

EDITOR'S NOTE

This edition is a celebration of relationship, adventure, compassion and life. It is a privilege to bring you these stories of courage, leadership and friendship.

We hear about two men of vision, neither of them health professionals, who have started grassroots community based palliative care in opposite parts of India, West Bengal and Lakshadweep. Interestingly, both were artists, one a tabla player, the other a Kathakali dancer and art teacher. Perhaps because art teaches us to respond to the movements and voices of the heart, these men had the courage to take extraordinary steps and were able to inspire others to dance with them in the relief of suffering of their fellowman.

Another inspiring leader, this time a medical professional, also took extraordinary steps, moving from his successful practice in Chennai, to Assam in far north India, to establish a cancer centre in that impoverished and poorly serviced part of India.

Three palliative care practitioners in Australia tell of their adventure into the unknown, to the Self-Care retreat run by Kosish the Hospice, in January this year. Their generous response to this experience is the foundation of future collaboration and exchange.

If you are inspired to step into the unknown and lend your hand and heart to help build these collaborations and contribute in some way to palliative care development in the Asia Pacific region, please contact APLI on info@apli.net.au, we will be happy to hear from you.

Odette Spruyt

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PROJECT HAMRAHI

WITH A CHAMPION, ANYTHING IS POSSIBLE



Moulana and volunteer

I hope you will let me tell you a story about Lakshadweep, a group of islands in the Arabian sea, off the coast of Kerala, India.

A teacher of art at a government girls' college in Kavaratti, one of the 10 inhabited islands of Lakshadweep, leads a grassroots palliative care project, Thanal. Starting alone, he responded to what he saw and felt was lacking in his island, home care relief for the people. On his bike, with a bag containing a meagre assortment of medical items and a heart full of compassion, he rode from home to home, caring for the ill and their families in whatever way he could. His first patient was an elderly man, abandoned by his family, soaked in excrement and dirt, lying alone in his home. From this beginning, one man dedicated to making a difference, one man without government or medical support, has been able to create a thriving palliative care program, extending across 5 of the 10 islands, primarily volunteer-based, which is now supported by health officials, government officials and other community leaders. His reputation is large, as is his heart and the hearts of the many volunteers he has inspired and offered a means of engagement in building a proud and self-sustaining community of action. There is next to no security, financial, staffing, nor external supports. It is a labour of love, a family more than a society where each member is able to contribute from their skills and learn new skills. It is a social movement, also promoting organic farming, cleaning up the island, exercise and diet, positive leadership and being responsible for your neighbours, literally. Sounds too good to be true, and yet, it is happening, 3 years in the making, big dreams, daily action. When such roots take hold, let's provide all the support and guidance and encouragement we can to help this tree to grow.

There is so much for us to learn from Lakshadweep.

We are reminded, strongly reminded, that providing palliative care is within the province of all of us. Anyone who has eyes to see and courage to act, can make a difference. Moulana started his work without a label. He then found out about Pallium India, an NGO working in Kerala, the state closest to Lakshadweep. He then found a name, palliative care, for what he was already doing. A doctor, Dr Ali Azher, and a nurse, Mr Ahammed Khafi,

saw what he was doing and joined him. They attended the PI 6 week training and are now fully involved in palliative care service delivery and training of volunteers, working as volunteers after their normal workday is over. They provide 24 hour on call cover and frequently respond to requests for help. There are many others, such as Rafiq who provides accounting and administrative expertise as well as direct care, Sayed Koya assists with programs and functions with his organisational skills and energy and Mansoor, another nurse, is always ready to lend a hand.

We are reminded that it is in the home where most of the care takes place. Those of us who are privileged to work in higher income countries know only too well the loss of capacity of our communities to care. Not so in Lakshadweep, where patients are cared for at home, definitely as a duty within the framework of this island with a population who are entirely Muslim, but also as a loving service.

We are reminded that palliative care is a philosophy of care that extends beyond walls, beyond diagnoses, beyond professional labels and hierarchies, beyond medicines, equipment, services, beyond ourselves. Yes, many of the home care patients visited are bedridden living with chronic illness, subarachnoid or CVA-induced hemiplegia, bronchiectasis, encephalopathy with spasticity. But in a setting without home care services of any type, this is the need. The team dress pressure ulcers, check blood pressures, urinary catheters, Ryles's tubes, tracheostomy tubes, contractures, hygiene and diet. They encourage and support the carers, mostly women, who are providing most of the hands-on care. Their visits reduce the loneliness of patients and carers alike.



Kiltan Thanal volunteers and Kavaratti team, in front of Kiltan Palliative Care office

Through Hamrahi, Australian palliative care professionals will continue to visit and support the development of services across the 10 islands of Lakshadweep, remote island communities which are being linked by the service of more than 75 volunteers, coordinated and motivated by the vision of one man who began this gigantic work on a simple bike.

Odette Spruyt, Sophia Lam & Sarah Begley

RETURN TO THE VALLEY: CACHAR CANCER CENTRE, SILCHAR, ASSAM, INDIA

The visit made in December 2015 was the third visit to Cachar Cancer Centre undertaken by members of APLI in the last three years. The visits have been part of Project Hamrahi, a collaboration between APLI and Pallium India. In all seven members have visited now. Sarah Corfe, Ofra Fried and Oliver Haisken have visited in the past, and last December Lisa King, Joan Ryan, Niamh O'Connor and I spent ten days there. We enjoyed ourselves immensely, learned a great deal and as before came away full of admiration for the skills, energy and compassion shown by the staff of this cancer hospital in one of the poorest areas of India. The hospital has grown before my eyes. Even in the four years since my first visit, bed numbers have grown from 60 to 100, with 200 staff now. Outpatient numbers have grown dramatically, so that there are now about 3000 new patients and 14000 reviews each year. The hospital has a new ICU, new accommodation for staff and many other improvements just in the last year.

Assam is a poor State of India. Tea production is a major employer in this part of Assam. The plantation workers are very poor and their reliance on piecework causes real fear of the costs of treatment, resulting in late disease presentation. More than half of the patients seen at the hospital earn less than R3000 per month (\$A60). It is typical of Cachar Cancer Centre that they have actively engaged with these social problems with programs of community education, outreach clinics, financial assistance and other creative responses such as employment for patients and families at the hospital.

Much of the development of the hospital has been due to the efforts of Dr Ravi Kannan. A commentary on his work can be found at <http://www.thebetterindia.com/48284/cachar-cancer-care-silchar-assam-doctor-kannan/>. An accomplished surgeon and oncologist, in addition his skill has been to cultivate an entire team of doctors, nurses and support staff who exhibit the same selfless energy in their work.



David in outpatients

We were welcomed at the airport and driven through Silchar town to the hospital by Dr Iqbal Bahar, Nurse Sarita, the head nurse of the palliative care ward, and Mr Kalyan Chakravorty, the Chair of the Cachar Cancer Centre Society. We worked in several areas on this visit. We engaged at a direct clinical level with nurses and doctors, sharing ward rounds in the palliative care ward and occasionally elsewhere, discussing individual patient problems. These were commonly related to pain and physical symptom control but also included much discussion of the social problems of the patients and families. Niamh and I spent regular time in the outpatient department with Dr Bahar, the palliative care physician, gaining a great respect for his ability to work effectively in a hot, cramped and busy space. His workday is bogging by our standards. So too is his flexibility: no waiting for a pleural tap or an abdominal ultrasound – it's done on the spot. This is a good teaching for those of us who are mired by protocol.



Niamh handing out certificates

Joan and Lisa spent time with the nursing staff in the ward and also in formal teaching. They also examined the nurses for their hospital palliative care certificate, and presented certificates to the successful nurses at the end-of-visit party.

A recurrent theme in our past discussions had been the difficulty in providing follow-up to patients after discharge from the hospital. This is a result of the very slow roads and the cost for patients of being away from the workplace. Since the last visit two telemedicine centres have been established at a distance from Cachar Cancer Centre. Patients attend these centres after discharge and the staff at the centres communicate with the nurses and doctors at the hospital. Although not qualified as nurses, they provide a contact point for staff and arrange the sites for the regular fortnightly visits by the hospital team.



Joan and Lisa at Karimganj community meeting

We were also given the chance to speak to large groups of interested local people, and to spread information about cancer prevention and palliative care in these areas. In particular, smoking and chewing tobacco cause many oro-pharyngeal cancers. One such speaking engagement was at Karimganj, a small city on the border with Bangladesh, and a difficult drive from Cachar along the Barak river. There Niamh spoke to a large group of local people, including nurses, in a tent erected for the purpose by the Rotary Club of Karimganj.

All of us had the chance to present tutorials and lectures on a very regular basis. Dr Iqbal enjoyed challenging us by asking all of us for yet another lecture at very short notice! An afternoon visit to a tea plantation and discovered a talk was required immediately on our return! We were all glad we brought our laptops with us.

We were constantly socialising over meals, both at the lunch cafeteria but also over the frequent dinners with staff members. This gave us the chance to talk about some social issues, and one such issue was that of truth telling. It is not usual practice for doctors in this part of India to tell patients bad news, but they usually tell a family member. It was interesting to find that this is beginning to change, and we were able to add our voices to the debate, and ask whether or not this represented a deeply held cultural belief. We hope to be able to discuss this matter further in planned ongoing Skype sessions.

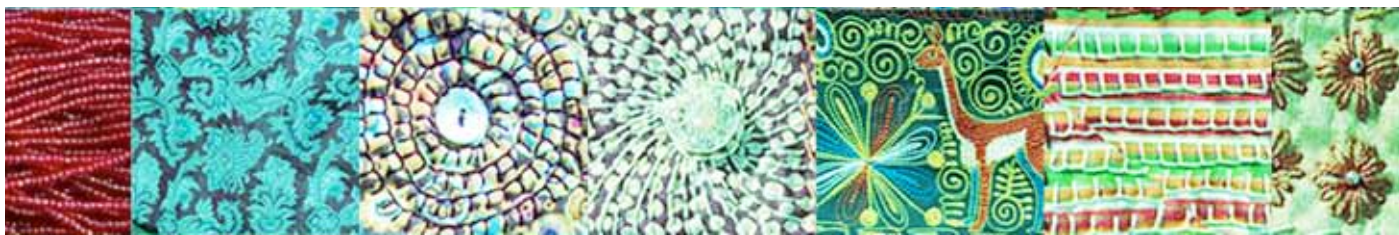
We were given some relaxation time too. We had a delightful boating afternoon on the Barak river: on a small boat seeing the lives of the people in this riverine land. We had an evening celebration on leaving, at which dressups and singing were required!

We all hope that you might consider a similar venture to this. Many palliative care staff have expressed interest but at the same time wondered about their skills. The main requirement is a willingness to engage with and enjoy the experience of another culture. In the process of doing this, the differences fade and the learning is shared. The generosity of the people in places such as this reinforce my faith in human nature, and act as a powerful antidote to any ennui that might develop in the course of our normal lives. Go for it!

Rabindranath Tagore says it well in Poem 63 of Gitanjali.

"Thou hast made me known to friends whom I knew not. Thou hast given me seats in homes not my own. Thou hast brought the distant near and made a brother of the stranger."

David Brumley



PALLIATIVE CARE IN KOLKATA

- A LESSON FOR US ALL

Working as a volunteer in India I always seem to learn more than the stated intention of travelling to India to teach others. In October 2015 I was fortunate to spend a week in Kolkata with my good friend and colleague, Santanu Chakraborty, and this trip reaffirmed this. Santanu is an incredible individual who left his career as a professional tabla (a form of Indian drums) player in order to establish a palliative care service 35km from the city centre on the northern outskirts of Kolkata.

I was initially introduced to Santanu in approximately 2002 when he was at the start of his journey to found the Ruma Abedona Hospice (RAH). Named in honour of his late wife, RAH is volunteer driven organisation providing predominantly community based palliative care. In 2005, the Ruma Abedona Hospice building was officially opened by Dr Rosalie Shaw and initial work concentrated on a community model of care together with a day hospice facility. In 2007 Santanu was the first non-health care professional applicant to be accepted into the Flinders University Certificate in Palliative Medicine, and as part of this course he spent time with me at Sir Charles Gairdner Hospital for the clinical component of his learning.

In 2012, Santanu was invited by the General Manager of Chittaranjan National Cancer Institute (CNCI), the sole public cancer hospital located in the centre of Kolkata, to enter into a formal partnership with them. After two years of discussions and planning, RAH volunteers began an outpatient clinic. It was on the background of all of this work and steady progress that I finally took the plunge and accepted an invitation from Santanu to spend a week with him, to observe RAH in action and hopefully provide some education to him and his team of volunteers.

As luck would have it, the timing of my visit was remarkable for two reasons. The first was that I was in Kolkata the week before the annual Durga puja. In India there is a great deal of regional variation as to which of the various gods and goddesses are more closely worshipped. In the state of West Bengal, the goddess of Durga rules supreme and the annual puja, or prayer ceremony, in her honour literally causes the state, and its capital city of 14 million people, to spend a week beautifying itself and then a week in shut-down when the puja occurs.

The second reason was that I left Australia just as The Economist Intelligence Unit and Lien Foundation released their second Quality of Death Index report to coincide with World Hospice and Palliative Care Day. This report was notable because it spoke clearly of low income countries that were able to provide

excellent palliative care through models of innovation and individual initiative; that quality of care requires not just access to opioids but also inter-disciplinary teams that provide psychological and spiritual support to patients and their families; and that community-based efforts to raise awareness are essential. All of these features were made real for me by the extraordinary team of local Indian volunteers who give their time so freely to RAH.

Santanu is a highly professional manager and lay clinician whose vision and determination has enabled the organisation to grow steadily over the last 10 years of service provision. Although they do not yet have the ability to prescribe and dispense morphine, RAH has demonstrated to me that in a grass-roots model of community and outpatient palliative care, trained volunteers operating as nurses and social workers can provide equal or superior care to what is provided in many settings in Australia. Certainly this point was obvious to me as I sat in a cramped and basic outpatient room in CNCI to observe a palliative care clinic where patients and their families would see the doctor in one room and then move to the next room where they would meet with the RAH volunteers for wound care, psychological support or perhaps just because they knew there would be a friendly face and a listening ear. It certainly is a model of superior palliative care that I wish I had access to in my clinic in Perth where consultations are dominated by completing reams of paperwork and reviewing results of the latest PET scan.

Santanu had organised two whole day workshops for me, with topics including a general introduction to palliative care, communication skills, wound care and lymphoedema management. Despite these attempts to impart some knowledge to the teams at CNCI and RAH, I returned home to Australia much richer, having seen what one man with determination can achieve and the power of community volunteering at its zenith.

Anil Tandon

NEED OF THE HOUR



Inaugural Ceremony, 2016



Conference dialogue



Dr Max Watson responds to comments from the audience

Indian Association Palliative Care 2016: Brief Conference notes

A key theme running through many plenaries of the 23rd IAPCON was that palliative care is at the forefront of a change in medical practice and a model of multidisciplinary, patient and family centred care. This is sobering for those of us who work in the field and are aware of our shortcomings. Nevertheless, we have articulated our patient-centred, holistic care aspirations and set about living up to those aspirations, which puts us ahead of much of current health care practice.

In keeping with this theme was the focus on the increasing integration of palliative care into medical care systems with an excellent example of this coming from the collaboration between the surgical and palliative care departments of AIIMS, Delhi. Surgical trainees are given opportunities to do training in palliative care in recognition of the importance of palliative clinical decision making in surgical practice.

Dr Mhoira Leng urged us to recognise that palliative care is the need of the hour across the world, and especially in Lower and Middle Income countries where the burden of suffering is often hidden and ignored. The program included a session dedicated to discussing the WHA 2014 resolution which placed palliative care squarely within health planning and policy at the international level. Again and again, we were reminded of the gross mismatch between resources and need, the 82:20 Pareto rule in action -80% of the health care resource consumed by 20% of population. We were urged to do our part to address this, to work with governments and remind them of the WHA resolution and ask what action they have taken or are planning to take, toward achieving this.

There were inspirational stories to motivate and encourage us. Bangladesh has achieved an MD course in palliative care and is working closely with government to produce a national policy for palliative care. The MD course in India is now offered in two institutions, Tata Memorial, Mumbai, and AIIMS, New Delhi, with Tata's students now residents and looking at research opportunities. Nepal is working on their national strategy and making great progress. A national end of life care collaboration has been established. Specialists from diverse areas of medical practice are beginning to take notice of palliative care and were participants in the conference. Research is definitely on the agenda in India with a preconference workshop held along the lines of the Accord research meetings, providing fantastic mentorship and discussion for participants. E-learning featured large with Cardiff university launching their e-learning module for India, following on the footsteps of e-learning for Africa. This work was auspiced by e-cancer and Karunashraya Hospice, Bangalore, which was also a key sponsor of the conference.

Congratulations to all members of the IAPCON2016 scientific and organising committee for their hard work and dedication to get the program across the line, no easy task in the midst of all the usual demands of work and life. It was an outstanding achievement for all concerned.

Come to Coimbatore 2017 for a conference not to be missed.

Odette Spruyt

UPDATES FROM THE REGION



NATIONAL STRATEGY FOR PALLIATIVE CARE IN NEPAL

In Nepal over 112,000 people each year will be in need of palliative care. An appropriate national strategy is an important step towards enabling palliative care to reach those in need. In recent weeks very significant progress has been made toward developing such a strategy.

In February 2016, the Nepalese Association of Palliative Care (NAPCare) was joined by Two Worlds Cancer Collaborative Canada (who have supported palliative care development in Nepal over many years), the Ministry of Health and Population, the WHO, International Nepal Fellowship (INF), and other stakeholders for an important 3-day Forum where 30 invited participants worked to develop a National Strategy for Palliative Care for Nepal.

Representatives from INF included Dr Dan Munday, Palliative Care Consultant, UK, living in Kathmandu, advisor to NAPCare and Dr Ruth Powys (Russell), Palliative Care Specialist from Australia, living in Pokhara, Western Nepal. Ruth and Dan presented key input from a current INF/NAPCare survey demonstrating how palliative care is continuing to expand in government, NGO and private institutions and how many hundreds of healthcare professionals have received basic palliative care training.

A palliative care strategy will need to include all settings from rural districts to the national level, with appropriate service provision, training, resource provision, quality standards and research. Specialist palliative care at the secondary and tertiary care levels needs to be developed, as well as palliative care delivered by generalists, including GPs and mid-level health workers.

WHO is committed to enabling member states to develop palliative care appropriate to their national context, integrating it into their health services. The Declaration on Palliative Care at the 67th World Health Assembly in 2014 to which Nepal is a signatory, has committed WHO and the government of Nepal to be partners in this important process. NAPCare has committed to work with government and WHO to produce an agreed national strategy to be launched August 2016.

*Dr Dan Munday & Dr Ruth Powys
Nepal, March 2016*



*Inauguration Ceremony (Left to Right)
WHO Head of NCD; Chief Secretary Ministry of Health; President NAPCare; President Two Worlds Cancer Collaborative; Professor Max Watson, Facilitator, Northern Ireland Hospice.*



Delegates deliberate as they discuss issues regarding a Palliative Care Strategy for Nepal

KOSISH THE HOSPICE, INDIA:

Contexts, Conversations, Compassion and a Conference 29 January to 15 February 2016

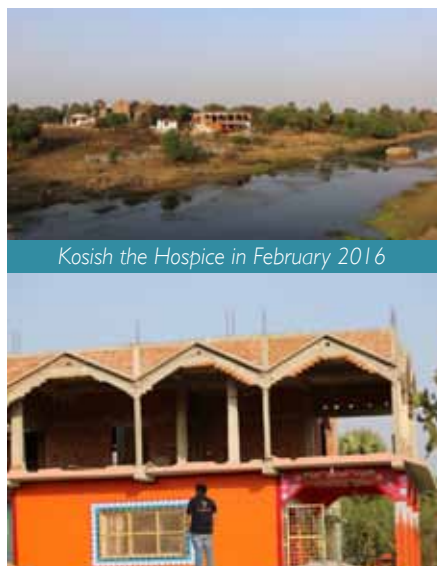
In the December 2015 Issue of the Australasian Palliative Link International Newsletter, Dr Odette Spruyt wrote of her personal experience of her mother's passing in April 2015. For Odette, knowing her beloved mother died according to her own wishes and with dignity brought Odette comfort in her bereavement. In the same Newsletter edition Dr Anil Tandon introduced himself as the incoming Chair of the Australasian Palliative Link International as well as writing about Project Hamrahi and the heat and dust during his adventures in Rajasthan. Included again in the same Newsletter was an article by Dr Abhijit Dam, the Director of Kosish the Hospice and an invitation for readers to attend the first ever 'Kosish the Hospice Self Care Retreat'. I read it with much interest and after a discussion with Tracy Robinson, Clinical Nurse Consultant at the Sandalwood Ward at Glengarry Hospital in Perth's northern suburbs I decided I'd love to visit Kosish the Hospice, meet Dr Abhijit Dam and learn more about his notion of compassion and the work he is pioneering with taking palliative care to the poor in remote and rural parts of India.



Sunday – local villagers attending the free weekly clinic mostly for women and the elderly.

Using a psychotherapeutic term, those of us working in palliative care and with the elderly provide 'containment' and 'holding' to our patients and clients, their family members and loved ones. In my work as a counsellor in psycho-oncology and palliative care this is mostly directed at emotional and psychological containment. To provide such containment to others requires each one of us to ensure we care for ourselves. Self-care is not a luxury or an additional task, when working in palliative care. It is

an essential professional responsibility so as to ensure we can 'be present' for and with others. The opportunity to participate in a first ever 'Self-Care Retreat at a Hospice' in India piqued my interest and felt like a balm for my soul.



Kosish the Hospice in February 2016

Whilst continuing to work professionally in my private practice and as an academic at Edith Cowan University, throughout the previous ten years I'd been primary carer for my severely intellectually disabled sister as she endured multiple critical health issues as well as for each of my aging parents in their 90s as their own health declined. Eventually this culminated with me being present as each of my beloved family members died. Both my sister's body and my father's body had gone to medical research at the University of Western Australia respectively in 2011 and 2014. My father was cremated in July 2015, and my sister in September 2015. In early December I made my decision to register for Dr Abhijit Dam's 'Self Care Retreat at Kosish the Hospice' and was filled with excitement at the prospect of a new adventure to a different part of India I'd not yet visited. Just two days after making my decision and informing my 93 year old mother, she fell badly in her aged care facility, was taken to emergency where I joined her in the early hours of the morning and where she died within four

hours. Her death came quickly in the end. Her funeral and cremation was held on 18th December 2015. The final 6 months of 2015 will always remain as a significant period in my life. I include this personal detail in the hope that those reading this appreciate that as health professionals working so closely with the terminally ill and with the elderly, we too have personal lives, families and loved ones for whom we care. We do need to balance our own care as we offer care to our patients and clients as well as to our own loved ones.



Morning sunrise at Kosish the Hospice

Life is a magnificent tapestry of colourful events and experiences. We never do know what is before us. Our professional work regardless of the roles we function in, demands that we step into 'the unknown' every day we go to work. Thus it is wise for us to 'walk our talk' and to practice what we promote to our patients and clients – to actively apply self-care. If we are to demonstrate compassion with others in a professional capacity then we quite simply must practice experiencing compassion towards ourselves. As Odette experienced earlier in 2015 and similarly myself at the year's end, there has been enormous value and comfort in knowing my sister, my father and my mother each benefitted from receiving the most professional medical, nursing and allied health support available in our fortunate country. Here in Australia my loved family members each retained their individual dignity and wishes as they were cared for, in hospital and at home, with great love and sincere respect. With this as my personal context I travelled to India and to Kosish the Hospice with an open heart filled with compassion and eager to learn from different contexts and to converse with others more about life and death and their myriad of meanings.



Taking of a pulse Ayurveda style



Usha working at the Kosish the Hospice Sunday weekly clinic

In preparing us for the visit Dr Abhijit Dam emailed each of us on several occasions requesting we 'come with an open heart filled with compassion'. As participants, we three Western Australians – Tracy Robinson, Clinical Nurse Consultant, Cheryl Fredericks, Senior Nurse, both working at the Sandalwood Palliative Care Ward at Glengarry Hospital, and myself plus two Americans – Christopher Paquette from Philadelphia and Carol Clark from Boston, together with the sixth member at the retreat, Dr Ranjan Singh, Consultant Anaesthesiologist & Critical Care, who drove almost 150 kilometres from the Brahamananda Naryana Hospital to Kosish the Hospice, certainly ventured to our destination with hearts open for a new and different experience. We were not disappointed despite any personal challenges we may have encountered.

Dr Abhijit Dam welcomed us before we even left Australian soils. His emails impressed me with the warmth and honesty of what he was offering – to come and view his establishment in its early development and not yet as a finished facility as well as to witness his work as he practiced providing palliative care to the poor in regional India. For us three Western Australians arriving at Kolkata Airport at 10.30pm, after leaving our homes at 3.00am earlier that day, meeting our driver who spoke little English and then driving for 7 hours through the night was a memorable introduction to India for sure!! Anil's description of the dust and

the bumpy roads became evident almost immediately as we drove out of Kolkata and hit the road so to speak winding north east towards Jharkhand.

Existential psychotherapist, Dr Irvin Yalom (1998) comments, '...this approach, "existential psychotherapy," defies succinct definition, for the underpinnings of the existential orientation are not empirical but are deeply intuitive'. Yalom clearly explains his definition: 'Existential psychotherapy is a dynamic approach to therapy which focuses on concerns that are rooted in the individual's existence' (1998, 170). Thus each person's process of dying and their moment of death form an essential part of their unique existence. I carried within me the notions proposed by Yalom that there are four ultimate concerns each individual will face at various times in their life. The four ultimate concerns include: death, freedom, isolation and meaninglessness. All four of these ultimate concerns are not only associated with end of life but may present during any of life's challenging events. Our precious time spent at this inaugural Self Care Retreat provided ample opportunities in a quiet place and in a slowed down pace, to contemplate and share engaging conversations indirectly discussing these four ultimate concerns. In particular to consider these within the poignant context of India – a country possessing a myriad of diverse contrasts was food for our souls.



Village boy quietly observing the visitors at Kosish the Hospice



Tracy Robinson and Cheryl Fredericks presenting at the Curie Abdur Razzaque Ansari Cancer Institute in Ranchi



Karen Anderson presenting at the Curie Abdur Razzaque Ansari Cancer Institute in Ranchi

With time out and away from, our regular intensive work and hectic work schedules and workplaces, space to go quietly within oneself enabled each participant to reflect upon both their professional and their personal 'self'. The process was made even more productive with the magnificent food stunningly prepared by Usha according to Ayurveda principles. The food was an attraction for all of us. Such fresh produce grown locally and prepared just prior to eating was delightfully flavoursome. I miss Usha's cooking so much as I'm sure the other retreat participants equally do.

Dr Abhijit Dam uses the phrase, 'Tat Thami Asi'. It is Sanskrit which translates as, 'That art thou', 'That thou art', 'Thou art that' – 'That you are' or 'You are that'. The meaning refers to 'the self' in its original, pure, primordial state. It is wholly or partially identifiable with the 'Ultimate Reality' which is the origin of all phenomena. The days spent at Kosish the Hospice as we partook of the different activities – introductions to Ayurveda medicine and lifestyle principles; yoga; meditation; indulgent massages; visits to historical ruins; local villages and marketplaces as well as to the Curie Abdur Razzaque Ansari Cancer Institute in Ranchi, the capital city of Jharkhand; observing clinics in practice; interacting with village children; watching the local wild life and especially the delightful monkeys playfully carry out their daily routines, the Kosish latest breed of cute puppies and the majestic rooster; listening to the spirituality of music, drumming and singing exquisitely preformed; watching the spectacular sunrises and sunsets; and simply sharing the routines of a day - made for a unique life enhancing and memorable cultural exchange. From morning rising to the day's quiet end we contemplated the universal question, 'Who am I?' as each of us spent time in the presence of being with our own 'ultimate reality'.

The friendliness, sincere and heartfelt care and nurturance provided by Dr Abhijit Dam, Usha Rani Mohanty and their wonderful staff – Mahato, Balli and Lakhhi – is now etched upon each of our hearts and minds. The days spent at Kosish the Hospice provided each participant with the space to go quietly within to reflect upon not only their practice within the field of palliative care, psycho-oncology and working with the elderly, but to meet with themselves and their own personhood. In doing so we were able to, whether consciously or unconsciously, inevitably reflect upon Yalom's four ultimate concerns of death, freedom, isolation and meaninglessness.



Lakhhi - staff member at Kosish the Hospice



Mahato - staff member at Kosish the Hospice

Kosish the Hospice is a truly remarkable innovative concept still in its early stages of development. More work is required to complete the total building complex and thus a regular funding source is necessary and is in the process of being sought. Some folk may find the location, the facility and or the resources limiting. But this too adds to the uniqueness and the richness of what we experienced In February 2016. We were invited in to share the vision of one man and his close colleagues who are pioneering introducing the concept of providing palliative care to the terminally ill and elderly into some of the poorest and most remote areas of India. This is an endeavour which I now firmly support, and endorse. It's a project which all of us as participants in the first such 'Self Care Retreat at Kosish the Hospice' actively want to commit to in whatever way we

can. It's one thing to provide palliative care where resources and funding are readily at hand even when such funds may be limited. It's a whole different challenge attempting to educate for, and to advance palliative care services to those living in poorer remote and rural regions of India wherein access to medical resources is extremely compromised.



Ready to depart Kosish the Hospice after a wonderful cultural exchange of contexts, conversations and compassion

Upon departing Kosish the Hospice, we three Western Australians thoroughly enjoyed the excitement of exploring just a little of Kolkata and New Delhi before spending time travelling in beautiful Rajasthan. We then flew to Pune and attended the IAPCON Pune 2016 conference. With over 700 participants from around the world the Indian Association of Palliative Care Conference 2016 delivered a broad collection of topics, including both research-based and practice-based presentations. The conference was superbly organised and

allowed for a vast array of stimulating conversations and encouraged excellent networking. I felt I learned and gained a great amount and I look forward now to attending future conferences. I curiously noted less coverage of aspects relating to bereavement, existential psychotherapy, reflective practice and in particular the use of Balint Groups and supervision. All these form important components when engaging, educating, empowering and excelling in palliative care. Hopefully some of these will be included in future IAPC conferences.

Continuing to educate and advance understanding for the value of palliative care services at all levels within not only Indian society but within our global society, is substantively worthwhile. This is particularly and urgently needed in regards to increasing support for the pioneering work and efforts of people such as Dr Abhijit Dam, Usha Rani Mohanty and others who are endeavouring to take palliative care to the poor in rural and remote areas of India. The challenges encountered in India are not dissimilar to what we face here in Australia with delivering palliative care services to those living in our own remote and isolated regions and mores specifically with our Aboriginal peoples. There is much work yet to do and it is exciting to be involved.

Karen Anderson,
Lecturer & Unit Coordinator,
Edith Cowan University

Reference:

Yalom, I.D. (1998). *The Yalom Reader: Selections from the Work of a Master Therapist and Storyteller*. New York: Basic Books.



IAPCON Pune 2016 Conference
– Dr Priyadarshini Kulkarni, Karen Anderson, Dr Abhijit Dam, Cheryl Fredericks and Tracy Robinson.

ELEARNING



<http://www.ehospice.com/Default/tabid/10686/ArticleId/18709/#.Vu4tznJkZQ>

Adapted from ehospice International, 15 March 2016 article by Fiona Rawlinson, ecancer

PALLIATIVE CARE FOR INDIA E-LEARNING MODULES LAUNCHED BY ECANCER

20 open access e-learning education modules about palliative care in India were launched at the Indian Association of Palliative Care Conference, 2016, in Pune, India. The education modules aim to provide palliative care teaching to health care professionals who have just qualified and not had any prior palliative care teaching. The modules combine teaching videos of interviews, teaching sessions and lectures on specific topics, fact slides and additional materials if needed.

The modules are free and hosted on the ecancer.org website.

Issues considered in the development of the modules include the need to have the modules globally available, accurate information in the context of rapidly changing political and legal environment, avoiding duplication and interactive approaches.

Odette Spruyt

PALLIATIVE CARE FRONT LINE GANGA PREM HOSPICE

INVITATION TO PALLIATIVE CARE PROFESSIONALS TO JOIN THE TEAM AT GANGA PREM HOSPICE

Dear Friends,

I am writing to invite anyone skilled in palliative care and with a desire to assist the team of Ganga Prem Hospice (GPH) Rishikesh, to consider volunteering this year.

Ganga Prem Hospice is a spiritually orientated, non-profit hospice for terminally ill cancer patients which currently offers home care to the districts of Rishikesh, Haridwar and Dehradun in Uttarakhand, North India. The Hospice provides medical, social, emotional and spiritual support for individuals and their loved ones facing life threatening cancer. Currently Ganga Prem Hospice is building an inpatient unit near Rishikesh. It is due to open in 2016. The hospice places a great significance on all dimensions of care in particular the dimensions of spiritual care to ensure holistic treatment.



Volunteer with patient and wife



Young boy and mother Rishikesh

Ganga Prem Hospice Services:

- Free monthly Cancer Clinics in Rishikesh
- Free periodical cancer clinics in other local cities in Uttarakhand
- Free Home Care programme
- Bereavement Support
- Palliative care training for health care professionals and volunteers
- Promotion of palliative care to local medical colleges, and hospitals in the State to start palliative care services in these institutions
- Raising awareness of palliative care in government institutes to initiate the development of a state palliative care policy
- Promoting research in palliative care

All the services offered by Ganga Prem Hospice are free-of-charge for its patients. Most patients are from the lower income bracket and very much need the hospice facility.

Greater awareness of palliative care at the hospice has resulted in increasing demand for the service and therefore a need to expand. As a small non-profit organisation, Ganga Prem Hospice relies on international volunteer support. Lack of trained professionals within the state requires GPH to seek the support of trained specialists—in particular physicians. I am very keen to ensure that GPH maintains the standards and quality it has achieved to date and makes no compromise on the compassionate care offered to the patients due to a shortage of staff or financial resources.

PALLIATIVE CARE FRONTLINE GANGA PREM HOSPICE

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Volunteering for The Ganga Prem Hospice

I am fortunate enough to be in the position to assure you that GPH is an inspiring place of work. It has a committed team of locally employed people, local volunteers and international volunteers. These volunteers assist GPH in all manner - from training by specialists to IT and fundraising. GPH is based in Rishikesh, a place which attracts people from all over India and the world due to its site at the river Ganges and the foothill of the Himalaya.

The hospice staff would be very happy to help the visiting palliative care staff in arranging their accommodation, transport etc but are unable unfortunately to provide expenses.

Our regular International volunteers may be contacted to discuss a placement if needed.

Preferable months for volunteering: April to October

Recommended minimum duration of volunteering: One month

Short Films on Ganga Prem Hospice Work :

<https://www.youtube.com/watch?v=QwKqjEyKwaM>

<https://www.youtube.com/watch?v=FsL2GViuq-c>

Contact Us

Phone: 91-9810931743

Email: info@gangapremhospice.org

Website: www.gangapremhospice.org

We look forward to working with you to develop the palliative care services in this local area and thank you for your assistance.

*Dr Aditi Chaturvedi,
Palliative Medicine Doctor,
Ganga Prem Hospice, Rishikesh, Uttarakhand, India*

