visits?

  Check box: (tick all that apply) Media/ general public forums, Opioid availability workshops, Outpatient clinics, Hospital ward rounds, Home visits, Bedside teaching, Educational lectures (doctors/ nurses/ allied health/ pharmacists etc.), Small group tutorials, Undergraduate teaching sessions, Examining graduates, Hospital grand rounds, CME teaching for GP's, Visiting other new centres, Meetings with politicians, Other (please specify).

- What do you think worked well during the visits?

  Free text

- What were challenges experienced in the visits?

  Dropdown options:

  - Mentoring aspects: availability of mentees – please specify; cultural dynamics – please specify; language barriers – please specify, programming – please specify; exposure to suffering in the Indian context – please specify; other – please specify
  - Short time frame of the visit
  - Logistics: travel arrangements – please specify; accommodation and food – please specify; safety – please specify; health – please specify;
  - Other – please specify

- Were you able to contact your mentees between visits?

  Dropdown options: Yes / No

  - If yes,
    - How often do/did you contact your Project Hamrahi Mentees?

      Dropdown options: weekly, monthly, occasionally, infrequently (i.e. less than 4 times between visits).

- What is/was the usual mode of contact?

  Dropdown options: WhatsApp, Email, Skype, Zoom, Other (please specify).
- What is/was the nature of your contact with your Project Hamrahi mentees –

  Dropdown options: patient care advice, informal discussions, ongoing education, follow-up of quality improvement project, arranging sponsorships e.g. travel to Australia, TIPS training, donations, other

- If no,
  - Why do you/have you not had any contact with your mentees?

    Dropdown options: Didn't find the need to, technological limitations, insufficient time, didn't have contact details, no responses from mentees, other (please specify)

- Please comment on the way your relationship with your mentees evolved over the years.

  Free text
- Do you feel like you were able to make a contribution to the palliative care services at your link organisation during your visit?

  Dropdown options: Yes / No
  - If yes, What makes you say that?

    Free text
  - If no, Why do you think so?

    Free text
- What changes in palliative care services have you seen at your link organization since your first visit? Please list these changes whether or not they were due to Project Hamrahi.

  Free text.
- What are some of your key learnings from being involved in Project Hamrahi?

  Free text
- As part of your mentoring role in Project Hamrahi, you were requested to provide a written report to APLI which included recommendations for your link organization to help in the development of services. Were you aware of this requirement?

  Dropdown options: Yes/No

        - If yes, Were you able to provide this report after all Project Hamrahi visits?

            Dropdown options: Yes / No
        - If no, Can you indicate the difficulties encountered in providing the report?

            Dropdown options: unaware of requirement; hard to find time on return; needed more assistance in preparing the report; needed more debrief before being able to prepare the report; other
- Were you provided with debrief opportunities on return from your Project Hamrahi visit?

    Dropdown options: Yes/No
        - If yes, did you take part in the debriefing after your Project Hamrahi visit?

            Dropdown options: Yes / No
            - If yes, Did you find this helpful?

                Free text
            - If no, Could you explain why?

                Free text

- Do you think debriefing is necessary?

    Dropdown options: Yes / No
        - If yes, How would you like to have debriefing?

            Free text
        - If no, Would you explain why?

            Free text
- Are you planning to continue as a mentor in Project Hamrahi?

    Dropdown options: Yes/ No
        - If yes, What are the things you enjoy most about being a mentor in Project Hamrahi?

            Free text
        - If no, Can you describe why you would not want to continue?

            Free text
- What suggestions would you have towards improving the design and delivery of Project Hamrahi in the future?

Free text

- How can engagement with the link organisations be improved in the future?

  Free text

- Do you think that the current model of three visits over three to five years should continue?

  Dropdown options: Yes/ No.

  - If no, Please provide your suggestions for a different model?

    Free text

Appendix 2: Survey guide for Mentees

- Name (Optional) :

  Free text
- Age:

  Dropdown options: 21-30, 31-40, 41-50, 51-60, 61-70, Over 70
- Participant Discipline:

  Drop down options: Doctor, Nurse, Social worker, Counsellor, Hospital Executive / Management, Other (please specify)
- Organization associated with:

  Dropdown options: list all the Project Hamrahi sites
- How did you hear about Project Hamrahi?

  Dropdown options: From staff within my hospital, From Pallium India staff, From APLI staff, Cannot remember, Other(please specify)
- Were you involved in initiating Project Hamrahi at your organisation?

  Dropdown options: Yes / No
- Are you aware of how long Project Hamrahi has been going on at your organization?

  Dropdown options: Yes / No
  - If yes, For how long? Dropdown 2010, 2011, … 2019.
- What year did you become involved in Project Hamrahi?

  Dropdown options: 2010-2011……2020.
- How many Project Hamrahi visits have you been involved with?

  Dropdown options: 1, 2, 3 etc.…
- How would you best describe your role at your organization?

  Dropdown options: Hospital Executive / Management, Head of department, Palliative care lead clinician, Palliative care team member, Other Clinician.
- Who are the people who have been / are involved in Project Hamrahi at your organization?

  Dropdown options with numbers from 0 up: Hospital Executive / Management, Palliative care specialist, Oncologist, Palliative care junior doctor, Oncology junior doctor, Other doctor, Palliative care nurse, Oncology nurse, Other nurse, Social worker, Counsellor, Other (please specify)
- Who are/were your Project Hamrahi mentors?

Dropdown options: list all the mentors

- What activities did you undertake with the Project Hamrahi mentors during their visit/s to your organization?

  Checkbox (tick all that apply): Media/ general public forums, Opioid availability workshops, Bedside teaching, Ward rounds, Home visit, Outpatient clinic, Grand round / lecture, Educational lectures (doctors/ nurses/ allied health/ pharmacists etc.), Undergraduate teaching sessions, Examining graduates, Small group tutorials, Informal conversation / discussion, CME teaching for GP's, Visiting other new centres, Meetings with politicians, Other (please specify)

- What did you find most useful about the visit/s?

  Free text

- What were challenges experienced in the visits?

  Dropdown options: developing a program for the week-please specify; logistics: hosting issues –please specify; interactions with mentors: cultural dynamics, language barriers, other –please specify

- Are/were you able to contact your mentors between visits?

  Dropdown options: Yes, No

  - If yes,
    - How often do/did you contact them?

      Dropdown options: Weekly, monthly, occasionally, infrequently (i.e. Less than 4 times between visits
    - What is/was the usual mode of contact?

      Dropdown options: WhatsApp, Email, Skype, Zoom, Other (please specify).
    - What is/was the main reason for your contact with your mentors –

      Dropdown options: patient care advice, informal discussions, ongoing education, follow-up of quality improvement project, arranging sponsorships e.g. travel to Australia, TIPS training, other
  - If no,
    - Why do you/have you not had any contact with your mentors?

      Drop down options: Didn't find the need to, Technological limitations, Insufficient time, Didn't have contact details, didn't feel it would be helpful, no responses from the mentors, Other (please specify)

- Who do you go to most for advice on palliative care issues?

  Dropdown options: Mentors in Australia, Colleagues in India, a combination of both.

- Please comment on the way your relationship with your mentors evolved over the years.

  Free text

- Do you think Project Hamrahi has made a contribution to your organization?

  Dropdown options: Yes, No, Unsure

  - If yes, what makes you say that?

    Free text

  - If no, why do you think so?

    Free text

- What changes in palliative care services have you seen at your organization since the first contact with Project Hamrahi? Please list these changes whether or not they were due to Project Hamrahi.

  Free text.

- What are some of your key learnings from being involved in Project Hamrahi?

  Free text

- Did you receive a written report from the Project Hamrahi mentors after completion of the visit?

  Drop down options: Yes, No, Unsure

  - If yes,
    - Did the report provide recommendations for development?

      Drop down options: Yes, no
    - Have you been able to implement these recommendations?

      Drop down options: Yes, No, Some
  - If no,
    - what have been some of the challenges that you see in implementing the recommendations shared by the Project Hamrahi mentors?

  - *(Provide option to skip this question if they did not receive a written report.)*

- What feedback would you like to receive from the Project Hamrahi mentors post their visit to your organization?

  Free text

- Would you like to have ongoing Project Hamrahi mentoring?

  Dropdown options: Yes/No.
- What suggestions would you have to improve the design and delivery of Project Hamrahi in the future?

  Free text
- How can engagement with your mentors be improved in the future?

  Free text
- Do you think that the current model of three visits over three to five years should continue?

  Dropdown options: Yes/ No.
  - If no, please provide your suggestions for a different model?

    Free text

Appendix 3: Survey guide for Project Officers

- Name (Optional):

  Free text

- Age:

  Dropdown options: 21-30, 31-40, 41-50, 51-60, 61-70, over 70

- Participant Discipline:

  Project Officer, Other (please specify)

- How did you hear about Project Hamrahi?

  Drop down options: From Pallium India staff, From Australasian Palliative Link International (APLI) staff, Cannot remember, Other (please specify)

- What organization have you been linked to?

  Dropdown option: List all Project Hamrahi sites – full names in both

- When was the first visit that you were a part of?

  Dropdown option: 2010-2011……2020.

- How many Project Hamrahi visits have you participated in (in total)?

  Dropdown options: 1, 2, 3 etc.…

- Are you currently involved in Project Hamrahi?

  Dropdown options: Yes / No

- Did you receive adequate advice and information when preparing for your Project Hamrahi from the mentors and Pallium India?
  - Dropdown options: Yes/No
    - If yes, how was this information and advice with regard to your preparation for the visit provided to you?

      Free Text
    - If no, what would have helped you to be better prepared for your Project Hamrahi visits?

      Free text

- Had you visited the link organisation as PI regional officer, before participating in Project Hamrahi?
- Did you have contact with APLI's mentors for your link organisation region before the visit?

  Dropdown options: Yes for each visit / Yes for some visits

- What activities were you a part of during your Project Hamrahi visits?

  Check box: (tick all that apply) Media/ general public forums, Opioid availability workshops, Outpatient clinics, Hospital ward rounds, Home visits, Bedside teaching, Educational lectures (doctors/ nurses/ allied health/ pharmacists etc.), Small group tutorials, Undergraduate teaching sessions, Examining graduates, Hospital grand rounds, CME teaching for GP's, Visiting other new centres, Meetings with politicians, Other (please specify).

- What do you think worked well during the visits?

  Free text

- What challenges did you notice in the visits?

  Checkboxes: availability of mentees, cultural dynamics, language barriers, programming, Short time frame of the visit, travel arrangements, accommodation and food, safety, health, Other – please specify

- Please comment on the way your relationship with your mentors evolved over the years.
- What changes in palliative care services have you seen at your link organization since your first Project Hamrahi visit? Please list these changes whether or not they were due to Project Hamrahi.

  Free text.

- What are some of your key learnings from being involved in Project Hamrahi?

  Free text

- As part of the mentoring role in Project Hamrahi, mentors were requested to provide a written report to APLI which included recommendations for the link organization to help in the development of services. Did you participate in preparing this report or offer feedback on the report?

  Dropdown options: Yes/No

- How did you provide feedback to PI/APLI after your Project Hamrahi visits?
  - Dropdown : By email, by discussion in person or phone/video call, by written report to PI
- Do you think debriefing with your mentors after the visit is necessary?

  Dropdown options: Yes / No

  - If yes, How would you like to have debriefing with your mentors after a visit?

    Free text

        - If no, Could you explain why you think that debriefing with the mentors is not necessary after a visit?

            Free text

- What are the things you enjoy most about being involved in Project Hamrahi?

  Free text

- What suggestions would you have towards improving the design and delivery of Project Hamrahi in the future?

  Free text

- How can engagement with the link organisations be improved in the future?

  Free text

- Do you think that the current model of three visits over three to five years should continue?

  Dropdown options: Yes/ No.

    - If no, Please provide your suggestions for a different model?

      Free text

Appendix 4: Interview guide for mentees

- Can you describe your professional role and background?

- Can you describe your journey or involvement with Project Hamrahi?
  (Prompts: number of visits, mentor relationship, mentor engagement between visits)

- What have you found most useful or successful about Project Hamrahi?
  (Prompts: site activities, mentor relationship, mentor engagement between visits, etc. for you? for your organisation?)

- What are some of the challenges experienced with Project Hamrahi?
  (Prompts: not useful site activities, mentor relationship, cultural or language barriers, etc. for you? for your organisation?)

- Have you seen many changes in palliative care services at your organization since its involvement in Project Hamrahi? Can you describe these?
  (Prompts: implementation of mentor recommendations, greater understanding of palliative care, improved resources, increased staffing, management support, etc.)

- What recommendations would you make for the future of Project Hamrahi to improve the program?

Appendix 5: Interview details

Sl. no	Interviewee ID	Sex of interviewee	Professional background of interviewee	Duration per interview (in minutes)
1	PH _D_001	Male	Doctor	23
2	PH_D_002	Female	Doctor	26
3	PH_D_003	Female	Doctor	32
4	PH_D_004	Male	Doctor	49
5	PH_N_001	Female	Nurse	34
6	PH_O_001	Male	Other	35
7	PH_O_002	Male	Other	34
8	PH_O_003	Male	Other	27

Appendix 6: Summary report example

Link Organization: Meherbai Tata Memorial Hospital (MTMH) and Tata Main Hospital (TMH), Jamshedpur, Jharkand

- The hospital commenced palliative cares service operations in 2009.

- Meherbai Tata Memorial Hospital (MTMH) is a 72 bedded charitable cancer institute and was established by the Jamshedpur Branch of Indian Cancer Society. MTMH treats all types of cancer cases and it has a well-equipped diagnostic center. The hospital runs on a non-profit basis and 10% beds are reserved for those living below poverty line. It is generally agreed that 70 to 80% of inpatients have a 'palliative' diagnosis for which many are receiving treatment.

- The Outpatient Department (OPD) Palliative Care Clinic runs every morning, 6 days per week and is free of cost. Dr Urmila also provides consultancy to inpatients, while she also completes her routine oncology medical officer duties. Sunita works on the female ward.

- The neighbouring Tata Main Hospital (TMH) is a 900-bed hospital with all major specialties. Dr Koshy works in the very busy Critical Care Unit and Sister Jeseentha works on a male medical ward. She also coordinates the opening of 'overflow' wards on demand. Palliative Care is provided on a consultative basis, throughout the hospital, following phone referrals to Dr Koshy.

- Most people travelled from long distances and some appointments were attended by family members or carers only, as the patient was too ill to attend.

Year of Visit 2010 (first visit)	**Year of Visit 2011 (second visit)**	**Year of Visit 2012 (third visit)**
Australian Palliative Link International • Dr Anil Tandon, Palliative Care Physician, Perth • Wendy Scott, Clinical Nurse Consultant, Perth **Pallium India** • Dr. M.R. Rajagopal, Chairman, • Mr. Anosh Varghese, Project Officer, CanKids Kolkata	**Australian Palliative Link International** • Dr Anil Tandon, Palliative Care Physician, Perth • Wendy Scott, Clinical Nurse Consultant, Perth **Pallium India** • Dr. M.R. Rajagopal, Chairman, • Mr Anosh Varghese, Project Officer, CanKids Kolkata	**Australian Palliative Link International** • Dr Anil Tandon, Palliative Care Physician, Perth • Wendy Scott, Clinical Nurse Consultant, Perth **Pallium India** • Dr. M.R. Rajagopal, Chairman,
Participants from Meherbai Tata Memorial Hospital	**Participants from Meherbai Tata Memorial Hospital** • Dr Master, Medical Director	**Participants from Meherbai Tata Memorial Hospital**

• Dr Master, Medical Director • Dr Urmila Patel, Senior Medical Officer ** • Ms Sunita Ekka, Staff Nurse, Meherbai Tata Memorial Hospital **Participants from Tata Main Hospital** • Dr Madhusudanan, General Manager, Tata Main Hospital • Dr Koshy Varghese , Anaesthetist, Critical Care Unit ** • Ms Jeseentha George, Staff Nurse, Tata Main Hospital ** (**Attended training in Trivandrum Institute of Palliative Sciences, Trivandrum, Kerala in 2009)	• Dr Urmila Patel, Senior Medical Officer ** • Ms Sunita Ekka, Staff Nurse, Meherbai Tata Memorial Hospital **Participants from Tata Main Hospital** • Dr Madhusudanan, General Manager, Tata Main Hospital • Dr Koshy Varghese , Anaesthetist, Critical Care Unit ** • Ms Jeseentha George, Staff Nurse, Tata Main Hospital ** (**Attended training in Trivandrum Institute of Palliative Sciences, Trivandrum, Kerala in 2009)	• Dr Bachoo Master, Medical Director (on leave) • Dr Urmila Patel, Senior Medical Officer ** **Participants from Tata Main Hospital** • Dr TP Madhusudanan General Manager Medical Services (absent, relieving another position) • Dr Koshy Varghese, Anaesthetist, Critical Care Unit ** • Ms Jeseentha George, Staff Nurse ** (** attended training at Trivandrum Institute of Palliative Sciences, Trivandrum, Kerala in 2009)
	Objectives of the visit: • Re-establish, foster and develop existing relationships • Mentor and support Dr Urmila Patel: MTMH wards rounds, OPD. • Mentor and support the new project officer (PO) Mr Anosh Varghese as to the history and objectives of Project Hamrahi. • Assist PO in identifying future opportunities to support and develop the local teams. • Assess if recommendations from the previous report have been implemented, and if so, to what benefit. • Complete audit tool for National Standards for Palliative Care and identify if essential standards have been met. • Wendy Scott to work alongside the two nurses, at the two sites and assist them to develop their role. • Deliver the “Essential Pain Management” workshop (over 5 days) to interested medical officers and nursing staff. • Encourage the prescribing and administration of morphine.	**Objectives of the visit:** • Re-establish, foster and develop relationships from previous visits • Mentor and support Dr Urmila Patel at MTMH Outpatient Department (OPD) and wards rounds • Assess if recommendations from previous reports have been implemented, and if so, to what benefit • Complete the audit tool for National Standards for Palliative Care, and identify if essential standards have been met • Encourage prescribing and administration of morphine • Meet with hospital management to discuss the progress and the benefits of the project

	Potential threats to achieving objectives: • Limited numbers and irregular attendees at education sessions due to lack of staffing resources and lack of promotion. • Palliative Care team members needing to perform other general duties. • No improvements in access to morphine.	**Potential threats to achieving aims:** • Limited numbers and irregular attendees at workshops due to lack of staffing resources and potential lack of promotion • Palliative Care team members needing to perform other general duties • No improvements in access to morphine • Access to MTMH and TMH executive staff
Summary: • The visit mainly consisted of promoting palliative care specialty and the project, meeting key stakeholders, and providing education on the requested topic of communication. • There was some, but limited opportunity, to mentor the four providers of palliative care providers from two neighbouring hospitals, the Meherbai Tata Memorial Hospital (MTMH) and Tata Main Hospital (TMH • The visit helped to establishing supportive relationships; identifying type of services provided and towards supporting the development of recommendations to assist improvements, particularly in the management of pain. • The team identified some challenges in service provision but there was obvious enthusiasm for training and for the development of local palliative care services. • It was extremely encouraging to see how much has been achieved with the existing small services but the visit also highlighted the need to continue the support to	**Summary:** • The team had a total of 60 consults during the week. • The majority of the clinical work occurred at the MTMH OPD and it was the expectation that the oncology and palliative care consults would require the same amount of time to complete and so Dr Urmila was under enormous pressure to finish a long and busy list, which always included some difficult cases. • There was no nurse in attendance nor was there a plan to replace the palliative care nurse. Thus nurse to nurse training was therefore not possible. Instead, Reena (a 'social worker' who had previously worked as a nursing assistant) a volunteer had been recently 'employed' for a short-term period to attend the clinic, to assist in the management of the OPD patient files, to visit patients on the wards in the afternoons. There were discussions expand her role to include the administration of pain medications. • Basic pain medication such as tramadol, amitriptyline, combination diclofenac / paracetamol and lactulose with varying benefit was being prescribed. With mentoring, increasing doses of oral morphine were prescribed and	**Summary:** • Five-day visit and the main aim of the visit was to focus on working alongside Dr Patel, reducing the amount of formalised education and other commitments. • Dr Master was on extended leave and Dr Wagji, MTMH Superintendent, assisted in promoting the week. • We did not attend TMH due to the absence of Dr Varghese. • The total number of consults (including follow-ups) completed during the week was 56. • The majority of the clinical work occurred in the MTMH outpatient clinic with time spent more evenly over both the male and female wards. There was greater opportunity to support medical officers and nursing staff and discuss cases in the staff offices. • The opportunity for the nurses to attend the bedside consultations was far greater than in previous visits and they were actively sought out and seemed to appreciate the opportunity to attend and participate during ward rounds. • This visit was very heartening as excellent changes and positive action at MTMH could be identified. • It felt as if the APLI team members had made a solid and mutually respectful relationship with all MTMH staff, and the return visits were maintaining awareness and interest in palliative care.

enhance sustainability and future growth. • The team decided to return in the 'soonest possible timeframe' to continue and enhance momentum in the most effective way and that the second visit needed to be specific and focused on individual mentorship of the palliative care team members • There was limited contact with the teams with no requests for intermittent support and guidance and it was identified that email access was unreliable and limited.	the ordering of tramadol reduced. • The majority of the inpatient consults occurred at MTMH, with minimal time spent at TMH. This year, more time was spent on the male ward with Dr Urmila, and less time mentoring the general medical officers. The nurses were not available to attend consultations as they were very busy with chemotherapy treatments and other tasks. The patient: nurse allocation appeared to be 10:1, including day chemotherapy cases. • The Executive team were able to identify the need for improvements, particularly in pain management, and were very keen in incorporating pain assessment in their routine documentation as the 5th vital sign. • The lack of staff at TMH prevents further development of palliative care services in the short term and it would continue as the current 'pop up' consultancy model, dependent on the availability of the team. • Service development at MTMH has also been limited during the year. With no strategic direction and no expectation that home care services would be considered. • Maximising the time with Dr Urmila and joining her in all of her consultations appeared to be beneficial in developing her confidence in both pain management and effective communication. • Visiting Jamshedpur is difficult and challenging. There is a lot of room for growth, greater knowledge and improvement. A lot of the learning needs appear very basic. The task that the palliative care providers have appeared insurmountable at times and they need greater support. • **Education and Dissemination Activities**	• It remains unfortunate that despite great support by management at TMH, the nominated team members remain constrained in their roles, reducing the opportunities for service growth and development at that site. • At MTMH, Dr Patel has an increasingly recognisable role as the palliative care doctor with a consistency in the development of the service, particularly in the OPD. She continues to be overworked, managing dual roles with limited support. The demand for her expertise remains high. Staff were encouraged to consider utilising their knowledge to also make palliative care decisions and orders thereby reducing dependency on while also assisting in generalisability, succession planning, timeliness to patient management, staff satisfaction and a greater team approach. • We do not expect there to be opportunity for service development in the short-term future and do not predict that there will be opportunities for community services. • There is a continued need to assist in the development of skills to aid effective clinical assessments and decision making. • A fourth visit is recommended. • **Education and Dissemination Activities** o No dissemination activities took place this visit.

	○ The APLI team met with the medical and nursing executives at TMH twice. ○ 220 people attended a session ○ The team conducted an Essential Pain Management workshop which was attended by 10 Medical officers and 20 registered nurses. The instructor workshop was not delivered due to time constraints. ○ Dr Anil delivered a lecture on 'the Primary Management of Severe Pain' which was attended by 90 Medical officers (TMH+MTMH). ○ Wendy Scott delivered a session on 'Pain as the 5th Vital sign' to 100 nursing students. • **Quality Assurance** ○ There was a pre and posttest of the EPM workshop. It was noted that prior to the workshop knowledge regarding opioid addiction, use of placebo, responsive treatment of pain and correct pain assessment was very limited. In the post test, there was substantial improvements regarding issues about opioid addiction (only 8% incorrect). Correct assessment and diagnosis of pain types improved moderately. Disappointingly, most attendees still felt placebos were useful and should be used in practice and there remained some limiting attitudes regarding pain treatment. ○ All respondents Agreed or Strongly Agreed that the program was useful,	○ In the absence of Dr Madhusudan at TMH, we met with the acting General Manager Medical Services to give a review of the week. ○ We had a meeting with Dr Master at her home along with Dr Wagii, Dr Patel and Reena. The meeting was very positive and the progress and future of Project Hamrahi were discussed. There was a request for the APLI team to return as the mentorship of Dr Patel was identified as being very valuable. ○ Case study education sessions occurred daily between 1230 and 1400hrs at MTMH, and were attended by up to 25 MTMH medical and nursing staff and one staff member from the Radiotherapy Department daily. ○ Unlike previous visits, the sessions were more informal and staff were encouraged to present a current inpatient, with attendees then discussing the management plan. • **Quality Assurance** ○ The 'Standards Audit Tool for Palliative Care Programs' was done on the service provided at MTMH in 2010 and 2011 in the OPD with Dr Patel's participation. ○ 8 of the 28 standards are currently 'always met'. ○ 'Essential' documentation criteria are met in the OPD, but not utilized for the inpatients. ○ The supply and access to morphine has improved and is now always available and essential criteria 1 to 5 are 'always met'. Poor patients have access to medication and treatment. Essential criteria numbers 6 to 8 remain unmet due to lack of team membership. Desirable standards 9, 11 and 14 are met. ○ As a sole provider of the Palliative Care at MTMH, and

	improved their understanding, enhanced their pain assessment skills and thought the training was effective. ○ The 'Standards Audit Tool for Palliative Care Programs' was used again in comparison to 2010 audit results, there was a decrease in the number of Essential Criteria effectively met due to the lack of a team approach, absence of regular meetings and the lack of a trained nurse. The APLI team does not expect the situation to improve without leadership, staffing, and a coordinated and collaborative approach. • **Access to Morphine** ○ There was an improvement in access to both oral and parental morphine although some limiting factors remained. ○ There were limitations to the supply of oral morphine and they were awaiting a signature from a Narcotics Officer. Currently TMH patients do not have access to oral morphine on discharge. TMH patients are administratively admitted to MTMH to access discharge medications. Staff did not expect an outpatient license to be given any time soon. ○ At MTMH there was no utilization of slow-release morphine, and despite having access to oral morphine, oral or IV tramadol appeared to be the treatment of choice. ○ Administrative procedures prevented the use of morphine in ampoules.	with limitations in executive and administrative guidance or support, it is not reasonable to expect Dr Patel to make substantial progress in meeting many more of the standards. ○ This audit is not necessarily reflective of the overall positive progress which has been made, particularly in the previous 12 months. • **Access to Morphine** ○ There were improvements in access to both oral and parenteral morphine and transdermal fentanyl at MTMH. ○ Storage and record keeping was satisfactory. ○ Progress at TMH was not reviewed. Previously there was a restriction on the supply of oral morphine and they were awaiting a signature from the Narcotics Officer.
	Review of 2010 Recommendations	**Review of 2010 Recommendations (MTMH only)**

	• Improved access to oral immediate release, oral slow release and ampoules of morphine at both sites
	  ○ Some improvements were obvious at TMH and Oral Morphine was still not available.
	  ○ At MTMH, immediate release oral morphine was still available which patients kept in their locker and self-administered. Ampoules of morphine were in stock but had not been utilised due to administrative delays, which was rectified during our visit. There was not an appropriate locked cupboard for storage.
	• Increased prescribing of morphine at appropriate doses to relieve pain and dyspnoea.
	  ○ At TMH, the team completed an IV Morphine trial, a process they had learnt at TIPS. Regular IV morphine was then prescribed as per dose effectiveness. On the day of discharge, this was then converted to immediate release oral morphine for dispensing by MTMH.
	  ○ At MTMH, IV and oral tramadol was prescribed in the majority of cases, which was usually not effective. Opiate rotation to morphine or commencement of morphine was appropriate in many circumstances and continual guidance to do this was required.
	• Improved prescribing of paracetamol at therapeutic doses.
	  ○ Not much of an improvement as paracetamol was prescribed, usually as part of a diclofenac / paracetamol combination and in sub therapeutic
		• Improved access to oral immediate release, oral slow release and ampoules of morphine at both sites
		  ○ At MTMH, immediate release oral morphine was still available. Ampoules of morphine remained in stock in the recommended locked cupboard in the male ward.
		  ○ Slow-release morphine 30mg tablets was available in Jamshedpur by mid-2012.
		  ○ Fentanyl patches (25mcg/hr.) were now available and had been used sparingly as neither the medical nor nursing staff had been taught how to use them. We encouraged the use of fentanyl patches on stable patients and assisted in the education of the application and disposal of the patches and made suggestions on how to make a record in the medication book which would minimize medication errors.
		• Increased prescribing of morphine at appropriate doses to relieve pain and dyspnoea
		  ○ There still appeared to be a reliance on IV and oral tramadol for inpatients who ideally should have been prescribed morphine. Staff preferred Dr Patel to be the morphine prescriber, due to morphine phobia, specifically fear of respiratory depression / arrest. This practice resulted several patients having to wait to be referred to Dr Patel for essential pain management so that she could write the order.
		  ○ We mentored medical staff to have confidence in their ability to make appropriate care decisions. The urgency of good pain management was discussed. It was also suggested that it was unnecessary for Dr Patel to make all the decisions, and their change in practice would reduce the burden of her workload as well as provide better patient outcomes.
		• Improved prescribing of paracetamol at therapeutic doses

	doses (50mg/500mg TDS).
	• Improved prescribing of laxatives.
	  ○ Remains to be an area where improvements can be made.
	• Increased awareness of the benefits of truth-telling and the risks of fostering false hope
	  ○ There appeared to be some improvement by some individuals, although the reasons for staff not being clear and precise are complex and likely to be difficult to resolve. Family expectations were high and their knowledge and understanding poor, causing unrealistic expectations.
	  ○ There also appeared some limitation in the ability to recognise and assess patients with acute and expected deteriorations in their condition, which in turn delayed the opportunity to provide appropriate treatment and discussion.
	• Improved opportunities for patient and family privacy to assist in effective communication and preservation of privacy and dignity.
	  ○ The busy and crowded MTMH OPD had its own Palliative Care consult room with an examination bed with a curtain and several chairs. The clinic was previously conducted in a shared room with an oncologist.
	  ○ Privacy remained an issue due to people spontaneously opening the door, entering and staying in the clinic room which was clearly disruptive to Dr Urmila. The team suggested Reena to instruct non-essential people to remain in the waiting room until called for.
		• Improved prescribing of laxatives
		  ○ Not formally reassessed during this visit but our impressions were that improvements had been made.
		• Increased awareness of the benefits of truth-telling and the risks of fostering false hope
		  ○ Though MTMH medical officers stated that there had been some improvements in the communication between staff, patients and their families, there remained a lack of confidence.
		  ○ Dr Patel gained experience during the visit and was observed to be 'breaking bad news' with greater confidence. Her time management of these discussions also improved.
		• Improved opportunities for patient and family privacy to assist in effective communication and preservation of privacy and dignity
		  ○ Improvements noted per 2011 recommendations review.
		• Improved medical and nursing teamwork at MTMH
		  ○ Nurse Sunita had returned from maternity leave but had not been reinstated in the role and had instead been allocated to general ward nursing duties. She had been replaced by Reena.
		• Improved collaboration between the palliative care teams at MTMH and TMH
		  ○ Collaboration remains limited.
		• More nursing and medical staff to access palliative care training
		  ○ Dr Patel had been awarded a scholarship for a palliative care diploma course by Cardiff University
		• Collaboration with 'The Mahadeo Education & Welfare Society', to enhance psychosocial and supportive care.
		  ○ This has not occurred and Reena and other volunteers continue to provide some services.

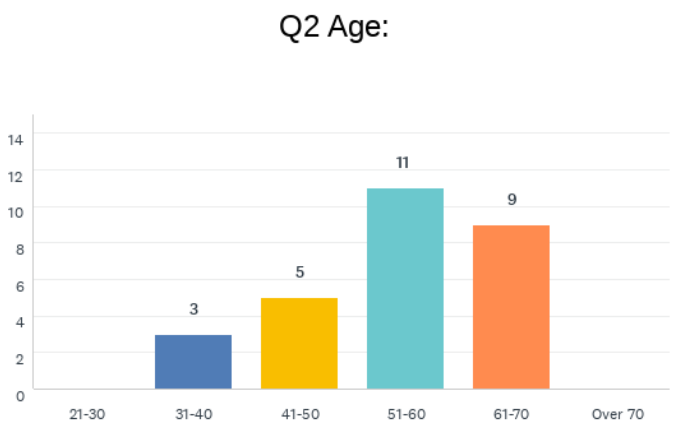
	○ There was a shortage of mobile screens on the ward, which were not utilised during the terminal phase, but instead were used to screen the body after death. • Improved medical and nursing teamwork at MTMH. ○ Dr Urmila was isolated in her role as nurse Sunita was on paternity leave and had some help from Reena. • Improved collaboration between the palliative care teams at MTMH and TMH. ○ Collaboration was limited as the non-palliative care workload for TMH staff had increased, due to which they didn't have time to develop palliative care activities. • More nursing and medical staff to access palliative care training ○ Dr Urmila has enrolled in the palliative care course run by Cardiff University. ○ Staffing resources at both hospitals had declined with no opportunities for leave cover or additional placements. • Collaboration with the 'Mahadeo Education & Welfare Society' to enhance psychosocial and supportive care. ○ This did not occur, due to the lack of coordination and leadership. Though there were a lot of volunteers providing multiple roles in the outpatient clinics, it was still unclear as to who was coordinating or supporting their roles. • Return visit by Australian team members in 2011	
	Recommendations 2011 • Amendments to '(4hourly) Clinical Charts' at TMH (document number	**Review of Previous Recommendations (2011)** Many of the 2011 recommendations had been implemented with positive benefits. We also noted there had

	TMH/FRM/CLIN/ALL/16.00) and MTMH to include pain as the '5th vital sign' with a 0 to 10 scale and to be utilised at the bed side. • Development and support of 'Pain Champion' role on each ward to support quality improvement, mentorship and education of colleagues. This could be a senior nurse who attended the recent EPM workshop. Champions could educate colleagues about 'RAT' using the EPM program. • Reena's role to be developed to only include palliative care patients seen by Dr Urmilla, to provide psychosocial support to the patient and their families. • To enhance dignity and privacy in the OPD clinic room, only the current patient and their family members should be present during the consult. • The Project Officer to explore the opportunities in regards to the provision of psychosocial care. This may include contacting 'The Mahadeo Education & Welfare Society' who had indicated great interest in developing services and the coordinated approach to volunteers. • Third visit by mentors in 2012. • Investigation of opportunities for creation of business case for submission to Australian Volunteers International, Indian office, to support an Australian palliative care health care provider to assist Jamshedpur to develop and sustain community palliative care services.	been many physical quality improvements at MTMH. These included a separate room for the preparation of chemotherapy, new mattresses, locked boxes on each floor for the storage of injectable opioids and other equipment. In addition, the general building was well maintained, had been recently painted and was regularly cleaned. • Amendments to '(4hourly) Clinical Charts' at TMH (document number TMH/FRM/CLIN/ALL/16.00) and MTMH to include Pain as the '5th vital sign' with a 0 to 10 scale, and to be utilised at the bed side. o The APLI team did not visit TMH and was therefore unable to comment on action. o The clinical chart at the end of the MTMH patient's beds remained unchanged, and Dr Patel still utilises a numerical pain score chart for patients to complete themselves. Compliance with this was poor. • Reena's role to be developed to only include Palliative Care patients seen by Dr Patel, to provide psychosocial support to the patient and their families. o Reena's became a salaried staff and her role was developed. She maintains the administrative requirements of the OPD in the mornings and then completes wound dressing and supportive counselling in the afternoons. • To enhance the dignity and privacy of patients in the OPD clinic room, only the current patient and their family members should be present during the consult. Reena to ensure the door remains closed and uninvited people removed promptly. A sign on the door may also help. o The new signage on the door and on an internal wall has proved to be valuable in raising the profile of the specialty service. o The examination table has privacy screening and the positioning of the desk, computer and chairs support a

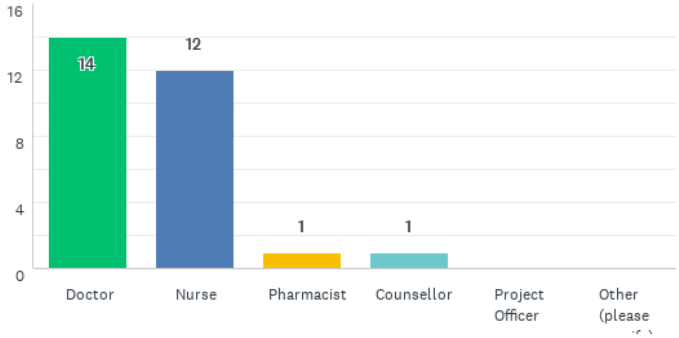
		reduction of physical barriers, enhancing a therapeutic relationship. o Reena was ensuring the door is closed and a consultation is complete before people have access to the room. • The Project Officer to explore the opportunities in regards to the provision of psychosocial care. This may include contacting 'The Mahadeo Education & Welfare Society' who had indicated great interest in developing services and the coordinated approach to volunteers. o It is unknown if there had been opportunity for this to occur. • Final return visit in 2012. o The visit was completed within 12 months to continue the momentum of the project and to support the objectives of Project Hamrahi.
		Recommendations 2012 As per 2011 recommendations: • Make amendments to '(4hourly) Clinical Charts' to include Pain as the '5th vital sign' with a 0 to 10 scale, and to be utilised at the bed side. Staff to complete the assessment each shift. • The Project Officer or other to explore the opportunities in regards to the provision of psychosocial care. This may include contacting 'The Mahadeo Education & Welfare Society' who had indicated great interest in developing services and the coordinated approach to volunteers. Additionally: • All MTMH medical staff to prescribe morphine for pain and other essential medications as appropriate, following their palliative care assessment to assist in the timely management of patient distress. Subsequent referral to Dr Patel for her to review and advise on ongoing palliative management should not prevent early treatment of distressing symptoms. • The development of planned 'debriefing' and 'clinical

		discussion' opportunities for team members. • OPD palliative care patient assessment information to also be available to ward staff if the patient is admitted as an inpatient. • The nomination of a palliative care nurse 'champion' on each ward to assist in the development and utilization of pain management assessment tools and to work informally with Dr Patel. • Return visit by APLI team members in 2014.

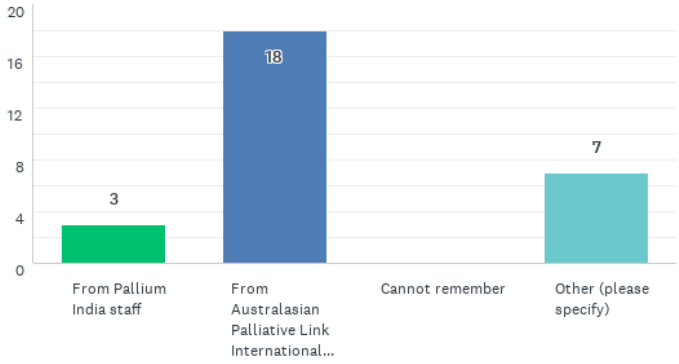
Appendix 7: Descriptive results from the mentor survey



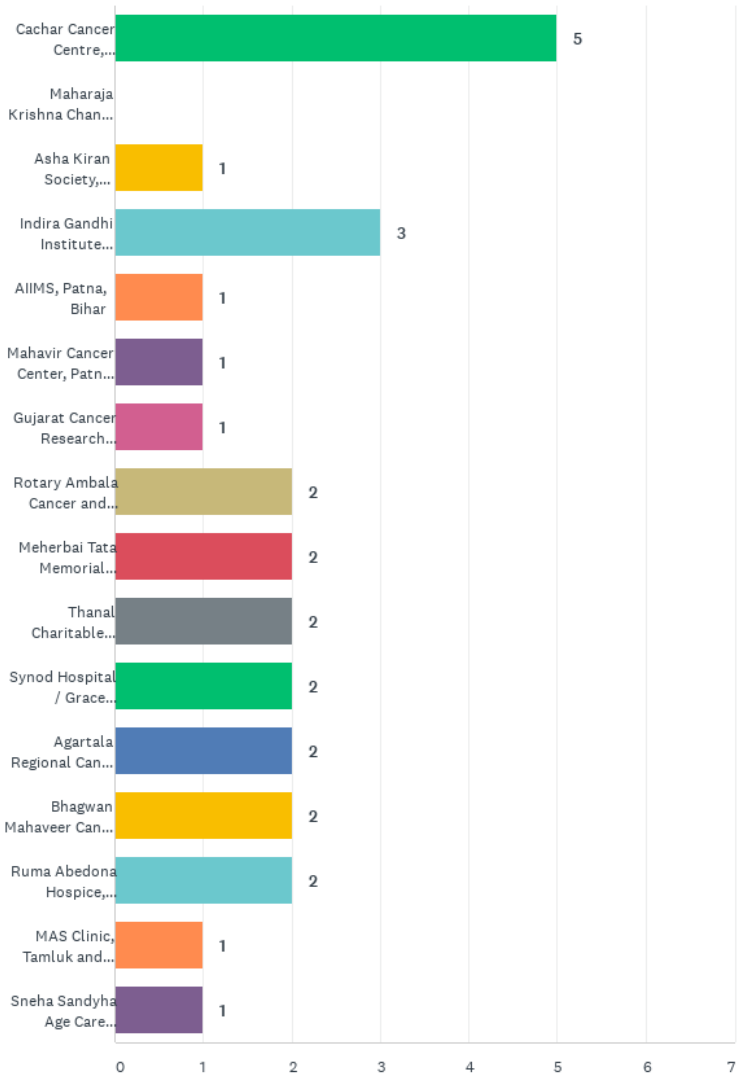
Q3 Participant Discipline:



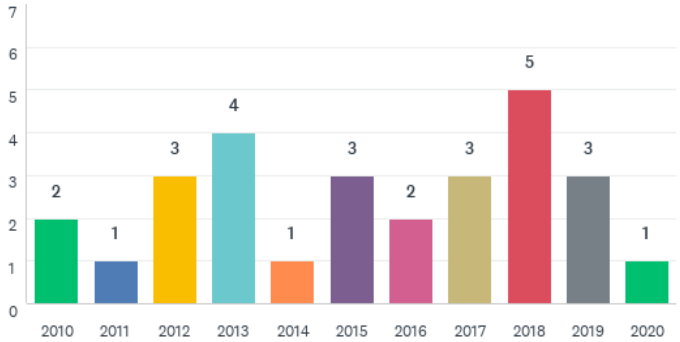
Q4 How did you hear about Project Hamrahi?



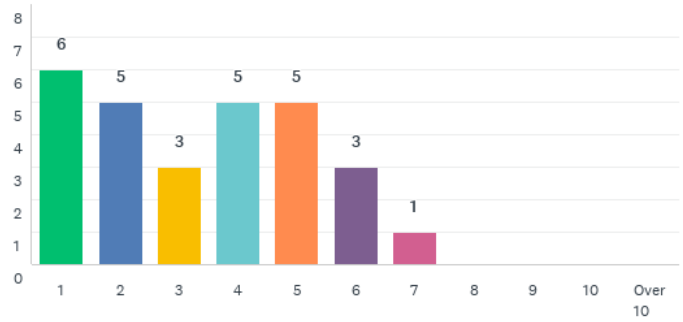
Q5 What is the organization you have been linked to?



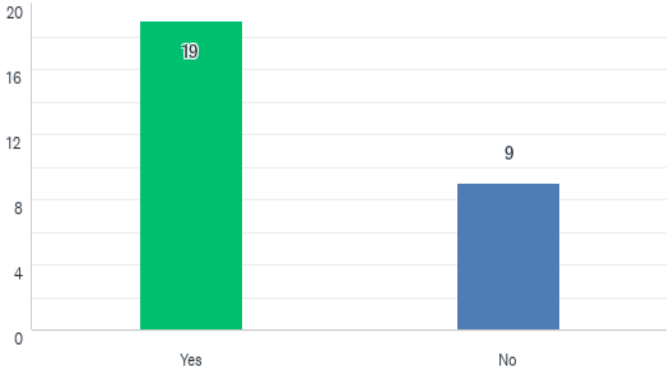
Q6 When was the first visit that you were a part of?



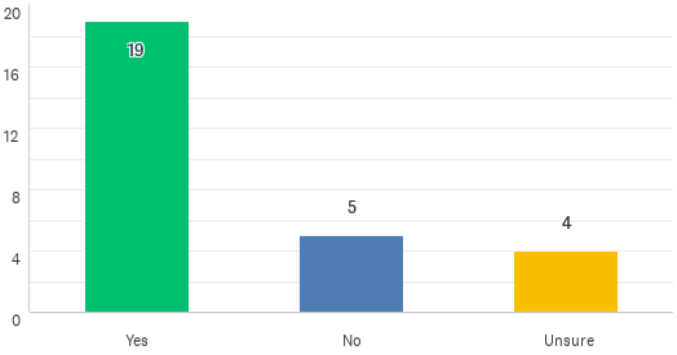
Q7 How many Project Hamrahi visits have you participated in (in total)?



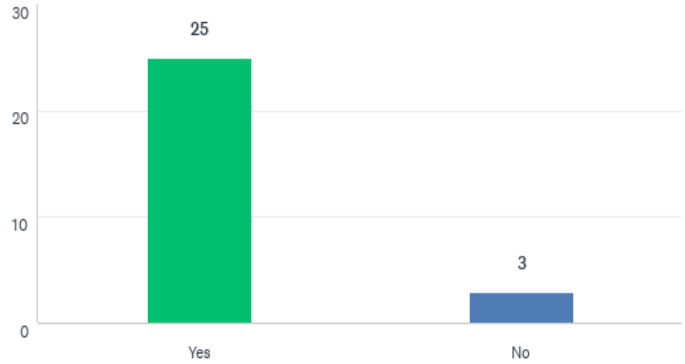
Q8 Are you currently involved as a Project Hamrahi mentor?



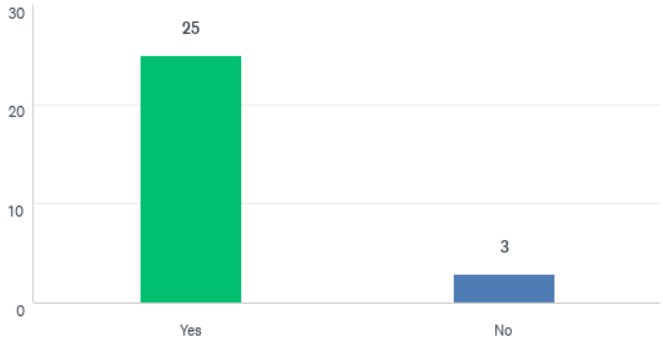
Q9 Did you receive the mentor pack for Project Hamrahi?



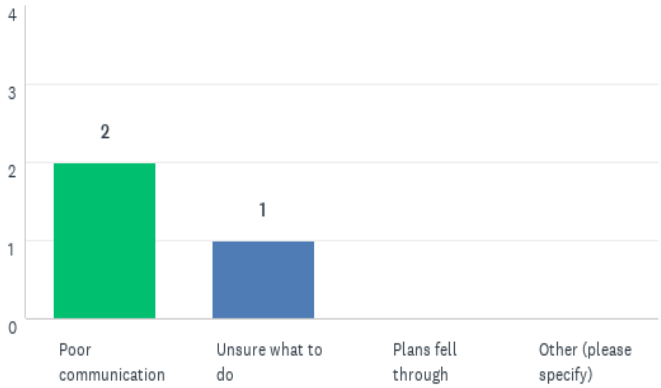
Q10 Did you receive adequate advice and information from APLI when preparing for your Project Hamrahi visit in India?



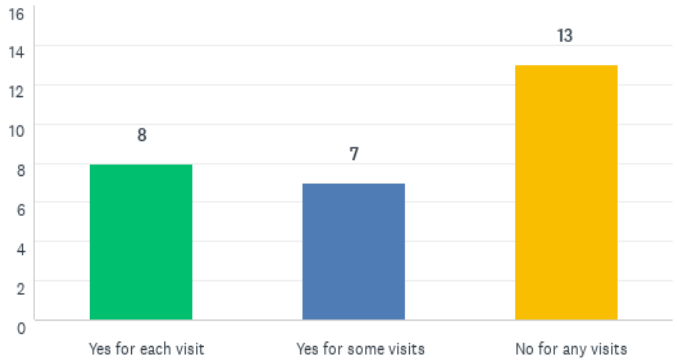
Q12 Were you able to connect with your link organisation before the visit and plan your visit together?



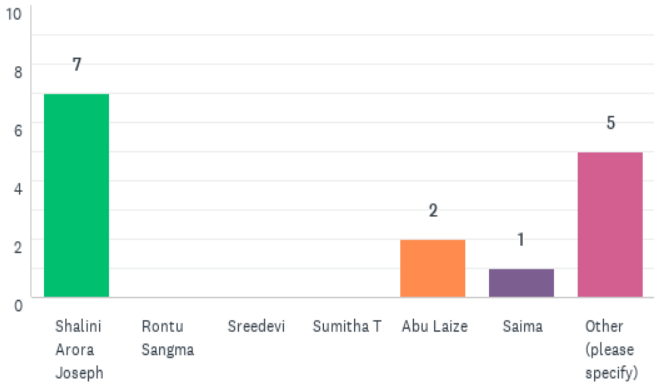
Q13 What problems did you encounter in connecting with your link organisation?



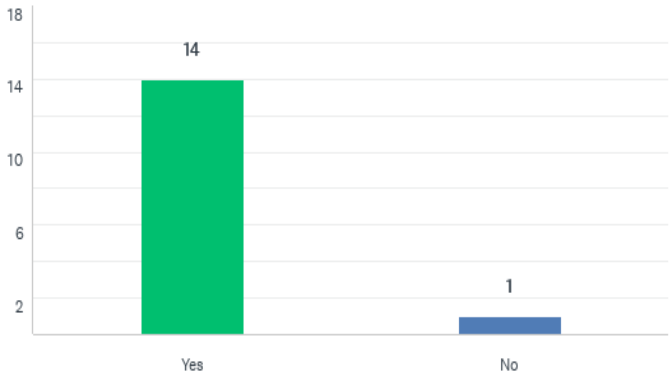
Q14 Did you have contact with Pallium India's regional project officer (PO) for your link organisation region before the visit?



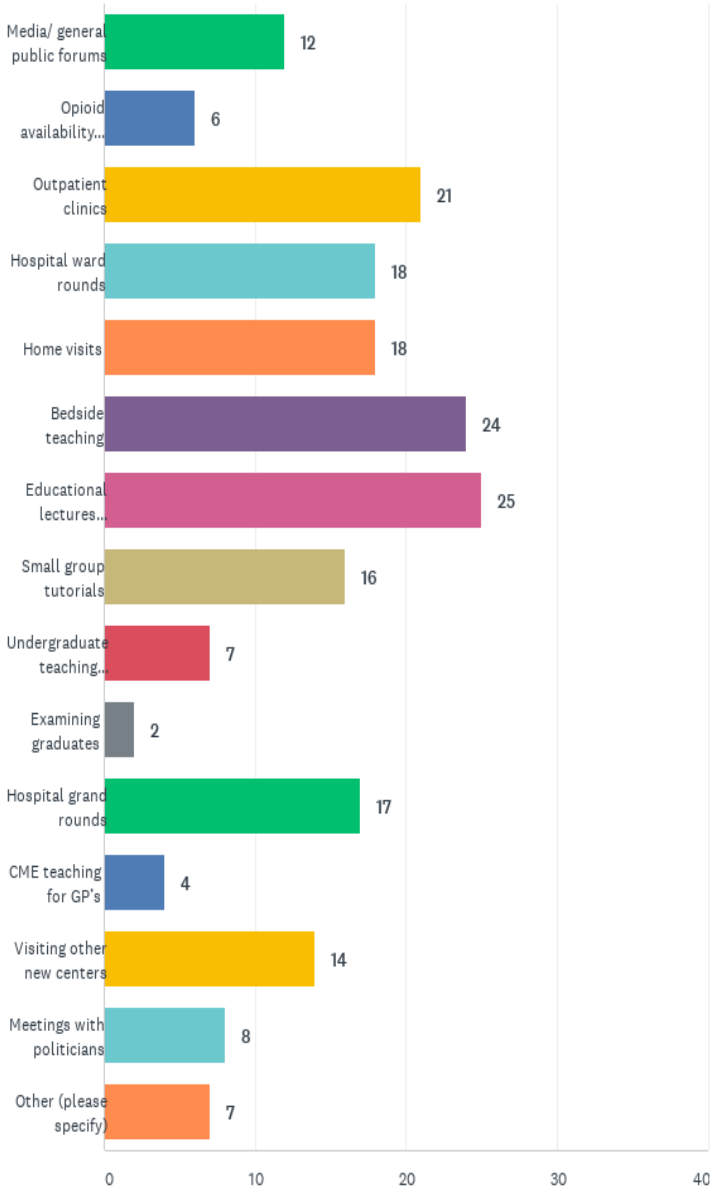
Q15 Who was your PO?



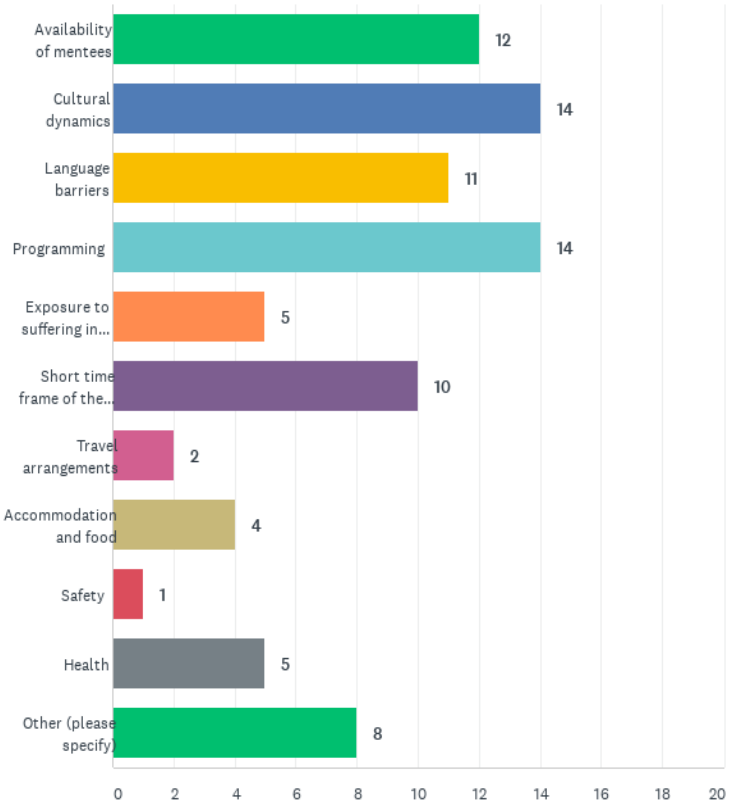
Q16 Did you conduct any Project Hamrahi visit with this PO?



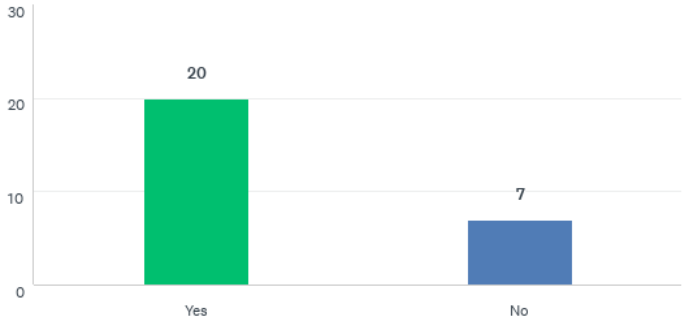
Q17 What activities did you undertake during your Project Hamrahi visits?



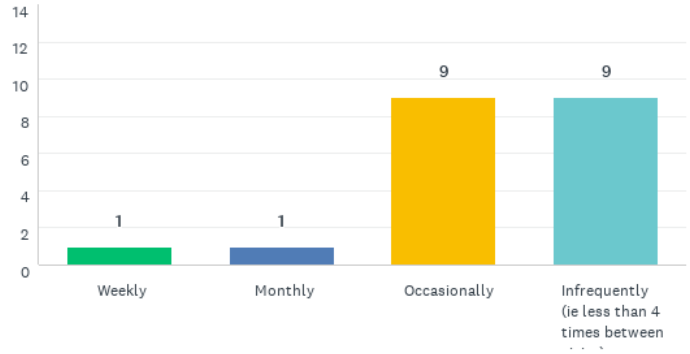
Q19 What were the challenges experienced in the visits?



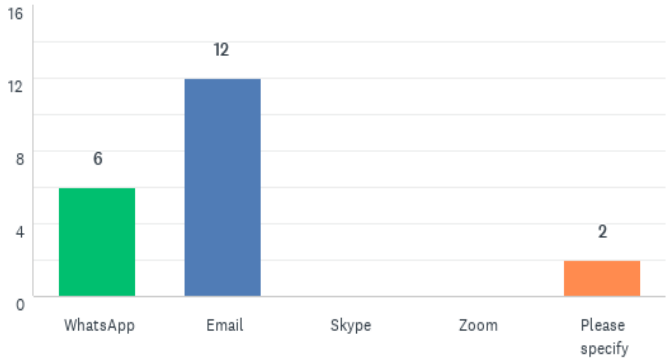
Q20 Were you able to contact your mentees between visits?



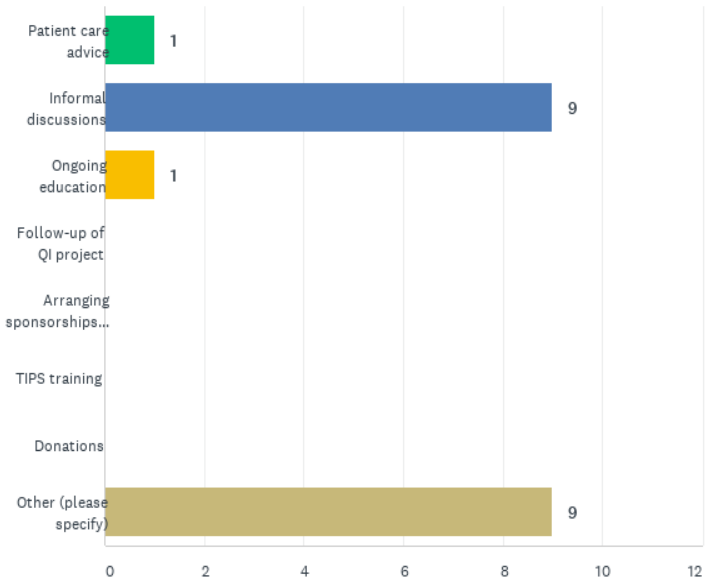
Q21 How often do/did you contact your Project Hamrahi mentees?



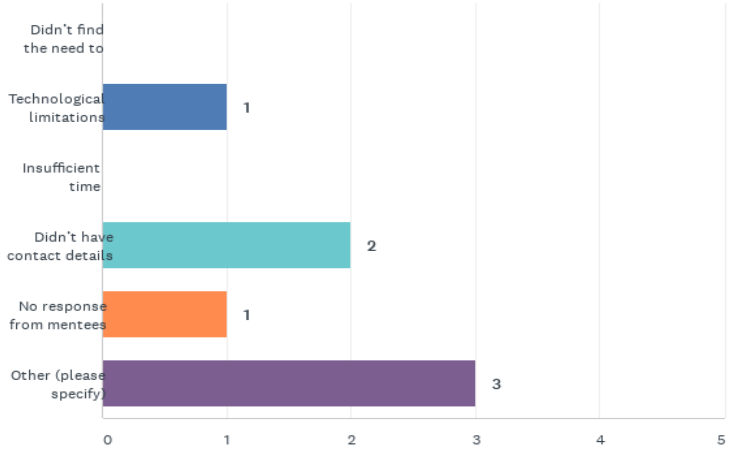
Q22 What is/was the usual mode of contact?



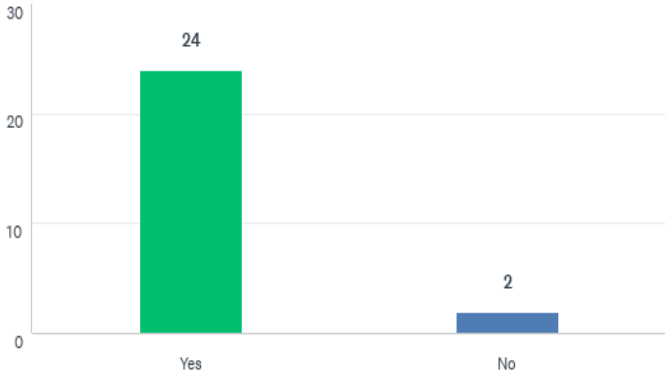
Q23 What is/was the nature of your contact with your Project Hamrahi mentees?



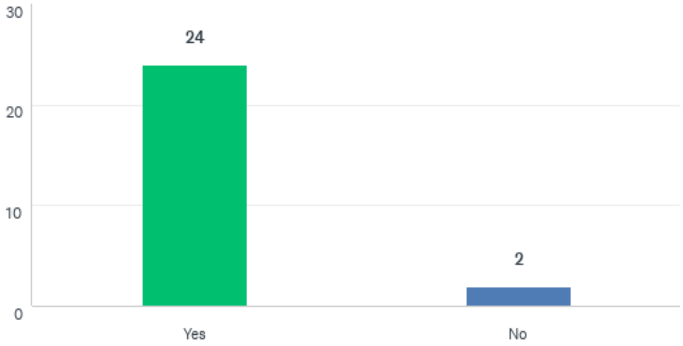
Q24 Why do you/have you not had any contact with your mentees?



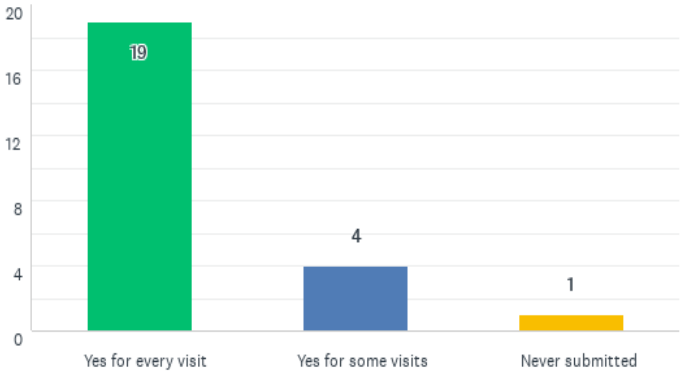
Q26 Do you feel like you were able to make a contribution to the palliative care services at your link organisation during your visit?



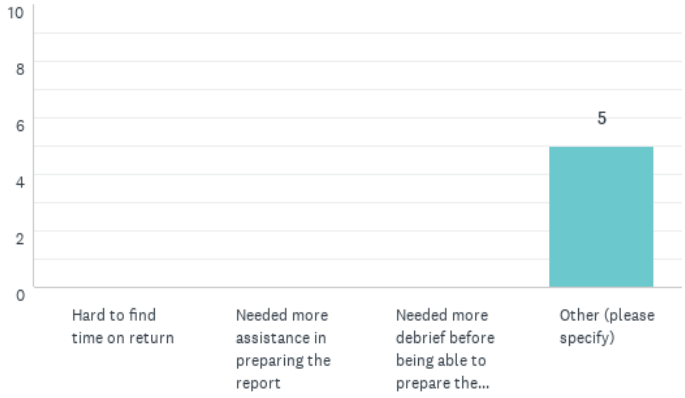
Q30 As part of your mentoring role in Project Hamrahi, you were requested to provide a written report to APLI which included recommendations for your link organization to help in the development of services. Were you aware of this requirement?



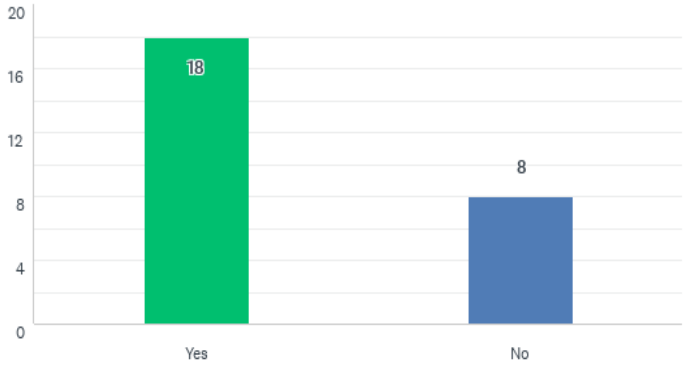
Q31 Were you able to provide this report after all Project Hamrahi visits?



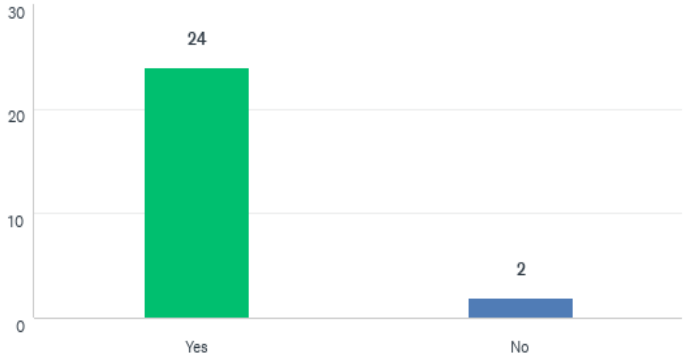
Q32 Can you indicate the difficulties encountered in providing the report?



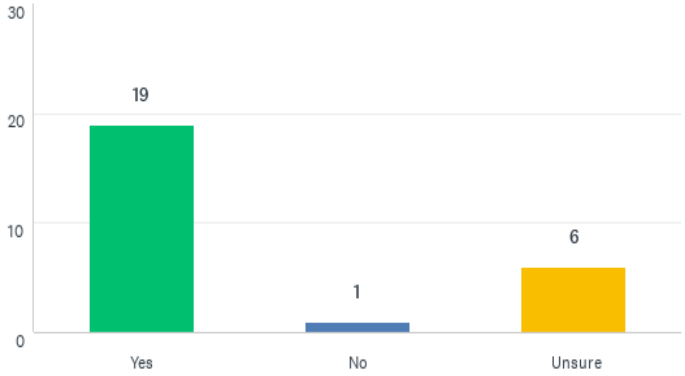
Q33 Did you take part in the debriefing after your Project Hamrahi visit?



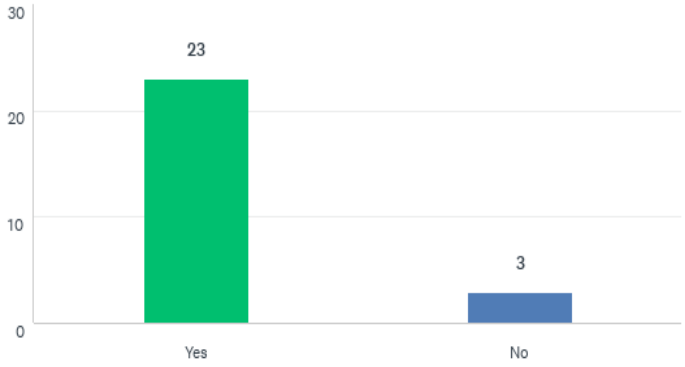
Q36 Do you think debriefing is necessary?



Q39 Are you planning to continue as a mentor in Project Hamrahi?

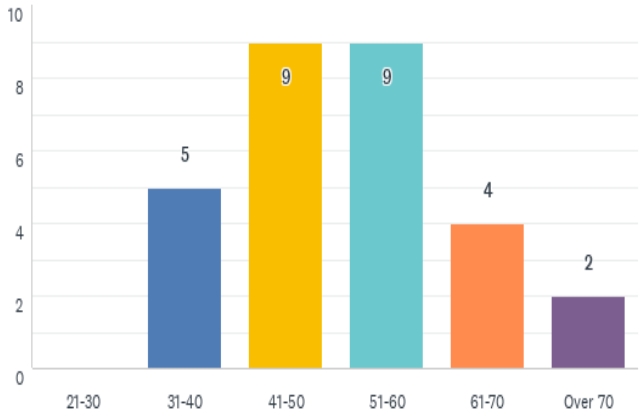


Q44 Do you think that the current model of three visits over three to five years should continue?

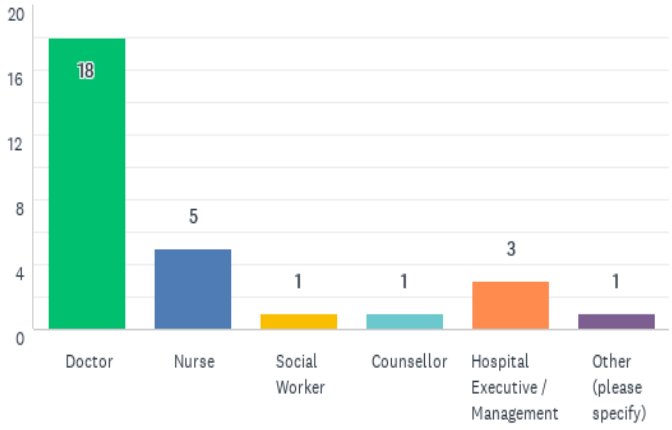


Appendix 8: Descriptive results from the Mentee survey

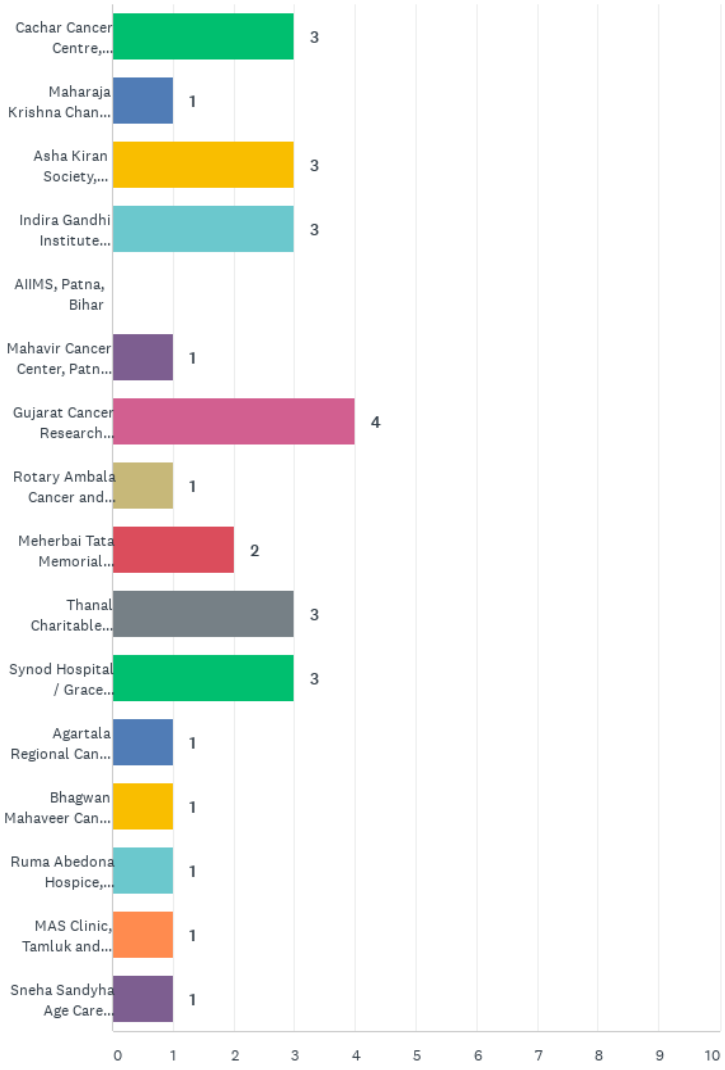
Q2 Age



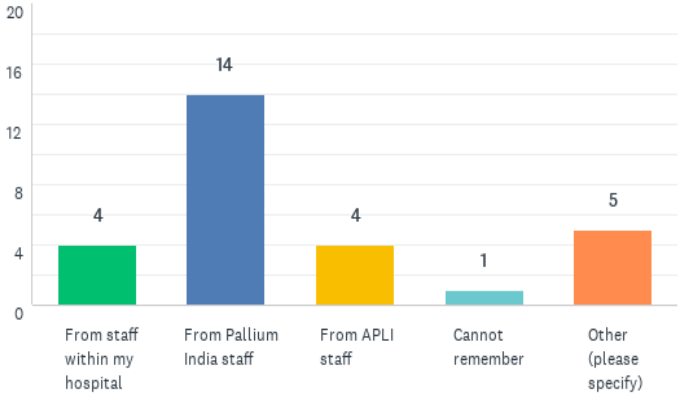
Q3 Participant Discipline



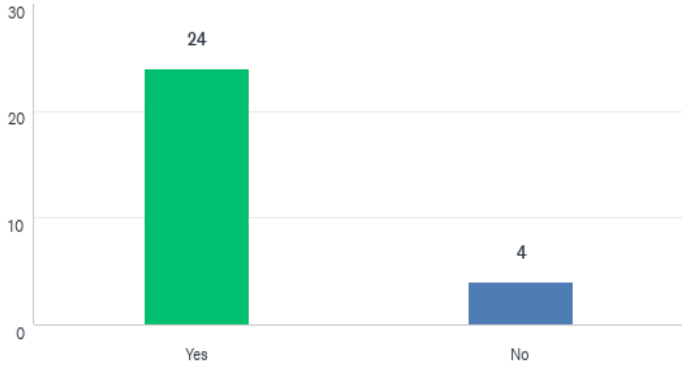
Q4 Organization associated with



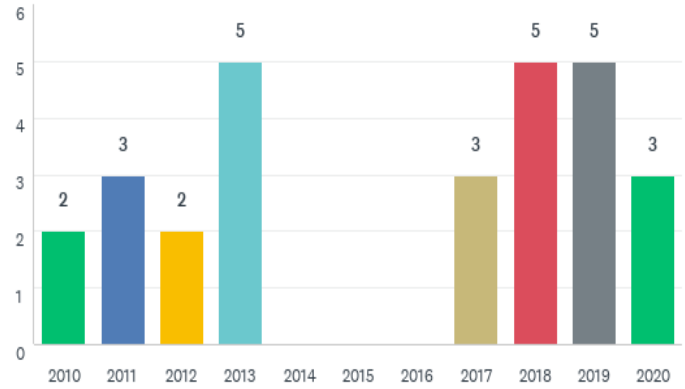
Q5 How did you hear about Project Hamrahi?



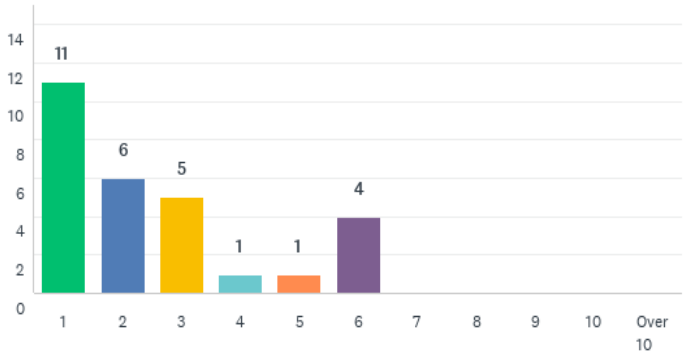
Q6 Were you involved in initiating Project Hamrahi at your organisation?



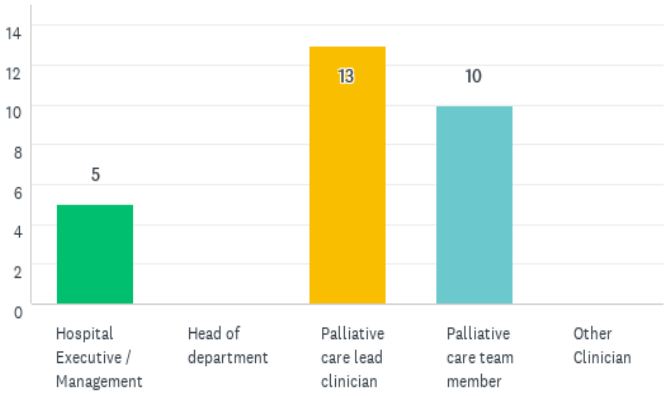
Q7 What year did you become involved in Project Hamrahi?



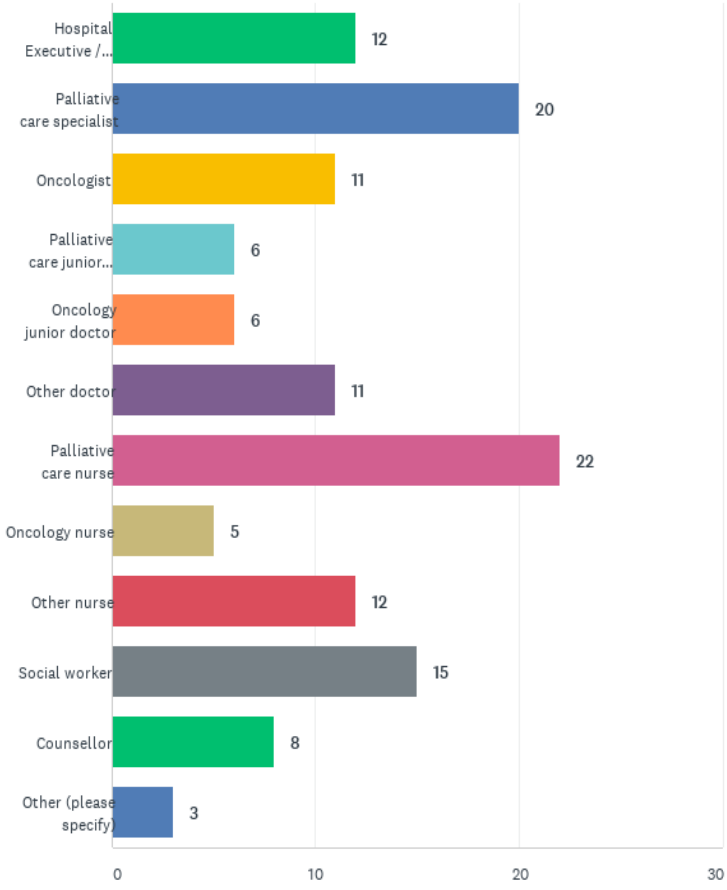
Q8 How many Project Hamrahi visits have you been involved with?



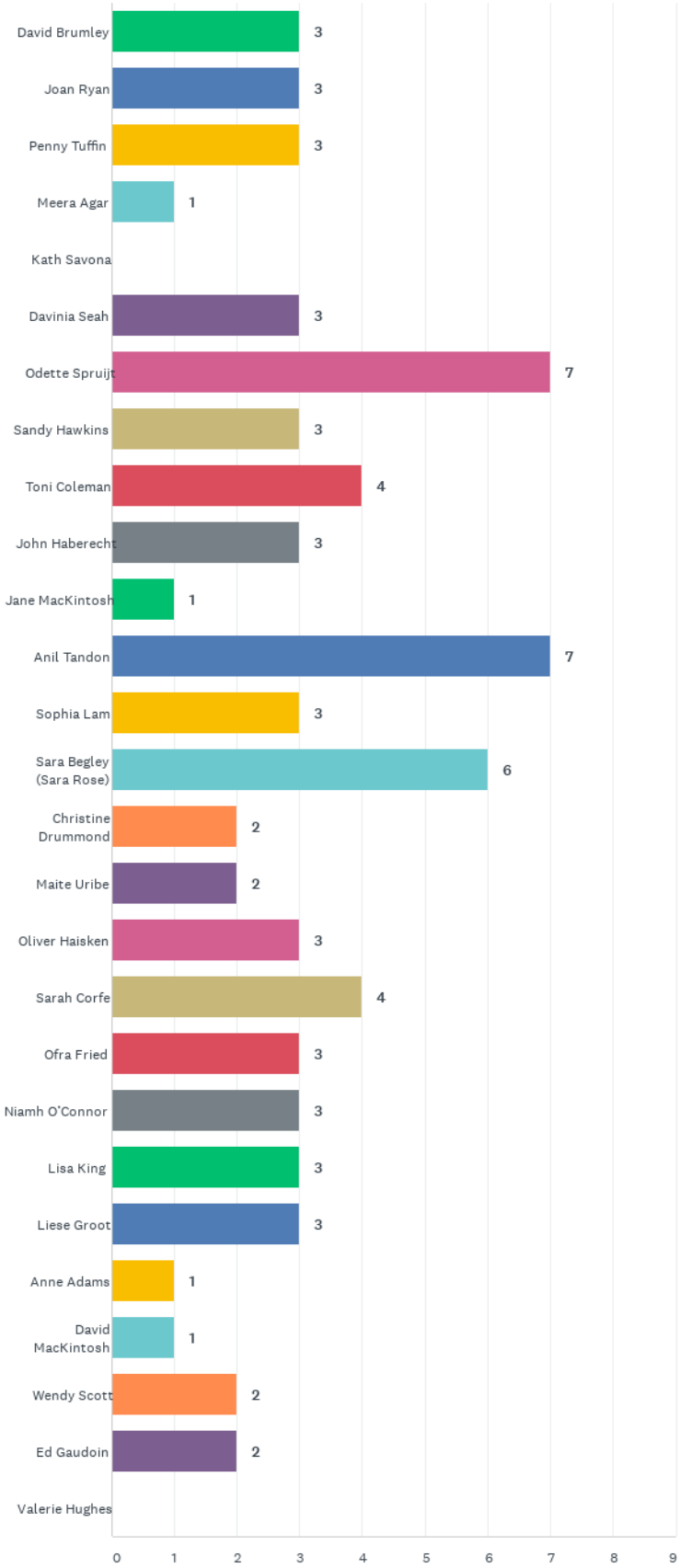
Q9 How would you best describe your role at your organization?



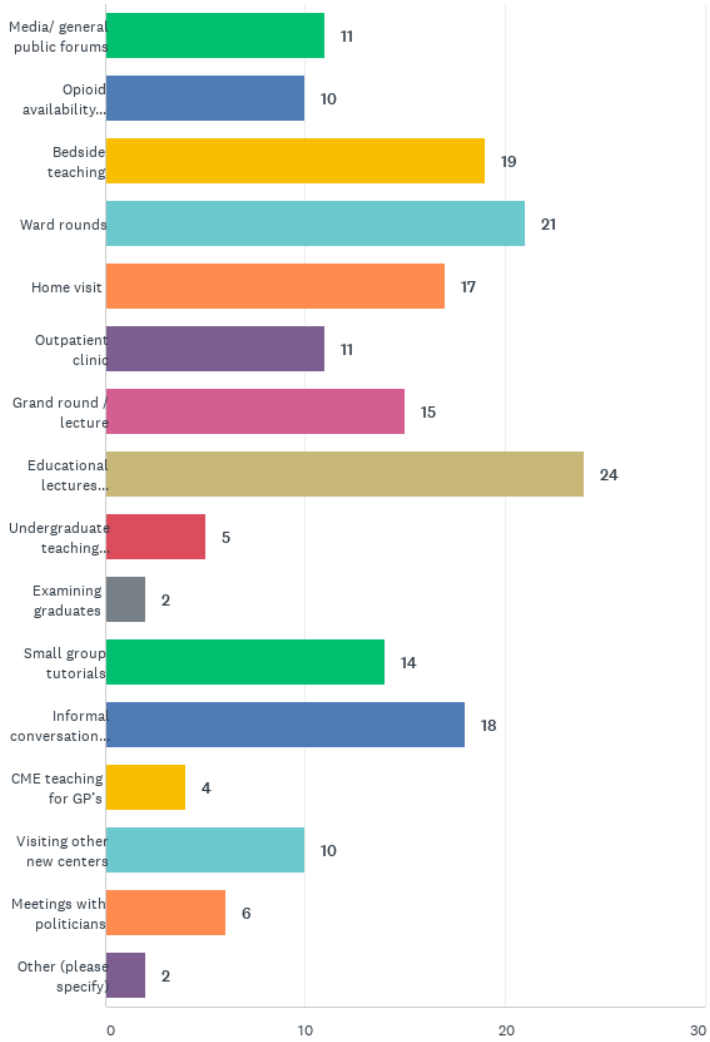
Q10 Who are the people who have been / are involved in Project Hamrahi at your organization?



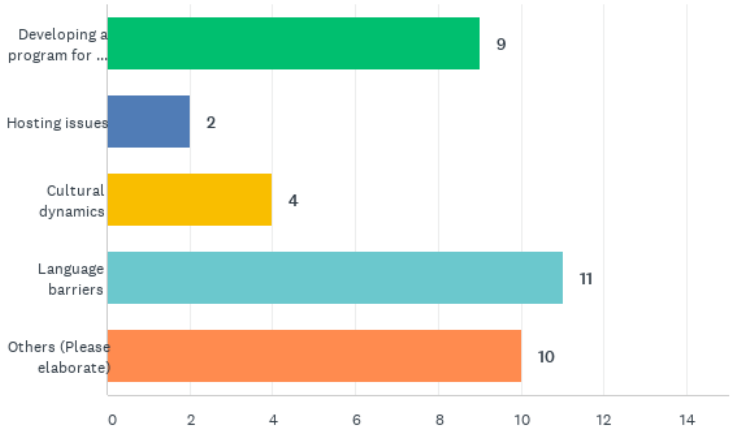
Q11 Who are/were your Project Hamrahi mentors?



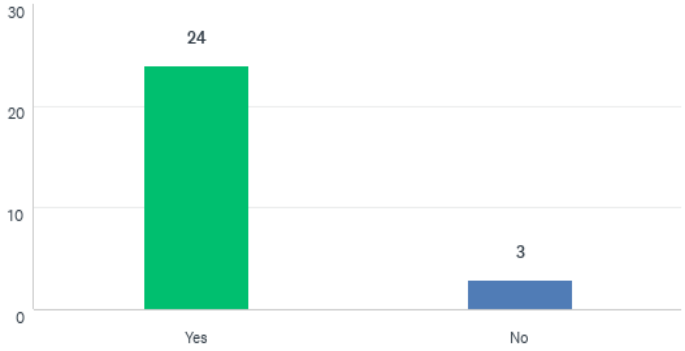
Q12 What activities did you undertake with the Project Hamrahi mentors during their visit/s to your organization?



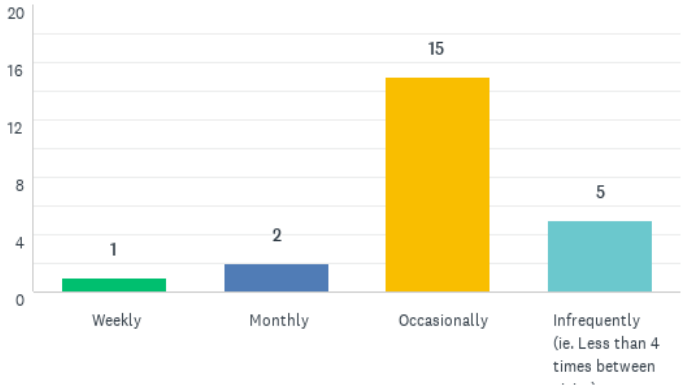
Q14 What were the challenges experienced in the visits?



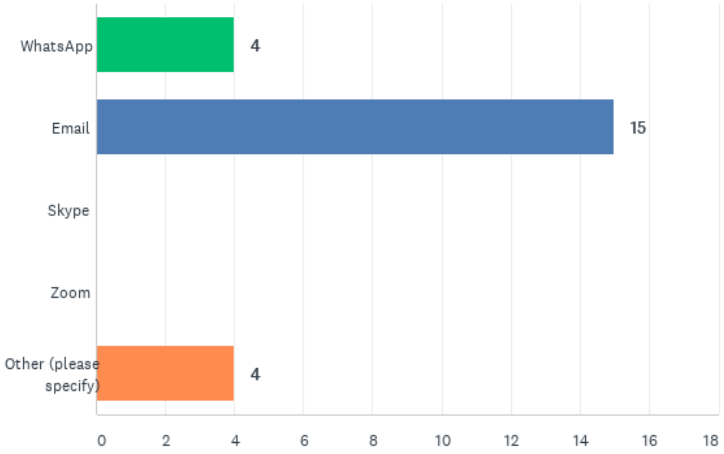
Q15 Are/were you able to contact your mentors between visits?



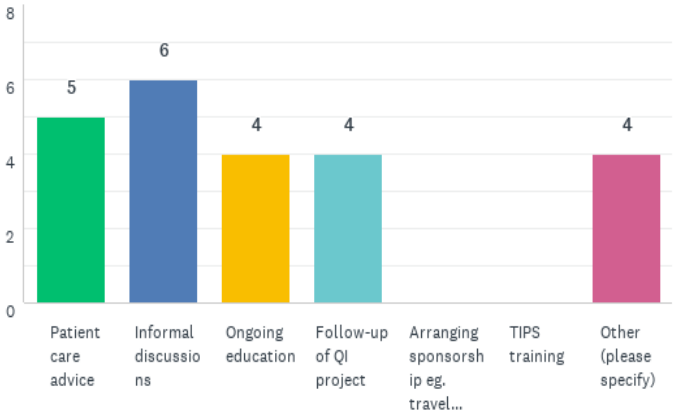
Q16 How often do/did you contact your mentors between visits?



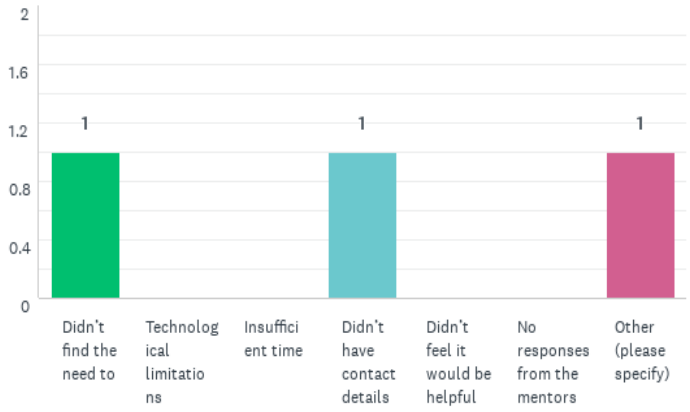
Q17 What is/was the usual mode of contact?



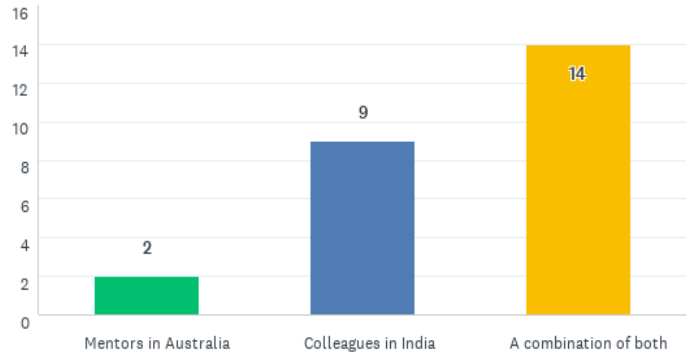
Q18 What is/was the main reason for your contact with your mentors?



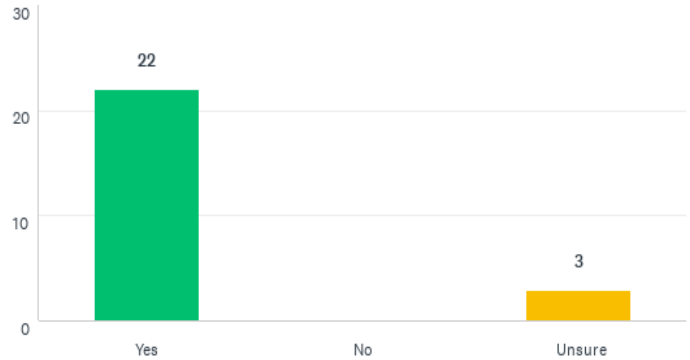
Q19 Why do you/have you not had any contact with your mentors?



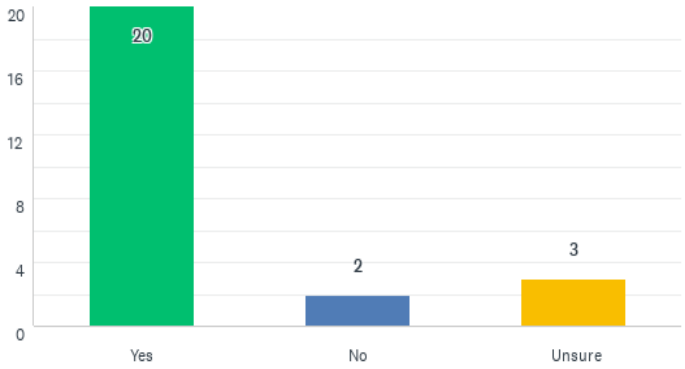
Q20 Who do you go to most for advice on palliative care issues?



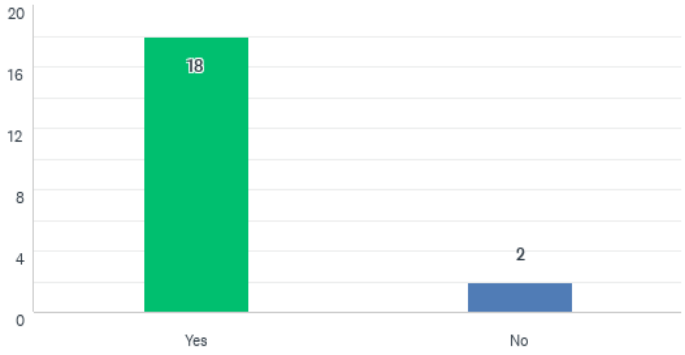
Q22 Do you think Project Hamrahi has made a contribution to your organization?



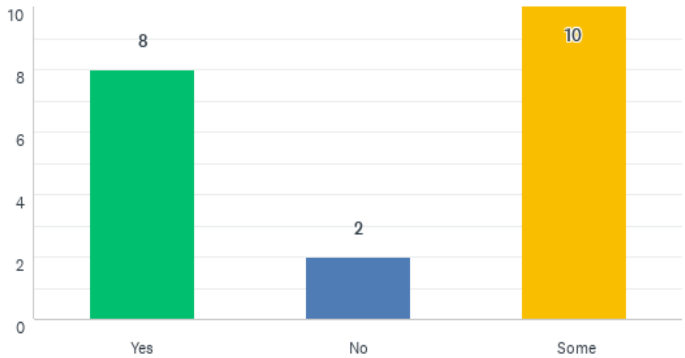
Q26 Did you receive a written report from the Project Hamrahi mentors after completion of the visit?



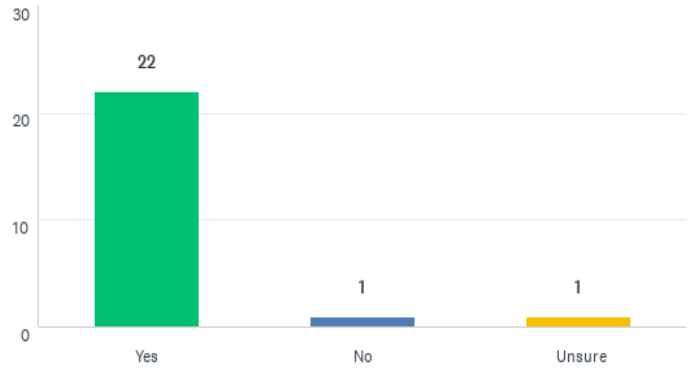
Q27 Did the report provide recommendations for development?



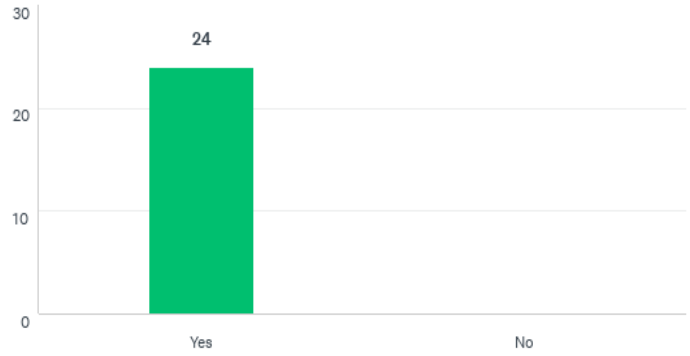
Q28 Have you been able to implement these recommendations?



Q31 Would you like to have ongoing Project Hamrahi mentoring?

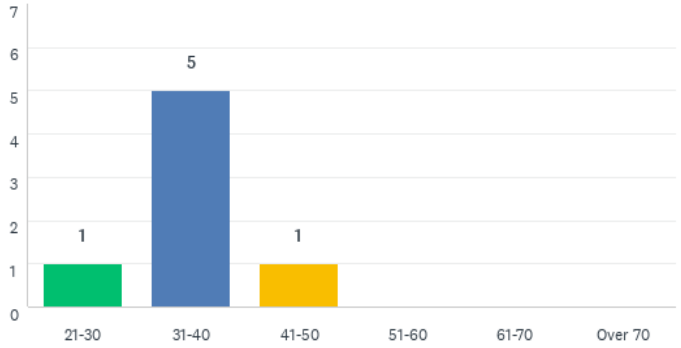


Q34 Do you think that the current model of three visits over three to five years should continue?

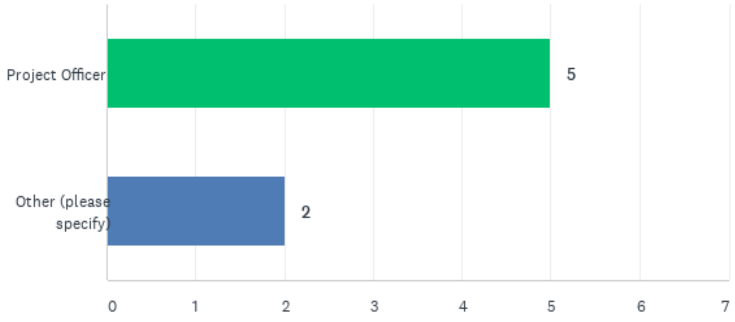


Appendix 9: Descriptive results from the Project Officers survey

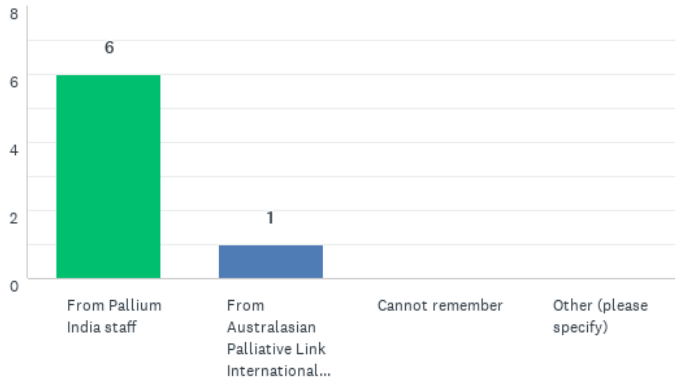
Q2 Age:



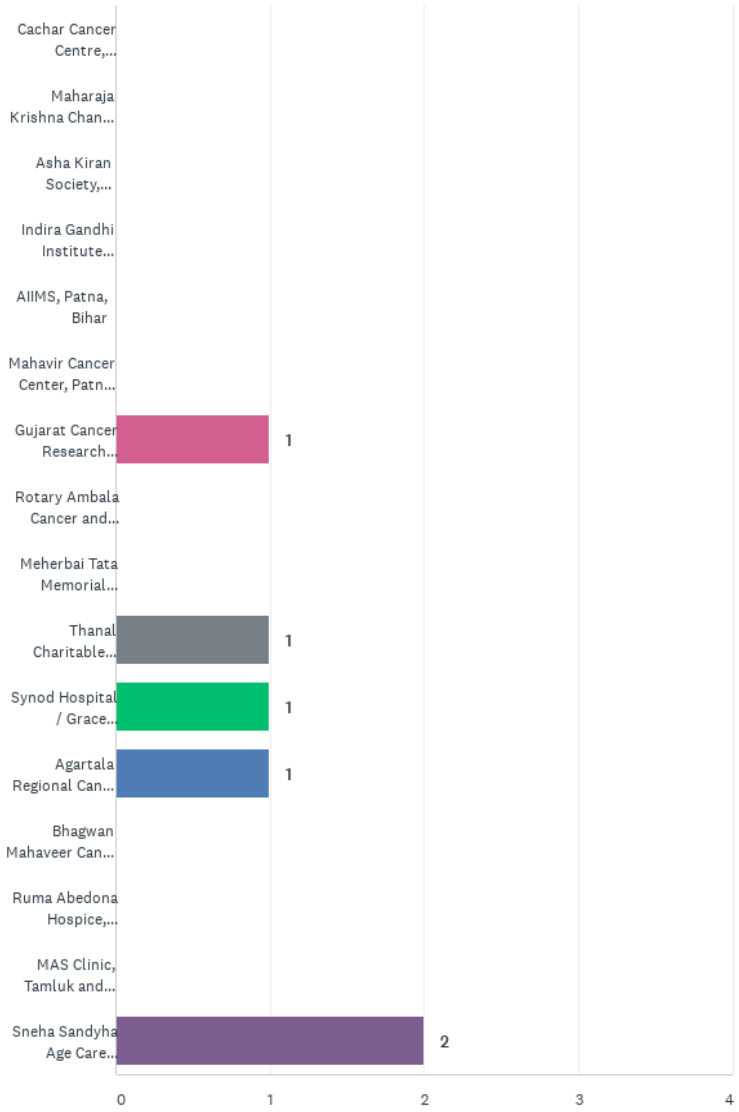
Q3 Participant Discipline:



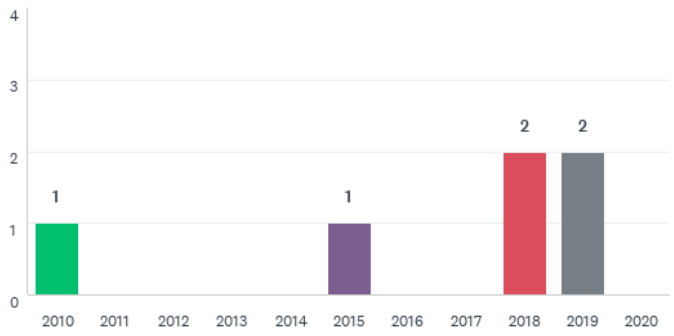
Q4 How did you hear about Project Hamrahi?



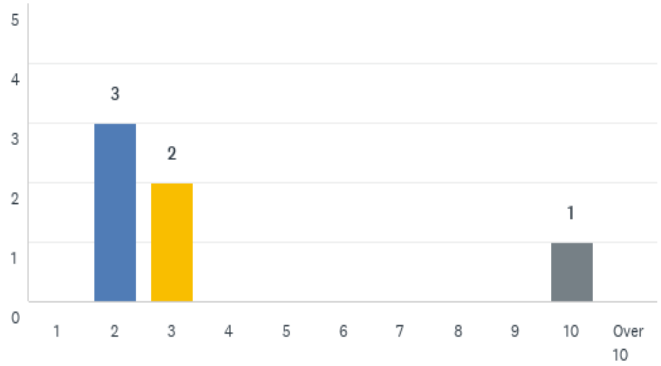
Q5 What is the organization you have been linked to?



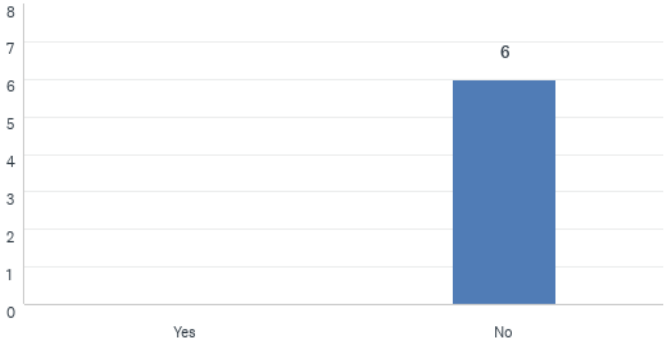
Q6 When was the first visit that you were a part of?



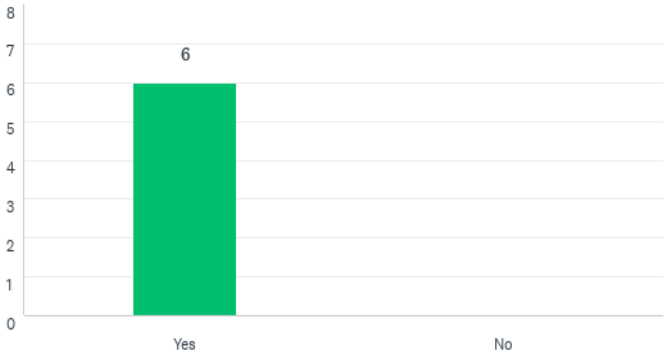
Q7 How many Project Hamrahi visits have you participated in (in total)?



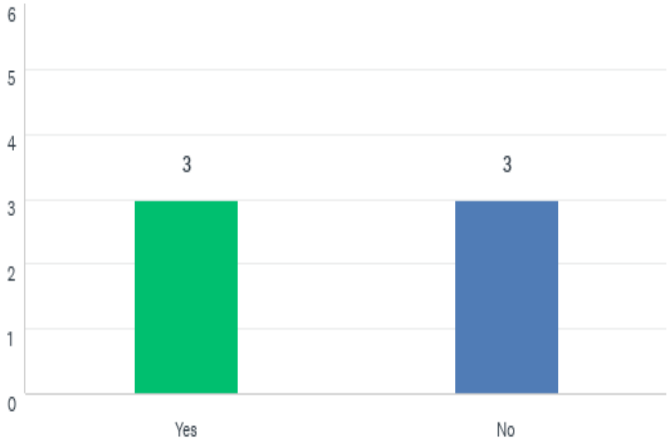
Q8 Are you currently involved in Project Hamrahi?



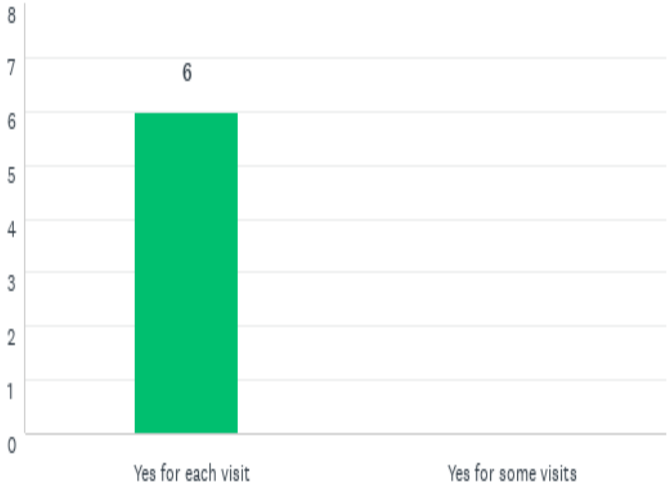
Q9 Did you receive adequate advice and information when preparing for your Project Hamrahi visit from the mentors and Pallium India?



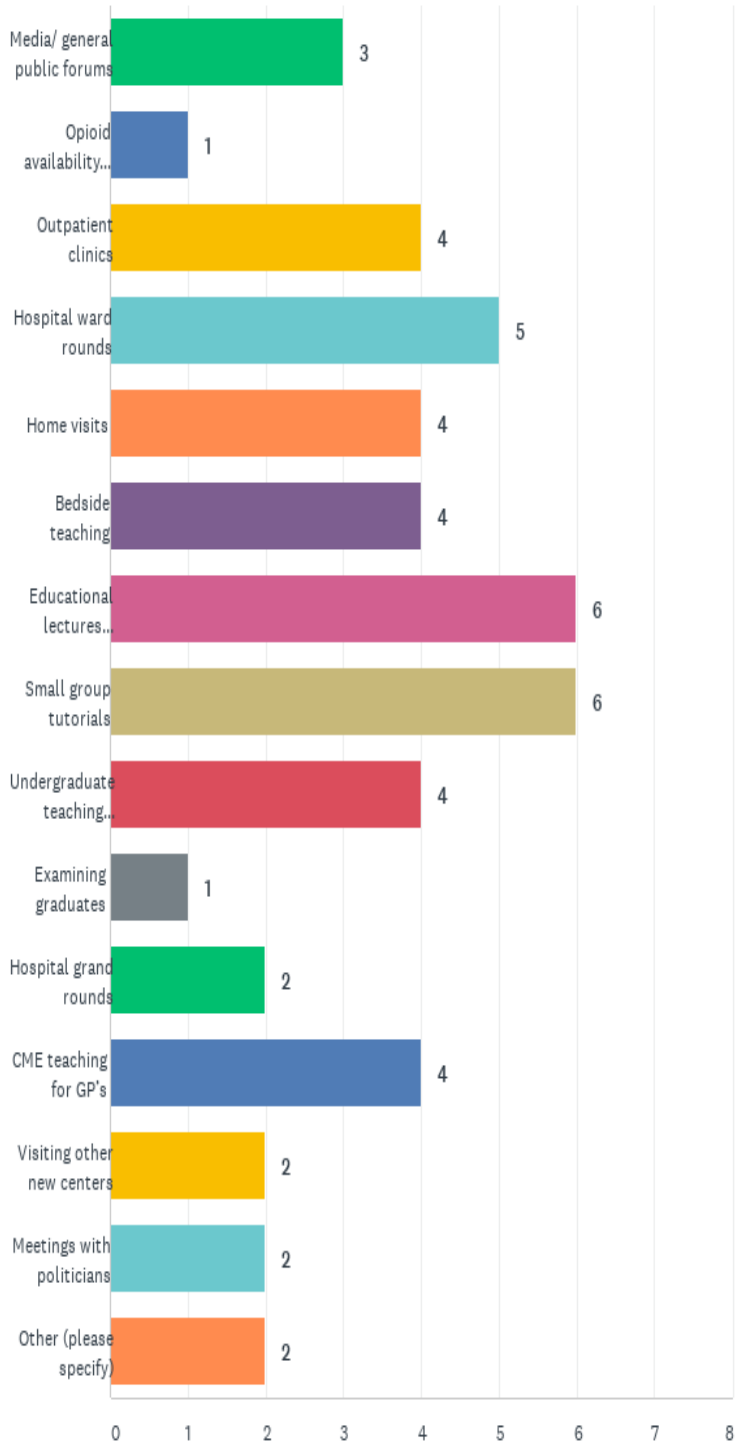
Q12 Had you visited the link organisation as a Pallium India regional officer, before participating in Project Hamrahi?



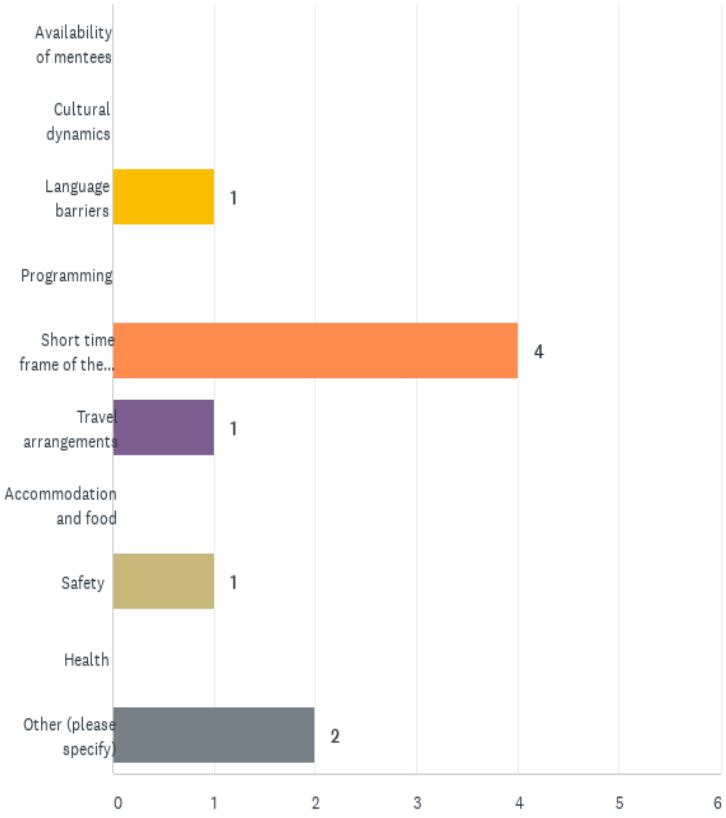
Q13 Did you have contact with APLI's (Australasian Palliative Link International's) mentors for your link organisation before the visit?



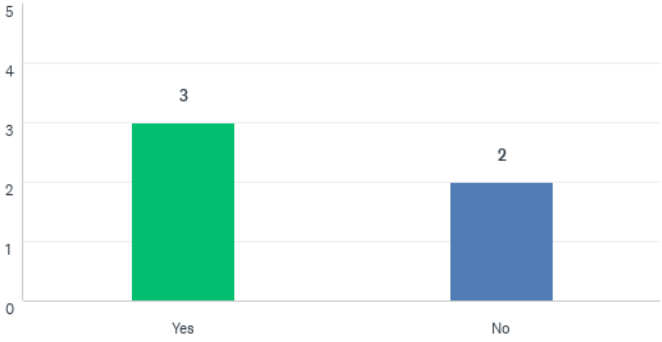
Q14 What activities were you a part of during your Project Hamrahi visits?



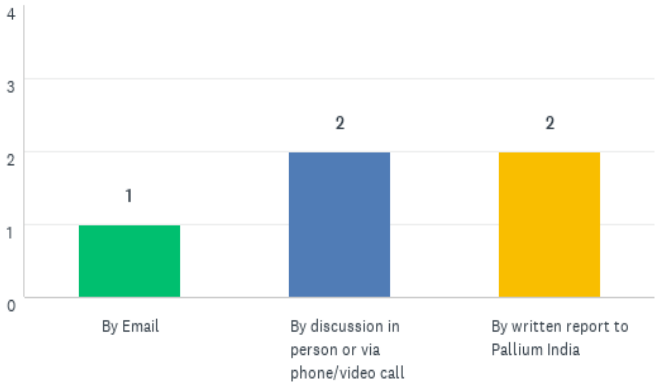
Q16 What challenges did you notice in the visits?



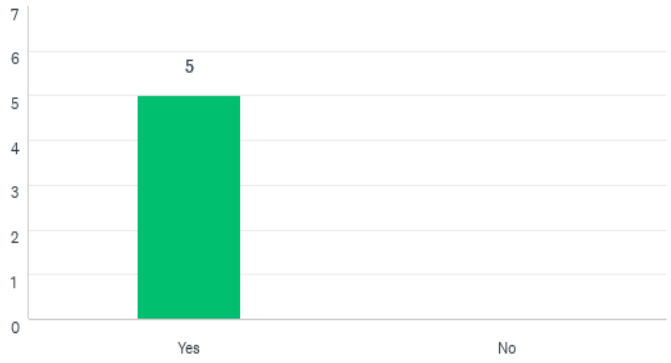
Q20 As part of the mentoring role in Project Hamrahi, mentors were requested to provide a written report to APLI which included recommendations for the link organization to help in the development of services. Did you participate in preparing this report or offer feedback on the report?



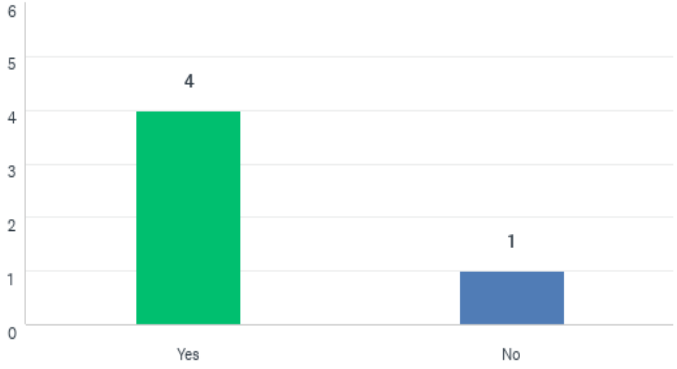
Q21 How did you provide feedback to Pallium India / APLI after your Project Hamrahi visits?



Q22 Do you think debriefing with your mentors after the visit is necessary?



Q28 Do you think that the current model of three visits over three to five years should continue?



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