GOVERNMENT OF KERALA

Abstract

Health & Family Welfare Department – Formulation and Declaration of State Policy for Pain & Palliative Care Services – Orders issued

HEALTH & FAMILY WELFARE (J) DEPARTMENT


ORDER

Palliative Care is a new specialty addressing the problems of the incurably and terminally ill patients. To help relieve thousands of patients suffering from acute pain due to cancer and other ailments like AIDS, paralyzing diseases and so on, Government have been working on such a Pain and Palliative Care Policy to streamline this in all hospitals of the State. The concept has its base on the view that most of the pain and sufferings of these patients are unnecessary. Modern principles of palliative care if routinely applied can tackle pain and most other symptoms and improve the quality of life of patients. In such a policy, the major thrust is on primary healthcare approach. Supportive care is also to be incorporated into the disease specific treatment programmes.

2. Government appreciated the importance of pain & palliative care services and in Government Order read above, constituted a Task Force of four medical professionals to encourage and spread to other areas of the State the good work done by Regional Cancer Centre, Thiruvananthapuram and a few other institutions like Pain and Palliative Care Society, Kozhikode, in this direction. The Task Force was asked to prepare a detailed proposal in this respect. The objective was to select one major institution in each district provided committed personnel were available. Two doctors, two nurses and one Pharmacist were to be identified for the purpose.
3. **Aim of the Pain & Palliative Care Policy** is to provide palliative care to as many needy as possible in the State. The policy which put forth short term as well as long-term objectives envisages the guiding principle of home-based care, palliative care as part of general healthcare and adequate orientation of available manpower and existing institutions in the healthcare field. The governmental machinery shall work in harmony with Community Based Organisations (CBOs) / Non-Governmental Organisations (NGOs) which have acquired training in delivery of palliative care.

Government after series of discussions formulated a Policy for Pain & Palliative Care for Kerala in consultation with Regional Cancer Centre, Pain and Palliative Care Society, Kozhikode, Pallium India (Trust), Kochi, etc.

Government are now pleased to adopt and declare the Pain & Palliative Care Policy for the State of Kerala as appended to this order with a resolve to have earnest endeavour in implementing the policy. The Pain & Palliative Care Policy will be implemented in the State on condition that no additional staff will be created and the existing staff will be trained and deployed for the purpose.

By Order of the Governor,

**DR. VISHWAS MEHTA**

SECRETARY

The Director of Health Services, Thiruvananthapuram.
The Director of Medical Education, Thiruvananthapuram.
The Director, Regional Cancer Centre, Thiruvananthapuram.
Dr. M.R. Rajagopal, Chairman, Pallium India, St. George Towers, Palarivattom, Kochi.
The Director of Ayurvedic Medical Education, Thiruvananthapuram.
The Director, Indian Systems of Medicine, Thiruvananthapuram.
The Director of Homoeopathy, Thiruvananthapuram.
The Principal and Controlling Officer, Govt. Homoeopathic Medical College, Thiruvananthapuram.
The Managing Director, Kerala Medical Services Corporation Limited, Thiruvananthapuram.
The Director, Social Welfare Department, Thiruvananthapuram.
The Mission Director, NRHM (To put in Arogya Kerala website).
The Social Welfare Department.
The Director, Information and Public Relations Department.
General Administration (SC) Department.

[Signature]

**Section Officer.**

*Forwarded order.*
PAIN AND PALLIATIVE CARE POLICY FOR KERALA
## Pain & Palliative Care Policy for Kerala

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1) PRE-AMBLE

a) The suffering in incurable and debilitating diseases:

i) Life with an incurable and debilitating disease is often associated with a lot of suffering. Pain, many other symptoms like breathlessness, nausea and vomiting, paralysis of limbs, fungating ulcers etc can make life unbearable not only for that person, but also for the family. Such suffering exists in incurable cancer, HIV/AIDS, many neurological, pulmonary, cardiovascular, peripheral vascular and end-stage renal diseases, incapacitating mental illnesses and in problems of old age.

ii) In addition to physical problems, they usually suffer from social, emotional, financial and spiritual issues caused by the illness. Many have clinical states of anxiety or depression. On the social domain, when wage-earners get the disease, in the absence of any social security system, families often get financially ruined. Cost of treatment adds to the problem. It may lead to their children dropping out of school, families losing their homes, and often going into debt.

b) The relevance of palliative care:

i) Modern Principles of palliative care can take care of the suffering in patients with incurable diseases, considerably diminishing the anguish for the patient and the family. Palliative care is aimed at improving quality of life, by employing what is called “active total care”, treating pain and other symptoms, at the same time offering social, emotional and spiritual support.

ii) The World Health Organization (WHO) in 2002 defined palliative care as “an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable
assessments and treatment of pain and other problems, physical, psychosocial and spiritual (WHO recommendations excerpted at Appendix II).

Palliative care:

- Provides relief from pain and other distressing symptoms
- Affirms life and regards dying as a normal process
- Intends neither to hasten or postpone death
- Integrates the psychological and spiritual aspects of patient care
- Offers a support system to help patients live as actively as possible until death
- Offers a support system to help the family cope during the patient’s illness and in their own bereavement
- Uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated
- Will enhance quality of life, and may also positively influence the course of illness
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

iii) In a study done in Malappuram District of Kerala it was found that around 40% of those people who are dying would have benefited from applying the principles of palliative care in their management. In Kerala, with a population of 32 million and a crude death rate of 6.3 (Reference: Census 2001) around 83,000 dying patients and their families would be benefited each year. To this if we add the number of people living for years with chronic conditions the total number will be much more.

iv) To ensure that palliative care is available and accessible to the majority of the needy, a major thrust should be on a primary health care approach. World Health Organisation observes that “The fundamental responsibility of health profession to ease the suffering of patients can not be fulfilled unless palliative care has priority status within public health and disease control programme. It
is not an optional extra. In countries with limited resources, it is not logical to provide extremely expensive therapies that may benefit only a few patients, while the majority of patients presenting with advanced disease and urgently in need of symptom control must suffer without relief” (National Cancer Control Programmes, Policies and Managerial Guidelines, WHO, Geneva 2002).

v) Even when the disease is amenable to curative treatment, especially if the treatment is a long-drawn out process like in cancer, all principles of palliative care need to be applied from the time of diagnosis. This is commonly called supportive care and needs to be incorporated into the disease-specific treatment programme.

vi) Palliative care is a well-established branch of health care in most developed countries. The State, under Article 21 of the Constitution of India, is duty-bound to ensure the fundamental right to live with dignity. This policy is aimed at ensuring that palliative care services are established and integrated into routine health care in the state.

c) Present palliative care scene in Kerala

i) At present there are around 100 palliative care units in Kerala. Majority of them are:

- organised and supported by Community Based Organisations (CBO) and the rest are based in government and private hospitals;
- supported by local communities;
- self-sustainable in terms of manpower, money and other amenities;
- dependent on trained volunteers for organising the services and psychosocial support;
- supported by Local Self Governments Institutions (LSGI) and are able to provide home visits, out-patient service and free drugs for the poor.

In some districts, however, palliative care services are rudimentary.

b. Currently palliative care training programmes for professionals are run by Institute of Palliative Medicine, Kottakkal, Trivandrum Institute of Palliative Sciences, Trivandrum and Regional Cancer Centre, Thiruvananthapuram.
Calicut Medical College has been offering regular placement in palliative care for house officers as part of training.

c. There are around 4000 trained volunteers in palliative care in Kerala at the moment. About 25 doctors, 15 staff nurses and 50 trained nurses are working full time in palliative care in the state. In addition to this there are many health care professionals who contribute part of their time for palliative care.
AIMS AND OBJECTIVES

a) **Aim:** To provide palliative care to as many of the needy in Kerala as possible.

b) **Objectives**

2.1. **Short-term objectives for the first two years**

(1) To train at least 300 volunteers in palliative care in each district to facilitate the development and involvement of CBOs with emphasis on districts where there are no palliative care facilities.

(2) To conduct sensitisation programmes in pain relief and palliative care for 25% of all doctors, nurses and other health/social welfare workers in the state.

(3) At least 150 doctors and 150 nurses in the State to successfully complete Foundation Course in Palliative Care. (Ten days 'hands on' training in Palliative Care with three days/20 hours of interactive theory sessions)

(4) At least 50 more doctors and 50 more nurses in the State to successfully complete six weeks' training in palliative care (Basic Certificate Course in Palliative Care). In addition to this availability of essential drugs including oral morphine and protected time for trained professionals and provision for inpatient beds where appropriate, to be ensured in government hospitals having doctors and nurses who have successfully completed six weeks' courses.

(5) To develop more than 100 new community based palliative care programmes with home care services in the State with active participation of CBOs, LSGIs and local government and other health care institutions.

(6) To develop common bodies/platforms in at least 25% of the LSGIs to coordinate the activities of CBOs, LSGIs and local health care programmes in the field of palliative care.

(7) To establish a palliative care service, with availability of essential drugs including oral morphine and with at least one trained doctor and trained
nurse, in all government medical college hospitals in the State and in district hospitals in districts without Medical College.

(8) To integrate the provision for palliative care into the house visit and field level activities of the field workers (Junior Health Inspector and Junior Public Health Nurse) and their supervisors.

(9) To make essential medicines for palliative care available to patients covered by palliative care services through palliative care units / Primary Health Centres/other government hospitals.

(10) To develop at least four more training centres in the State for advanced training in palliative medicine and nursing.

(11) To develop and incorporate palliative care modules in medical, dental, nursing, pharmacy and paramedical courses.

(12) To introduce palliative care into the training programmes for elected members to LSGs and concerned officials.

(13) To modify current regulations regarding recognition of Recognised Medical Institutions and for improving availability of opioids for medical use.

(14) To review results and formulate/modify action plans after two years in accordance with the long-term objectives.

f) Long term objectives (five - ten years)

(1) To ensure the presence of at least 1000 active volunteers trained in palliative care in each district at any time.

(2) To make community based palliative care programmes with home care services available to most of the needy in the State with active participation of CBOs, LSGs and local health care programmes.

(3) To develop common bodies/platforms in most of the LSGs to coordinate the activities in the field of palliative care of CBOs, LSGs and local health care programmes.

(4) To ensure the presence of the minimum necessary trained professionals in palliative care in each district. This will mean all the doctors, nurses and
other health/social welfare workers; minimum of 75 doctors and 75 nurses to complete Foundation course; minimum of 25 doctors and 25 nurses to complete six week course in Palliative Care. There should be a mechanism to utilise the services of trained professionals in the delivery of services.

(5) To empower the LGIs in the State to develop programmes for training volunteers in palliative care and facilitating the development and involvement of CBOs.

(6) To develop a system of monitoring the palliative care service in the State to facilitate quality assurance. A guideline for quality control to be developed at state level with a monitoring/implementing mechanism at the district level.

(7) To develop a system to document and compile data on the palliative care related activities and patient population at district and State level.

(8) To continue training and facilitation to empower community to share the care and support of people needing palliative care by organised human and financial resources available locally.

(9) To develop post graduate courses in palliative care in Medical and Nursing Colleges in the State.

(10) To establish Palliative care as part of basic health care available at the community level.
DEVELOPMENT OF SERVICES

a) Guiding principles:

i) Home-based care should be the cornerstone of palliative care in the State. The role of family in the care of chronically ill patients should be recognised. They should be socially supported and empowered to cope with the situation. The patient and the family should be the focal points of the palliative care programme.

ii) Palliative care should be part of general health care system of the Government machinery.

iii) The three tier governance system in Kerala in which health care institutions up to the district level are transferred to the LSGs, gives good opportunity for the LSGs to facilitate the development of pain and palliative care services through the existing network of institutions in co-ordination with CBOs and community in general.

iv) Field level health workers and their supervisors should be able to incorporate the principles of palliative care into their routine activity at the household level. For this purpose the existing manpower and institutions in health need to be oriented and equipped adequately.

v) The Government machinery will make use of the experience that CBOs / NGOs have acquired in training and delivery of palliative care in the State and will work with them.

b) Involvement by different sectors

i) Government Sector: There should be adequate facilities in govt. hospitals and other health institutions for providing palliative care services at the institutional
level and field level. They are expected to work closely with the CBOs and NGOs under the overall coordination of the LSGIs.

(1) Field level and Sub Centre level activity: Male and female multi purpose health workers, who are expected to provide the components of comprehensive primary health care services at the household level through the sub centers and at the PHCs, can be provided with the necessary orientation-cum-skill development training to play a major role along with the CBO volunteers and family members in providing home based care. CBOs and LSGIs should be encouraged to participate in palliative care delivery at this level.

(2) Primary Health Centres and Community Health Centres: The PHCs and CHCs in the rural areas should be empowered to provide the necessary institutional level palliative care. Through the necessary training programmes and by filling the critical gaps in availability of drugs and other components of service provision, these institutions are to be equipped for the above purpose. The medical officer of the PHC/CHC will have a crucial role along with the CBOs and the LSGIs in developing a common platform for the coordination.

(3) Taluk Headquarters hospitals: Wherever the existing palliative care services are located at far away centres, efforts should be made to provide full fledged palliative care services in Taluk hospitals. Efforts should also be made for the integration of the pain and palliative care concepts and skills into the existing specialty services of the Govt. Hospitals

(4) District Hospitals & Medical Colleges: Each district must have a tertiary level pain and palliative care service with a trained doctor and staff nurse, housed either in a Medical College Hospital or a District Hospital. They should have specialist and inpatient palliative care services and ideally, facilities for training too.

(5) Creation of training centres: More training centres need to be developed in the State. In addition to training centres which may evolve in the NGO/CBO
sector, efforts should be made to start more training centres in government sector.

b) Community Based Organisations (CBOs) Issues associated with patients needing palliative care are as much social as emotional or physical. The society can pool its resources through CBOs to address many of these issues. As shown by experience in some Northern districts of Kerala, there is tremendous improvement in palliative coverage where CBOs are active. So participation of CBOs in palliative care should be encouraged.

(1) Proposed minimum criteria for involving Community Based Organisations (CBOs) in palliative care are -

a) They should be local organisations having clearly stated interest in the care of patients needing palliative care in their area.

b) The organisation should take the lead role in providing home care services to the bedridden patients.

c) They should not charge patients or family for their services.

d) The persons involved in the care of patients needing palliative care – volunteers, nurses, doctors and other health care workers – should have basic training in palliative care.

(2) Responsibilities of CBOs

a) Identify patients needing palliative care in the area with the help of Local Self Government (LSGs).

b) Assess the needs of each patient and provide care accordingly.

c) Provide home care services for needy patients.

d) Empower the patient and their families; provide social support and rehabilitation wherever necessary.

e) Conduct awareness programmes in palliative care for the community and provide training for volunteers and health care workers.

f) Work together with Local Self Government and the Government/Non Government Health Institutions in the area for improving the care received by the patients.
(3) Identification of CBOs: With the help of palliative care programmes in the neighbourhood, the LSGs can identify and support CBOs.

(4) Support for CBOs
   a) Local Self Governments can take initiative to form a common platform for CBOs, Governmental and Non Governmental Health Institutions for organising support to the patients and family.
   b) Local Self Governments should take steps to provide medicines and other accessories to the poor patients with chronic diseases identified by the CBOs, with the help of Government health care system.

(5) Private Sector: Private sector plays a major role in the health care scenario in Kerala. Many private hospitals in Kerala are providing palliative care to needy patients free of cost. Palliative care initiatives by private hospitals should also conform to the quality control and training criteria set by the palliative care policy.
CAPACITY BUILDING

In Kerala at any time there may be a minimum of one lakh people needing palliative care. So each Panchayat will be having approximately 100 patients at any given time. To give adequate care to these patients there should be at least one doctor and two nurses trained in palliative care in every Panchayath to work along with CBOs and other health care institutions. Also there should be enough trained volunteers for effectively organising and running the programme at local level.

i) Capacity building in government sector. Considering the higher prevalence of the Non Communicable Diseases including cancers in Kerala, the significant number of people with HIV/AIDS and due to the increase in the percentage of the elderly population and the associated conditions requiring the palliative care services, it is essential that the health staff including the doctors are equipped with adequate technical and humanitarian skills for dealing the pain and palliative care services in a systematic manner.

(1) Palliative care sessions will be built into existing educational programmes (some of them are given in Appendix V)

(2) Deputation of staff will be given for the following training programmes

(a) One to two day sensitisation programmes in palliative care arranged for the purpose in collaboration with existing training programmes in the field

(b) 10 day foundation course on pain relief for doctors and nurses. This course will authorise the doctors to man Recognised Medical Institutions
(RMFs) which can store and dispense oral morphine and can provide basic pain relief to the needy.

(c) Four to six weeks' certificate course for doctors and nurses in approved centres.

(d) Other training programmes yet to be developed for other categories of staff including pharmacists, public health nurses, health inspectors etc.

ii) Capacity building at CBO/NGO level: There are many NGOs and CBOs actively involved in palliative care training programmes for doctors, nurses and volunteers. Along with supporting these initiatives, these training programmes should be validated and guidelines given. The experience the NGOs and CBOs have in training can be used to formulate and initiate palliative care training programmes in government sector. There should be efforts from governments, CBOs and NGOs to recruit and train more volunteers at local level.
AVAILABILITY OF MEDICINES AND OTHER EQUIPMENTS

a) A palliative care programme cannot exist unless it is based on a rational drug policy. Persons with incurable and other chronic illnesses need medicines for prolonged periods, which they may not be able to afford. In many areas NGOs and CBOs are now providing medicines and other equipments, which is not enough to cover the enormous needs in the State.

b) Medicines commonly needed for palliative care should be included in the essential drug list of the government hospitals. (Appendix III: List of medicines to be added to the present 'Essential Drug List') Also LSOs should have provisions to purchase and distribute medicines and other equipments based on the need in their area with the help of health care institutions and CBOs.

c) There should be clear and adequate guidelines for procuring, storing, and dispensing medicines needing special licenses like morphine (Appendix IV: Guidelines on training).
6) ROLE OF OTHER SYSTEMS OF MEDICINE
Currently, palliative care services are developing more as part of Modern Medicine. The possibility of having similar programmes in other recognised Systems of Medicine should be explored.

7) RESEARCH
There should be provisions for locally relevant audit and research at various levels for improving the programmes and for sharing the experiences.

8) BUDGET ALLOCATION
a) There should be separate provision for budget allocation for palliative care services under
   i) Directorate of Health Services
   ii) Directorate of Medical Education
   iii) Local Self-Government Institutions
   iv) National Health Programmes
   v) Employees State Insurance Scheme
more should be provisions for deployment of government doctors and nurses to palliative care services for supporting clinical work and training programmes.

PALLIATIVE CARE POLICY AND OTHER HEALTH PROGRAMMES

a) Palliative care can be a component of many health programmes like National Cancer Control Programme, National AIDS Control Programme, National Non-communicable Disease Control Programme, National Rural Health Mission etc. The state palliative care policy is also in line with these related health care programmes.

b) EVALUATION AND MONITORING

It is necessary to evaluate the progress of the programme at the end of one year, so as to analyse the strengths and weaknesses of the system and to formulate strategy for the long term policy. An advisory panel of palliative care workers will be formed comprising of representatives of the concerned government departments along with palliative care workers. The annual review will be followed by revision of short term strategy for the second year as well as formulation of long term strategy.
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| 2.2.a.1              | To train at least 300 volunteers in palliative care in each district to facilitate the development and involvement of CBDOs with emphasis on districts where there are no palliative care facilities. | - Identification and training of volunteers  
- Facilitation of formation of CBDOs | - Existing palliative care groups, Networks and training centres  
- Local Self Government Institutions (LSGs) | - Number of volunteers trained  
- Number of districts covered |
| 2.2.a.2              | To conduct sensitisation programmes in pain relief and palliative care for 25% of all doctors, nurses and other health/social welfare workers in the state. | - Formulate and conduct sensitisation programmes for doctors, nurses and other health/social welfare workers.  
- Inclusion of palliative care sessions in Government health training programmes  
- Inclusion of palliative care sessions in Cancer control and HIV/AIDS training programmes | - Training centres, palliative care organisations (Formulation and training)  
- Director of Health Services (Facilitation) | - Number of government training programmes conducted in which palliative care incorporated  
- Total number of sensitisation programmes conducted  
- Number of doctors, nurses and health/social welfare workers sensitised |
| 2.2.a.3              | At least 150 doctors and 150 nurses in the State to successfully complete Foundation Course in Pain management. (Ten days hands-on training, with three days/20 hours of interactive theory sessions) | - Formulate training programmes  
- Announcement of the programme  
- Self selection by the candidates | - Existing Training centres (Institute of Palliative Medicine, Kozhikode and Regional Cancer Centre, Trivandrum) | - Training module for Foundation Course  
- Number of doctors and nurses trained |
### 2.2a.4
At least 50 more doctors and 50 more nurses in the State to successfully complete six weeks’ training in palliative care (Basic Certificate Course in Palliative Care). In addition to this availability of essential drugs including oral morphine and protection time for palliative care and provision for inpatient beds where appropriate to be ensured in government hospitals having doctors and nurses successfully completed six weeks’ courses.

- **Formulate training programmes**
- **Announcement of the programme**
- **Self selection by the candidates**
- **Ensure availability of essential medicines**

### 2.2a.5
To develop more than 100 new community based palliative care programmes with home care services in the State with active participation of CBOs, LSGIs and local government and other health care institutions.

- **Identify CBO/ volunteers**
- **Training of volunteers**
- **Facilitation of establishment of palliative care services with Home Care programmes**
- **LSG support through projects**

### Training Centres
- **Director of Health Services** (Authorise DMOs for deputing interested doctors and nurses for training)
- **Existing Training centres** (Institute of Palliative Medicine, Kozhikode)
- **Newly identified training centres**
- **Director of Health Services** (Authorise DMOs for deputing interested doctors and nurses for training and provision of medicines)

- **Existing palliative care units and networks, State and District palliative care Associations and training centres.**
- **LSGIs (Formulation and implementation of projects)**
- **Dept of Local Administration, (Modification of rules if necessary) and evolving guidelines for projects**

- **Training module for 6 Weeks’ Course**
- **Number of doctors and nurses trained**
- **Number of Government hospitals having palliative care services with essential drugs including oral morphine**

- **Number of palliative care programmes established**
- **Number of patients covered**
- **Number of projects from LSGIs**
| 2.2.4 | To improve the production of the various essential drugs needed for the control of the disease.
| 2.2.5 | To improve the production of the various essential drugs needed for the control of the disease.
| 2.2.6 | To improve the production of the various essential drugs needed for the control of the disease.
| 2.2.7 | To improve the production of the various essential drugs needed for the control of the disease.
| 2.2.8 | To improve the production of the various essential drugs needed for the control of the disease.

- **Training PHNs and CNSs:**
  - Interactions between local health programmes and PHNs/CNSs.
  - Purchase of medicines/purchase of medical equipment.
  - Purchase of medications/purchase of medical equipment.

- **Identification of trained doctors and nurses:**
  - To provide doctors and nurses at least at the district level.
  - To provide at least one doctor and nurse at the district level.

- **Meeting of stakeholders:**
  - To coordinate the activities of the different stakeholders.
  - To coordinate the activities of the different stakeholders.

- **Education of medical students:**
  - To educate medical students on palliative care.
  - To educate medical students on palliative care.

- **Evaluation of medical students:**
  - To evaluate medical students on their knowledge of palliative care.
  - To evaluate medical students on their knowledge of palliative care.

- **Programmes of training and education of medical students:**
  - To train medical students on palliative care.
  - To train medical students on palliative care.

- **Number of medical colleges:**
  - To increase the number of medical colleges offering palliative care programmes.
  - To increase the number of medical colleges offering palliative care programmes.

- **Programmes of training and education of medical students:**
  - To train medical students on palliative care.
  - To train medical students on palliative care.

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  - To increase the number of medical colleges offering palliative care programmes.
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<td>Workshop for Palliative Care - Stakeholder Engagement</td>
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<td>Training modules in palliative care</td>
<td>Develop and implement training modules</td>
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<td>Practical sessions and case studies</td>
<td>Enhance learning through hands-on experience</td>
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<td>考核和评估</td>
<td>Establish mechanisms to assess and monitor progress</td>
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**Palliative care services**
- Development and implementation of guidelines for palliative care services
- Provision of palliative care services in hospitals and other settings
- Training and education for health professionals in palliative care

**Policy and regulation**
- Establishment of a national palliative care policy
- Regulation of palliative care services

**Support and resources**
- Provision of palliative care drugs and equipment
- Financial support for palliative care initiatives
- Research and evaluation of palliative care practices

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<tbody>
<tr>
<td>Government</td>
<td>Policy development, regulation, and oversight</td>
</tr>
<tr>
<td>Health providers</td>
<td>Service delivery, training, and quality assurance</td>
</tr>
<tr>
<td>Patients and caregivers</td>
<td>Access to care, feedback, and advocacy</td>
</tr>
<tr>
<td>Community organizations</td>
<td>Outreach, education, and support</td>
</tr>
</tbody>
</table>

**Implementation steps**
1. Identify key stakeholders and their needs for palliative care training
2. Develop and implement training modules
3. Establish mechanisms to assess and monitor progress
4. Establish a national palliative care policy
5. Regulate the delivery of palliative care services
6. Provide financial support for palliative care initiatives
7. Conduct research and evaluation of palliative care practices
8. Ensure access to palliative care drugs and equipment

**Measures**
- Evaluation of policy implementation
- Monitoring of training program outcomes
- Assessment of service delivery quality
- Evaluation of resource allocation effectiveness
<table>
<thead>
<tr>
<th>2.2.a.12</th>
<th>To introduce palliative care into the training programmes for elected members to LSGs and concerned officials.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2.a.13</td>
<td>To modify current regulations regarding recognition of Recognized Medical Institutions and for improving availability of opioids for medical use.</td>
</tr>
<tr>
<td>2.2.a.14</td>
<td>To review results and formulate/modify action plans after two years, in accordance with long-term objectives.</td>
</tr>
</tbody>
</table>

| To develop module for training |
| Incorporate the module into training programmes |

| To restructure current procedures bringing in updated standard operating procedures |

| Action plan for future |
| Existing State and District level organisations in palliative care |
| Department of Health and Family Welfare |
| Department of Local Administration |
| Advisory panel to Drugs Controller |

| Modules developed for training |
| Number of elected members and officials trained |

| Kerala Institute of Local Administration (KILA) |
| Existing palliative care training centres |
| Drugs Controller with help of advisory panel |

| New standard operating procedures |
WORLD HEALTH ORGANISATION RECOMMENDATIONS

The World Health Organization (WHO) recommends that, to be effective, any palliative care policy has to address all three sides of the following triangle with the State Policy at the base, their broad objective being to improve access to palliative care to all those who need it.

The WHO also gives the following specific guidelines:

1. Governments should establish national policies and programmes for palliative care.

2. Governments of member states should ensure that palliative care programmes are incorporated into their existing health care systems; separate systems of care are neither necessary nor desirable.

3. Governments should ensure that health-care workers (physicians, nurses, pharmacists, or other categories appropriate to local needs) are adequately trained in palliative care.

4. Governments should review their national health policies to ensure that equitable support is provided for programmes of palliative care in the home.
5. In the light of the financial, emotional, physical, and social burdens carried by family members who are willing to care for cancer patients in the home, governments should consider establishing formal systems of recompense for the principal family caregivers.

6. Governments should recognize the singular importance of home care for patients with advanced cancer and should ensure that hospitals are able to offer appropriate back-up and support for home care.

7. Governments should ensure the availability of both non-opioid and opioid analgesics, particularly morphine for oral administration. Further, they should make realistic determinations of their opioid requirements and ensure that annual estimates submitted to the NCH reflect actual needs.

8. Governments should ensure that their drug legislation makes full provision for the following:
   > regular review, with the aim of permitting import, manufacture, prescribing, stocking, dispensing, and administration of opioids for medical reasons;
   > legally empowering physicians, nurses, pharmacists, and wherever necessary, other categories of health-care workers to prescribe, stock, dispense and administer opioids;
   > review of the controls governing opioid use, with a view to simplification, so that drugs are available in the necessary quantities for legitimate consumption by patients.
## APPENDIX III

Drugs to be added to the "essential drugs list" of Govt. Of Kerala for palliative care services

### PRIMARY CARE HOSPITALS (DISPENSARY & MINI PHC)

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>NAME OF THE DRUG</th>
<th>STRENGTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>T. MELOXICAM</td>
<td>25 mg</td>
</tr>
<tr>
<td>2</td>
<td>T/C. DEXTROPROPOXYPHENE+ PARACETAMOL</td>
<td>65 mg + Paracetamol</td>
</tr>
</tbody>
</table>

### VI. ANTI ALERGIC AND DRUGS USED IN ANAPHYLAXIS

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>NAME OF THE DRUG</th>
<th>STRENGTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>T. DEXAMETHAZONE</td>
<td>0.5 OR 4 mg</td>
</tr>
<tr>
<td>2</td>
<td>INJ. DEXAMETHAZONE</td>
<td>8 mg vials</td>
</tr>
<tr>
<td>3</td>
<td>T. CETIRIZINE</td>
<td>10 mg</td>
</tr>
</tbody>
</table>

### VII. ANTI EPILEPTIC DRUGS

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>NAME OF THE DRUG</th>
<th>STRENGTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>T. SODIUM VALPROATE</td>
<td>200 mg</td>
</tr>
</tbody>
</table>

### X. ANTI FUNGAL DRUGS

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>NAME OF THE DRUG</th>
<th>STRENGTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>T. FLUCONAZOLE</td>
<td>150 mg</td>
</tr>
</tbody>
</table>

### XXL GI T DRUGS

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>NAME OF THE DRUG</th>
<th>STRENGTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>LIq. Paraffin + Mix of Magnesia</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>T. METOCLOPRAMIDE</td>
<td>10 mg</td>
</tr>
<tr>
<td>3</td>
<td>T. RANITIDINE</td>
<td>5 mg</td>
</tr>
<tr>
<td>4</td>
<td>SODIUM PHOSPHATE ENEMA</td>
<td>20 mg</td>
</tr>
<tr>
<td>5</td>
<td>CAP. OMEPRAZOLE</td>
<td></td>
</tr>
</tbody>
</table>

### OTHERS

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>NAME OF THE DRUG</th>
<th>STRENGTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>T. ALDACTONE</td>
<td>100 mg</td>
</tr>
<tr>
<td>2</td>
<td>T. ETHAMSULilate</td>
<td>300 mg</td>
</tr>
<tr>
<td>3</td>
<td>LIGNOCANE GEL</td>
<td></td>
</tr>
</tbody>
</table>

### ANTI DEPRESSANT/ANTIPSYCHOTICS

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>NAME OF THE DRUG</th>
<th>STRENGTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>T. IMIPRAMINE</td>
<td>25 mg</td>
</tr>
<tr>
<td>2</td>
<td>T. FLUOXETINE</td>
<td>20 mg</td>
</tr>
<tr>
<td>3</td>
<td>T. HALOPERIDOL</td>
<td>5 mg</td>
</tr>
</tbody>
</table>

### SECONDARY CARE HOSPITALS (BLOCK PHC & CHC)

#### 1. ANALGESICS & ANTIPYRETICS

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>NAME OF THE DRUG</th>
<th>STRENGTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>T. MELOXICAM</td>
<td>15 mg</td>
</tr>
<tr>
<td>2</td>
<td>T/C. DEXTROPROPOXYPHENE+ PARACETAMOL</td>
<td>65 mg + Paracetamol</td>
</tr>
<tr>
<td>3</td>
<td>T. CODEINE</td>
<td>10 MG</td>
</tr>
<tr>
<td>4</td>
<td>T. MORPHINE</td>
<td>10 mg/ 20 mg</td>
</tr>
</tbody>
</table>

#### VI. ANTI ALLERGIC AND DRUGS USED IN ANAPHYLAXIS

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>NAME OF THE DRUG</th>
<th>STRENGTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>T. DEXAMETHAZONE</td>
<td>4 mg</td>
</tr>
<tr>
<td>篇 药物</td>
<td>剂量</td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>氟康唑</td>
<td>150 mg</td>
<td></td>
</tr>
<tr>
<td>抗精神病药物</td>
<td></td>
<td></td>
</tr>
<tr>
<td>氟西汀</td>
<td>20 mg</td>
<td></td>
</tr>
<tr>
<td>利尿药物</td>
<td></td>
<td></td>
</tr>
<tr>
<td>多潘立酮</td>
<td>100 mg</td>
<td></td>
</tr>
<tr>
<td>抗抑郁药物</td>
<td></td>
<td></td>
</tr>
<tr>
<td>多塞平</td>
<td>10 mg</td>
<td></td>
</tr>
<tr>
<td>乳酸钠镁乳</td>
<td></td>
<td></td>
</tr>
<tr>
<td>乳酸钠镁乳</td>
<td></td>
<td></td>
</tr>
<tr>
<td>排便调节剂</td>
<td></td>
<td></td>
</tr>
<tr>
<td>奥美拉唑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>抗过敏药物用于过敏性休克</td>
<td></td>
<td></td>
</tr>
<tr>
<td>地塞米松</td>
<td>4 mg/ml</td>
<td></td>
</tr>
<tr>
<td>抗真菌药物</td>
<td></td>
<td></td>
</tr>
<tr>
<td>氟康唑</td>
<td>150 mg</td>
<td></td>
</tr>
<tr>
<td>胃肠道药物</td>
<td></td>
<td></td>
</tr>
<tr>
<td>乳酸钠镁乳</td>
<td></td>
<td></td>
</tr>
<tr>
<td>乳酸钠镁乳</td>
<td></td>
<td></td>
</tr>
<tr>
<td>乳酸钠镁乳</td>
<td></td>
<td></td>
</tr>
<tr>
<td>地塞米松</td>
<td>4 mg/ml</td>
<td></td>
</tr>
</tbody>
</table>

|区域医院 |  |
|抗抑郁药物 |  |
|西米替丁 | 15 mg |
|抗恶心药物 |  |
|丙谷安定 + 丙谷安定 | 65 mg + 丙谷安定 |
|吗啡 | 10 mg |
|西米替丁 | 10 mg |
|吗啡 | 10 mg/ml |
|抗真菌药物 |  |
|氟康唑 | 150 mg |
|胃肠道药物 |  |
|乳酸钠镁乳 |  |
|乳酸钠镁乳 |  |
|乳酸钠镁乳 |  |
|地塞米松 | 4 mg/ml |
|地塞米松 | 4 mg/ml |
|地塞米松 | 4 mg/ml |

|高级医院 |  |
|抗抑郁药物 |  |
|西米替丁 | 15 mg |
|抗恶心药物 |  |
|丙谷安定 + 丙谷安定 | 65 mg + 丙谷安定 |
|吗啡 | 10 mg |
|西米替丁 | 10 mg |
|吗啡 | 10 mg/ml |
|抗真菌药物 |  |
|氟康唑 | 150 mg |
|胃肠道药物 |  |
|乳酸钠镁乳 |  |
|乳酸钠镁乳 |  |
|乳酸钠镁乳 |  |
|地塞米松 | 4 mg/ml |
|地塞米松 | 4 mg/ml |
|地塞米松 | 4 mg/ml |
APPENDIX IV

Minimum training required for doctors-in-charge of Recognised Medical Institutions (RMIs) for storage and dispensing of oral Morphine

Educational Qualification:
- The doctor should have MBBS with successful completion of internship and Indian Medical Council Registration.
- He/she should have successfully completed the foundation course at a recognised centre for Palliative Care training. The course should have a minimum of ten days ‘hands on’ training in Palliative Care with three days interactive theory sessions.

Recognised Training Centre (RTCs)
For recognition by the government as a training centre in palliative care for doctors and nurses, the training unit should have the following minimum facilities:

- a) Out patient Services
- b) Home care services
- c) Inpatient Unit or access to Inpatient care facilities
- d) A minimum of 100 patient contacts every week.
- e) A minimum of 20% of the working time of the doctors and nurses identified as trainers should be kept protected for the training activities.

The Trainer Doctor (TD)
Should be a qualified doctor with Indian Medical Council registration. She/he should have experience of at least one year as a full time Palliative Care Physician at a centre described above.

Or
She/he should have six months’ experience as a full time Palliative Care Physician at a centre described above after successful completion of a minimum of six weeks’ training in Palliative Care at a recognised training centre.

It should be mandatory for the recognised training centres to submit a report of training activities to the government every year.

The Government will notify the training programmes conducted by the Recognised Training Centres (RTCs).
Human Resource Development in the Government Sector as part of Capacity Building in Palliative Care.

I. Human Resources Development of doctors and other health staff on pain and palliative care services

Considering the higher prevalence of the Non Communicable Diseases including cancers in Kerala, and due to the increase in the percentage of the elderly population and the associated conditions requiring the palliative care services, it is essential that the health staff including the doctors are equipped with adequate technical and humanitarian skills for dealing with the pain and palliative care services in a systematic manner.

Training programmes for the Health staff can be organized as separate programmes intended for the above purpose, and also can be included as a component in the various ongoing training programmes of the Health Services Department.

A. RCH training:

i. Integrated skill development training. It is the purpose of this training to develop comprehensive skill development in their respective area of work. It is intended to develop clinical, skill, communication skill and managerial skill connected to their respective job responsibilities. Since all these trainings are long duration trainings extending to few weeks, it may be possible to allocate at least few theory and practical sessions on pain and palliative care.

   a. For PHNs: Duration - Two weeks, (12 Working days). It includes theory classes, along with hospital and field level on the job training. Theory classes, and hospital based and field level training on the pain and palliative care can be very well incorporated as part of this package.

   b. For JHIs, HIs & HIs: One week training.

   c. For LHS & LHS: Three weeks (18 Working days)

   d. Medical Officers: Two weeks training.

   e. Staff Nurses: Two weeks training.

   f. Pharmacists: Two weeks training.

Palliative care can be incorporated in the RCH training programmes taking place in all the 14 districts.

B. Training Programmes implemented through the State Institute of Health and Family Welfare Thiruvananthapuram and Family Welfare Training Centre, Kozhikode, and Training centre Thrissur, Ernakulam.
i. Trainings included in the plan scheme: Generally these trainings for various category of health staff are being implemented through the State Institute of Health and Family Welfare located at Thrissur. In various training programmes sessions on the pain and palliative care can be included. Also based on the requirements from next year onwards special pain and palliative trainings can be included for doctors and other paramedical in co-ordination with Institute of Palliative Medicine, Kozhikode and Regional Cancer Centre, Thrissur.

ii. State Training Policy trainings: Based on the training need assessment of the Health Services Department for the last three years, State Training Policy trainings were planned and being implemented for a major category of the health staff (for clinical and field level workers including doctors).

Two sessions on palliative care can be included in these training programmes.

C. Training programmes implemented through the State Level Cancer Control Programme

Utilizing the plan fund under the head of the cancer care, for last few years, state level orientation training of 2-3 days duration for the medical officers working in the peripheral institutions are being provided. It is the aim of these trainings to make them familiar with the components of the National Cancer Control Programme (NCCP). The importance of the awareness generation, prevention, early diagnosis and case management, and the importance of the pain and palliative care in the cancer are being covered in these short duration trainings. Utilizing the services of these trained doctors district level training of two days were conducted for the field workers and supervisors in most of the districts.

In co-ordination with the regional Early Cancer Detection Centres (ECDCs) of the NCC cancer detection camps are also being arranged in many districts. Based on the requirements training programmes in palliative care to be formulated and implemented through this scheme.

D. Training Programmes organized through the KSACS

HIV/AIDS training including that on care and support are being provided to doctors (3 days duration) and various category of Paramedical staff (2 days duration) through the KSACS. Awareness training for Anganwadi Workers and Kudumbashree volunteers is also provided. Palliative care of course is a component of the care and support part of the HIV/AIDS programme. Sessions on the importance of the palliative care in general and HIV/AIDS in particular can be organized through the KSACS trainings.

E. Special training for Medical Officers and paramedical staff for providing the institution based palliative care services

Considering the requirements of the palliative clinics in the peripheral institutions, skill development trainings can be provided for more number of doctors and other paramedical staff, so that adequate services centres can be started. The existing training programmes may be evaluated and modified if necessary by a review committee (and the
II. Awareness Generation Training (AGT) of one day duration: May be newly planned and organized for the LSGI representatives, or the other departmental officials etc.

National Rural Health Mission and palliative care

Next year onwards preparation of the implementation plans will be done by the Village Health and Sanitation Committees (VHSC) at village levels. District action plans are in reality the consolidation of the village plans. If there is a genuine requirement of the pain and palliative care services in the periphery, it can be very well included in the village/panchayat district action plans and fund requests can be made.

The multi purpose health workers in their annual household survey can make an assessment of the patients requiring palliative care in their respective field areas. Then under the National Rural Health Mission (NRHM) framework for every village, while preparing health and sanitation plans, the requirement of the pain and palliative care services can also be brought into the planning process from the grass-root level through the health workers.

III. Integrating the component of the Pain and Palliative care services into the Medical, Nursing, Dental and Paramedical curriculum

Considering the field level requirement of the pain and palliative care services at the various levels of the health care services, a basic understanding of the theory and practice of the palliative care is to be made available for all the medical and para-medical students as part of their regular course. For the above purpose specific allocation of the theory class hours and facility for attending the pain and palliative clinic to be made mandatory. Medical Council, Nursing Council and other paramedical councils may take necessary steps for this.

IV. Post Graduate Training in palliative care

* All the postgraduate students in clinical departments in various medical colleges in the State should undergo a minimum of two weeks' training in palliative care as part of their regular training programme.

Action will be taken to initiate post graduate courses in Palliative Medicine and Nursing in Kerala.
Palliative Care Policy for Kerala

APPENDIX VI

Proposed Structure of Monitoring Committees

State Level Monitoring Committee

Chairman/Chairperson : Minister for Health and Family Welfare
Deputy Chairman/Vice Chairperson : Health Secretary
Convener : Director of Health Services
Members : Special Secretary (Health)
(Secretary (Local Self Government)
State Mission Director (URLM)
Project Director (KSACS), Principal (KSMWT)
Director of Medical Education
Director of Social Welfare
Director of Urban Affairs / Panchayats
Director of Local Self Government Institutions
Drug Controller
Representative, Indian Association of Palliative Care - Kerala Chapter
Representatives from Training Centres
(Institute of Palliative Medicine,
Trivandrum Institute of Palliative Sciences,
RCC)
Convenor, Advisory Panel on Palliative Care to the Drugs Controller, Kerala

equancy of meeting: The state level monitoring committee should meet at least 1 - 2
not an year.

District Level Monitoring Committee

Chairman/Chairperson : President, PSCP
Deputy Chairman/Vice Chairperson : District Collector
Convener : District Medical Officer of Health
Members : Secretary, District Level Palliative Care Initiative
Superintendent, District Hospital
Superintendent / Head of Department (Radiotherapy) of Medical College
Hospitals catering to the district
Deputy Director, Panchayath Department
District Social Welfare Officer
Representatives from Govt. Hospitals at Taluk level and above having palliative care clinics
Representatives from Training Centres in the district
Representatives from NGOs (Through the District Level Palliative Care Initiatives)

**Frequency of meeting:** The district level monitoring committee should meet at least 3 - 4 times a year.

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**Local Self Government Level Monitoring Committee**

**Common body/platform formed (see policy)**

<table>
<thead>
<tr>
<th>Role</th>
<th>Position/Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chairman/Chairperson</td>
<td>President, LSGI</td>
</tr>
<tr>
<td>Convener</td>
<td>Medical Officer in Charge, Local Govt. Health Facility</td>
</tr>
<tr>
<td>Joint Convener</td>
<td>Secretary, Local Palliative Care Unit</td>
</tr>
<tr>
<td>Members</td>
<td>Nurse/Doctor from Local Palliative Care Unit, Health Supervisors</td>
</tr>
</tbody>
</table>

**Frequency of meeting:** The LSGI level monitoring committee should meet at least once every month.
APPENDIX VII

Proposed Budgetary Sources

I. 11th Five Year Plan
Efforts have been taken for the inclusion of the public health programmes for the Non Communicable Diseases, Elderly care, Palliative Care etc in the 11th Five year plan. The above schemes may be included as:

A. Centrally Sponsored Schemes
- National Rural Health Mission (NRHM)
- National Disease Control Programmes (Cancer, AIDS etc.)

B. State Sponsored Schemes
- Directorate of Health Services’ support to
  1. Training
  2. Home care services and field level activities
  3. Institutional support to develop palliative care facilities

- Directorate of Medical Education’s, support to
  1. Training
  2. Institutional support to develop palliative care facilities

A separate budget at DME and DHMS for palliative care as necessary

II. Local Self Government Institutions (LSGs)
Budget allocation to health care including palliative care from both
1. Plan funds
2. Own funds