**Kerala created a palliative care policy in 2008. It is only a few months since Pallium India requested a review and revision, and the department of Health has done precisely that to coincide with World Universal Health Coverage Day, the 12th of December 2019.**

**The following are the major changes that the new policy document brings about.**

1. **Implementation at the Primary level-** Strong and active Neighbourhood Network in Palliative Care would be put in place in each Ward of every local government in the State. ***All staff and field workers at the primary level would be trained to provide outreach care in the patient’s homes.*** The strengths of NGOs & CBOs shall be leveraged to ensure the provision of optimum service to the community.
2. **Implementation at the Secondary Level**- The Community Health Centres (CHCs) would be developed to act as the ***first referral centres with earmarked beds to provide inpatient palliative care inclusive of physiotherapy and specialist home visit services.*** The CHC will also facilitate services at the primary level. Taluk Hospitals will serve as FRUs for palliative care emergencies. Staff at the taluk hospitals will be equipped to deal with such emergencies. Private hospitals and care providers who voluntarily undertake secondary palliative care service will be included in the service provision for secondary palliative care.
3. **Implementation at the Tertiary Level-** ***A Division of Palliative Medicine would be set up in all Medical Colleges and in General/District Hospitals within one year.*** Dedicated staff would be put in place at the earliest. The Division would coordinate the provision of palliative care by the relevant departments with the support of NGOs/CBOs. The Division of Palliative Medicine would initially consist of existing trained personnel including doctors, nurses and allied health professionals and provide Out-Patient Care /Ward Consultations and Home Visits. Home Visits will be made in collaboration with Community Medicine in the current service area with NGO/ CBO collaboration. This will be upgraded to a full-fledged ‘Department of Palliative Care’ with service, training and research capability in time in Medical Colleges.
4. **Training and Capacity Building-** Standards for Training Centres would be developed and the existing centres duly accredited to facilitate minimum standards. Common training modules would be developed for different types of courses. High-quality training of trainers programmes would be conducted and trainers formally accredited for conducting training for various stakeholders.  ***Doctors and other health personnel working in primary, secondary and tertiary levels would be given mandatory training according to a training calendar*** for which they would be deputed before the start of the financial year. Refresher courses would be regularly conducted at periodic intervals for those who have been trained. ***All elected heads of local governments and members of the health standing committees would be trained on different aspects of Palliative Care. Similarly, training would be conducted for NGOs and CBOs working in the area to develop their capacity for service delivery and training. The Government would also provide training free of cost to the staff of the hospitals in the private sector which volunteer to join the Palliative Care programme*.** Sensitization training would be organized for students in schools and colleges and for interested citizens.
5. **Additional Education-** ***High-quality handbooks would be prepared for different stakeholders.***  Also, distance learning would be facilitated through Certificate and Diploma courses. A knowledge portal would be developed.
6. **Citizen Education-** Training sessions for High School and Higher Secondary School and colleges including professional colleges students with home visits as part of community outreach.

* Practical training for National Cadet Corps (NCC), and Student Police Cadets & all NSS volunteers.
* Promotion of students palliative care Units in all educational institutions.
* Sensitization training for all Neighbourhood Groups of Kudumbashree, other Self Help Groups and Residents Associations.
* Introduction of a module in all programmes of the State Literacy Mission.
* Sensitization training for Youth Clubs, village libraries and other social groups.
* In addition, conventional and social media would be widely utilized to highlight the importance of Palliative Care.

1. **Access to essential medicines- *The state government will revise the essential drug list to include drugs & supplies relevant for palliative care.*** These drugs would be made available to all government hospitals where a trained doctor is available. ***Proper documentation would be ensured to avoid inappropriate use***. Mechanisms will be put into place for effective delivery of medicines and supplies as per a standard list through home visit teams, whether government or accredited non-governmental agencies
2. **Role of NGOs & CBOs- *All NGOs and CBOs providing medical and nursing services at home would be accredited on the basis of transparent norms by a group of experts constituted for the purpose.*** Further NGOs and CBOs interested in providing medical and nursing services in government hospitals would be accredited in a similar manner. All NGOs and CBOs providing only social support who would like to work with local governments would be registered at the level of the local government concerned.There would be a training plan to ensure that all accredited and registered NGOs are suitably trained to attain minimum standards in the provision of palliative care. Medicines and other aids can be made available free of cost by the local governments to the accredited NGOs and CBOs which do voluntary work without charging for their services with appropriate monitoring mechanisms in place.The government would facilitate the development of capacity of NGOs and CBOs to initiate and upgrade primary, secondary and tertiary programmes.
3. **Role of Local Self Governments-** Local Governments, Village Panchayats, Municipalities and Corporations would incorporate the preparation of a comprehensive palliative care plan as part of the People’s Plan.Local Governments also would nurture the Neighborhood Networks in Palliative Care in their Wards. They would formulate schemes for the socio-economic rehabilitation of palliative care patients. They would facilitate all the monitoring arrangements.
4. **Role of Private Hospitals-** The private hospitals including private Medical Colleges would be brought into the palliative care network through a process of advocacy & dialogue. Training would be provided free of cost by the government to such hospitals and institutions to improve capacities to provide good quality palliative care.
5. **Role of AYUSH**- The Department of AYUSH would come out with a plan of action for providing palliative care through their institutions in consonance with the general parameters of this policy including quality assurance, procurement and distribution of medicine.
6. **Special Focus on vulnerable population**- Children and Care Compromised groups including people belonging to scheduled tribes, people living in geographically inaccessible areas and other vulnerable groups and people living with HIV/AIDS would be reached out to proactively. Palliative care services would also be extended to all migrants working in Kerala irrespective of their period of stay.
7. **Livelihoods-** Efforts would be taken to ensure the socio-economic rehabilitation and promotion of livelihoods of people with debilitating illnesses.
8. **Documentation & Research-** . High-quality research is essential for policy interventions. Research fellowships and grants would be provided for research in palliative care. Action research to try out new models will be done through institutions in the public sector as well as in the non-government sector. This would aim at nurturing “resource clusters” in the field which could then be developed as “schools of practice” for others to learn from.
9. **Monitoring & Evaluation**- Multiple levels of monitoring would be put in place. These include:

* Community-based monitoring
* Monitoring by Committee at the level of the local government, district and state
* Independent monitoring by specially trained quality monitors.
* Social audit at the level of the local governments
* Independent assessment by a reputed external agency once in every five years

1. **Specialization in Palliative Care-** 
   * MD Palliative Medicine Programme in a minimum of two Government Medical Colleges under the Department of Palliative Medicine
   * MSc Palliative Nursing Programme in a minimum of two Nursing Colleges in the state
   * Residential Fellowship in Palliative Medicine Programme in a minimum of two Medical Colleges in the state
   * PG Diploma course in Palliative Care Nursing in a minimum of two Nursing Colleges in the state
   * Curriculum and training will be linked with all primary and secondary care programmes in the state
2. **Institution of Excellence** - set up within the next 5 years.
3. **Palliative Care Grid-** Networking of institutions providing Palliative Care according to levels and kinds of care providing information, education, mentoring and quality assurance and developing an authentic directory of palliative care service providers including NGOs and CBOs