Mixed method evaluation of a palliative care project in rural North India

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Background
EMMS International, a healthcare charity based in Scotland, worked with its partner Emmanuel Hospital Association (EHA) in rural North India on a three year project to develop and support palliative care delivery by EHA.

Following on from a needs assessment in 2010, EHA developed a home based model of palliative care delivery as a response to gaps in its service. EHA’s partnership with EMMS International enabled the model to be further established and implemented as part of EHA service across 5 different sites in rural North India. All teams were attached to an EHA hospital but had dedicated staff with patients’ access to outpatients’ service and inpatient beds. In addition to provision of holistic palliative care emphasis was made on raising awareness of palliative care in the communities and empowering families to provide effective care in the home. Evaluation of the project took place in April 2015.

Aim
Evaluating the impact of the EHA-EMMS community based palliative care programme, developed and funded by a UK agency and an Indian agency and set up in five hospitals in rural North India.

Method
Mixed method rapid realist evaluation, with data collected from documents, activity records; field observation of services and 44 in-depth interviews with hospital leaders and staff, patients, carers and community members. All teams were assessed against Pallium India PC Standards and overall programme approach through WHO Public Health for PC.

Results

Model of Care
The palliative care teams worked to reduce the social stigma involved with advanced illness, death and dying which reduced isolation.

“They try to return to the humanity, the love and the care that was due to that patient.” – EHA staff member

Impact of the care
Over the period of 3 years and between the five sites the service included 4164 home visits for 3202 patients and their families, 4322 patient visits to the outpatient clinic as well as having 537 formal awareness raising meetings in the communities.

All teams achieved most Pallium India markers apart from morphine utilization; despite great effort only 2/5 had secured morphine licenses. The programme demonstrated compliance with WHO Public Health PC principles.

Supporting and teaching families empowered them to care for their loved one.

“Her worries go away when she sees them.” – Husband of a patient the team visits

“She doesn’t feel alone anymore and she’s very grateful for people coming to take care of her. She is grateful for the PC team as they share her pain.” – Relative of a patient

“They understand me and they understand my pain.” – A patient

Conclusion
The model developed, through a health-promoting palliative care approach, exemplifies a locally appropriate, evidence-based, iterative approach to palliative care service development. The palliative care services delivered by the EHA teams in rural North India are transformative for the communities in which they are delivered, which results in enhanced quality of life for patients with palliative care needs and their families. Implementation of this model by these five teams has led to other member hospitals of EHA across northern India being influenced to start to offer palliative care service through this model of care. The overall approach has wider applicability for palliative care service development.

References