Project work plan

Project Title:

Hope for people living with metastatic cancer:

Identification, Awareness and Motivation:

We will select doctors, volunteers, social workers, nurses, paramedics, retired persons and other social organizations for starting this project. Few doctors and volunteers are also have been working in our organization for more than 6 years in home base palliative care, mostly all type cancer including metastatic breast cancer (MBC).

Following categories of persons will be involved in our project -

1. Doctors
2. Volunteers
3. Nurses
4. Rural Medical Practitioners (RMP)
5. Retired persons
6. Cancer survivors
7. Family members of past cancer patients
8. NGOs

Family member discussion:
We plan weekly discussion with family members of metastatic patients in our nodal center MAS Clinic & Hospital at district head quarter Tamluk. And it will be conducted by trained doctors and volunteers. If this project can be carried on properly then we can plan to open few satellite centers in every block of this district.

General awareness camps:
We plan to arrange monthly seminars at our nodal center MAS for basic training about the metastatic disease, and palliative care for social workers, volunteers, family members of new MBC patients. These persons will work their surrounding areas for advanced cancer patients.

Institute based awareness camps:

Yearly 4-6 awareness camps will be conducted at schools / colleges / other NGOs / clubs at different locations of the district to spread awarness about cancer focusing mainly on breast cancer including terminal breast cancer patients. If we can involve students, teachers and young men and women then early detection of the disease will be more effecting and simultaneously more effecting for counseling of the MBC patients and their family members.

Hospital base care:

The patients who can't be managed at the homes, will be admitted to our nodal center MAS Clinic and Hospital. Some of the staff members of the nodal center are also working in our organization. So, we can good indoor service for terminal patients in the nodal center.

Home base Care:

Already have a number of trained caregivers in our organization; they are quite good in providing home based palliative care. They have more than 10 years of experience in this field. We plan to cover the whole district (adjoining districts if possible) through these caregivers. We estimate about 200 volunteers will be added through this project and it will be more helpful for sustaining this project in future.

Telephonic communication:

Due to lack of proper transport, financial incapability and absence of adequate manpower poor families often fail to carry their advanced cancer patients to the nodal centers. Through this project we plan to explore whether communication by mobile phone can be useful in helping them. We have already tried this on a small scale and found the following positive result -

- In providing regular physical and emotional support to the patients and their families.
- In significantly reducing the financial and manpower problems of carrying patients to the nodal units.
- In improving the quality of life of patients by continuous guidance.

Awareness through social media:

We have a facebook page. We can spread our voice about metastatic cancer through this social media. Also we can use twitter, slideshow, leaflet, etc for awareness generating.

Goal and objective:

Our goal is to give a pain free good quality of life in these advanced stage cancer patients. Objective of this project is to identify the main difficulties in achieving the above goal in a rural setting of India.

Learned and implementation:

We should have more patience, spend more time with metastatic patients, to convince them the big benefits of palliative care, in the form of pleural paracentesis, to relive their respiratory distress, about the course of palliative chemotherapy to diminish their other physical distress. We have learned the use of strong opoids in proper dose and intervals, thereby relieving the unbearable pain these patients suffer from. We have learnt, the complication, especially nausea and constipation, opoids cause. We have learnt about the 'total pain' – when the patient plunges into absolute despondency. How to manage those situations! 'WHO' – pain management ladder – is a great learning experience to us. We never thought – paracitamol if given in appropriates dose, as much as 1000mg – 4/6 hourly – can be such a good analgesic. Then, about the adjuvant, like tricyclic anti depressants, steroids, showed new lights of managing the terminal patients.

Conclusion:

There is a wide gap of trained manpower in this field of palliative care in rural areas like our district Purba Medinipur, West Bengal, India. Dedicated groups from rural area itself need encouragement and proper training, so that difficult symptoms can be managed locally along with necessary social and psychological support to these advance cancer patients. It will be of immense help through our project "Hope for people living with metastatic cancer" to achieve this goal.

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