**1.1 INTRODUCTION**

Palliative care system is an integral component of the total health care in advanced countries. It aids a patient right to live with dignity and die in peace. Palliative care is a health care specialty that is both a philosophy of care and an organized highly structured system for delivering care to person with life threatening or debilitating illness from the family. Palliative care improves health care quality in three domains, 1)the relief of physical and emotional suffering. 2)improvement and strengthening of the process of patient physician communication and decision making. 3) assurance of coordinated continuity of care across multiple health care setting hospital home and long-term care.

WHO defined, palliative care as an approach that improves the quality of life of patients and their family facing problems associated with life threatening illness through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems physical, psychosocial and spiritual.

Palliative care policy Government of Kerala 2002 defined, palliative care 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.

The basic aim of palliative care system;

* Offer relief from pain through constant care and support.
* Enhance the quality of life by making them as possible and extend emotional as well as psychological support.
* Relieve the patients from the fear of death and enable to admit dying as a normal phenomenon.
* Uses a team approach to address the needs of patients and their families including bereavement counselling if indicated.
* Offer a social support system to help family cope during the patient illness and in their own bereavement.

The concept of palliative care relatively new to India, having been introduced only in the mid 1980’s. since then Hospice and palliative care services have developed through the efforts of committed individuals including health professionals as well as volunteer in collaboration with international organizations and individuals from other countries. In 1975 the Government of India initiated a national cancer control program. By 1984, this plan was modified to make pain relief one of the basic services to be delivered primary health care level, unfortunately this policy was not translated in to extensive service provision. The hospice and palliative care movement in India started tentatively in the mid 1980’s and has slowly increased over the last two decades. The Indian association of palliative care came in to existence from Gujarat 1985.

**1.2 SIGNIFICANCE OF THE STUDY**

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through prevention and relief of suffering by means of early identification, assessment and treatment of pain, and other problems - physical, psychosocial, and spiritual. It is estimated that in India the total number of people who need palliative care is likely to be 5.4 million people a year. Though palliative care services have been in existence for many years, India ranks at the bottom of the Quality of Death index in overall score. However there has been steady progress in the past few years through community-owned palliative care services. One of the key objectives of the National Programmed for prevention and control of cancer, diabetes, cardiovascular diseases, and stroke is to establish and develop capacity for palliative and rehabilitative care. Community models for the provision of home- based palliative care is possible by involving community caregivers and volunteers supervised by nurses trained in palliative care. Training of medical officers and health care professionals, and sensitization of the public through awareness campaigns are vital to improve the scope and coverage of palliative care. Process of translating palliative care plan into action requires strong leadership, competent management, political support and integration across all levels of care.

**1.3 STATEMENT OF THE PROBLEM**

There has been an unprecedented rise in the need of palliative care services be- cause the increase of communicable and non-communicable diseases. The need of palliative care services mostly wanted the ageing population. Due to falling fertility mortality and increasing standard of living increases the ageing population. The aged people suffer ring number of diseases. The palliative care units provide homecare, medical facilities, mental support and physical care to the patients and their family. The present day many people choose palliative care due to the efficiency in their work, behavior towards patients and to reduce unnecessary hospital admissions. It was considered as a global policy and a human right. The goal of palliative care is therefore to improve the quality of life both patients and family by responding to pain and other distressing physical symptoms, as well as to provide nursing care psychosocial support and spiritual support .In this study examine the role of palliative care in promoting health care and the service orientedness of palliative care units.

**1.4 OBJECTIVES OF THE STUDY**

* To find out the role of palliative care in promoting health care
* To study about satisfied with the service from palliative care workers
* To study about service providers will talk to you in a smooth manner
* To Understand the service orientiveness of palliative care units

**1.5 SCOPE OF THE STUDY**

The scope of this study on the role of palliative units in supporting healthcare encompasses an in-depth examination of the functions, impact, and challenges faced by palliative care units within the healthcare system. It will investigate various aspects including the services provided by palliative units, their contribution to patient care, collaboration with other healthcare professionals, integration into the broader healthcare framework, as well as the socioeconomic factors influencing their effectiveness. Additionally, the study will explore the extent to which palliative care units meet the needs of patients and families facing life-limiting illnesses, and how they contribute to improving quality of life and overall healthcare outcomes.

**1.6 METHODOLOGY**

The following methodology adopted for study.

* Method of data collection

The study is conducted by collecting data from both primary and secondary sources. The data is collected using two types of well-designed questionnaire prepared according to their specific objective of the study. Further, the direct personal investigation method has also been employed to collect required information for a descriptive study.

* Sources of primary data

Primary data collected through direct personal investigation. Intensive study conducted among palliative care receivers randomly by taking 50 samples. A structured questionnaire is prepared for collecting the required information from the respondent.

* Sources of secondary data

Secondary data collected for palliative care units. There are 14 palliative care units, data collected from the official records of palliative care units.

**Tool of Analysis**

For collecting new unknown data required for the study of any problem, one may use various devices. The data analysis process will be qualitative content analysis. For the analysis and interpretation of the data collected, various statistical tools like percentage, bar diagrams, pie charts etc. have been used.

**1.7 LIMITATIONS**

* Samples for this study confined to only in one Area.
* Limited time for conducting a detailed study.

**2.1 REVIEW OF LITERATURE**

Ingalill Rabm, Hall berg Int j palliate nurse-(2006)This article (palliative care as a framework for older people’s long-term care) drawn from the findings from several years of research on the health problems, quality of life and care for older people especially during the last years of life and argues that there is a need to develop and provide care according to principles of palliative care. The findings indicate that palliative care including a focus on symptom management. Psychosocial and existential issues may be appropriate for the long-term care for the older or very older people not just those at the very end of life.

Richard Brumley M D, Paula Jamison, Nora Morgenstern, Joan McIlwaine and Jorge Gonzalez (2007)the study (increased satisfaction with care and lower cost Result a randomized trial in home palliative care) is to determine whether an in-home palliative care intervention for terminally ill patient can improve patients’ satisfaction, reduce medical care costs, and increase the proportion of patients dying at home. The sample design randomized and controlled trial in two health maintenance organization in two states. The respondent or samples in the study was home bound, terminally ill patient with prognosis of approximately 1 year or less to live plus one or more hospital or emergency department visits in the previous 12 months.

Elizabeth McDermott, Lucy Selman, Michael Wright and David Clark –(2007) palliative care has been developing in India since the mid 1980’s, but there is a dearth evidence about service provision on which to base national policy and practice. The aim of this study was to assess the current state of palliative care in India, mapping the existence of services state by state, and documenting the perspectives and experiences of those involved. A multi method review was used, which included synthesis of evidence from published and grey literature, ethnographic field visits, qualitative interviews with 87 individuals from 12 states, and collation of existing public health data. The review identified 138 hospice and palliative care services in 16 states and union territories. These are mostly concentrated in large cities, with the exception of Kerala, where they are much more widespread. Nongovernmental organizations, public and private hospitals are the predominant source of provision. we were unable to identify palliative care services in 19 states/union territories. Development of services is uneven, with greater pro- vision evident in the south than the north, but for the majority of states, coverage is poor. Barriers to the development of palliative care include: poverty, population density, geography, opioid availability, workforce development, and limited national palliative care policy

Nitin Joseph, Jayaraman, and Sashidhar Kotian-(2009) This research (A comparative study in assess the awareness of palliative care between urban and rural areas of Er- anakulam district Kerala, India) attempted to find out and compare knowledge and attitude towards palliative care and its contributing factors and its contributing factors among people living in urban and rural areas of Ernakulum district in Kerala. Cross sectional study was conducted among 185 urban and 165 rural household. This study resulted which the level of knowledge of palliative care is high among urban than rural participants. However overall awareness of palliative care was poor among all participants. In spite of a good literacy status in the study was majority of participants felt that palliative care can be best given at homes rather than hospitals. The aim should there for to train a good number of doctors, nurses, community workers and volunteers in palliative care based on requirements. Training should also target communication skills and people manner of breaking bad news to participants and their family members as well.

Hubert R Jocham, R N Theonassen Gredy Widdershoven and Raud Halfens- (2009) This article (Evaluating palliative care) is investigating the outcome measures developed and used in palliative care. The outcome of palliative care is quality life. In Italy (Peruselietal) defined some potential indicators of palliative care outcome with the aim of assessing quality of homecare provided by a palliative care unit. The outcome re- search in palliative care represents a new dimension of clinical research that should be investigated near future.

Colleen fisher, Moira O Connor and Kaye Abel-This study (the role of palliative care in supporting patient: a therapeutic community space) examined the work of palliative day care extends the philosophy and practice of palliative care patients in the com- munity especially the key aim was to explorepatients’ experiences of palliative day care in a western Australian context and the method of study is interview method

Robin B home, Hillary l luminous, Deborah A Bourgoeing Christopher m bi- as,(2011) This article gave importance of role of palliative care in the end of life. The goal of palliative care is to relieve the sufferings of patients and their family by the com- prehensive assessment and treatment of physical, psychosocial and spiritual symptoms experienced by patients. As death approaches, the symptom burden of a patient may worsen and require more aggressive palliation. As comfort measures intensify so should the support provided to the dying patients family. After patients’ death, palliative care focuses primarily on bereavement and support to the family

Alexandra Pereira, Amelia, Ferrarea, Jose martins, ceuBarbeiri Figueredo. This study (Nursing theories inpalliative care investigation) aims to identify and analyses the nursing theories used in palliative care needs increasing worldwide. Although the nurses play a central role in the team context Palliative considered as an essential component of any health care system.

Nandi Daniel chakwanyere, 2019 Palliative care is an area of health care that focuses on relieving and preventing the sufferings of patients. It utilizes multidisciplinary term approach to a holistic care of the patients it is relatively a new concept in medicine and the Nigerian experience has not been widely studied.(palliative care : Nigerian prospective) It is still faces a lot of challenges in terms of integration in to the health care system implementation and governmental policy with increasing longevity urbanization, high prevalence of HIV/AIDS and chronic diseases including malignancies there will be an increasing number of Nigerian requiring palliative care. Both specialist and integrated palliative care have important role in Nigeria as the extended family system is fast breaking down. The problem of facing the implementation of palliative care in Nigeria cannot be exercised from the overall prevailing socioeconomic conditions in the country. poverty, ignorance, insecurity, poor funding of health care in adequate manpower and poor policy formatting and implementations constitute obstacles to effective good health care delivery.

.Erin Vernon, Courtney Hughes, Monica Kowalczyk(2022) Community based palliative care service seriously ill individuals by integrating care for symptoms and stress relief with local health care systems. This review provides the systematic review of the literature to date on the effectiveness of community-based palliative care (CBPC)programs and includes their measure of success challenging faced,and characteristics of the population served. A systematic review on CBPC program effectiveness was conducted across four electronic data bases for academic articles published through Au- gust 2021. PRISMA reporting guidelines were followed throughout this review, study quality was assessed using the mixed methods. Appraisal tool and results were summarized in a narrative synthesis. The EI included articles were separated in to quantitative and qualitative studies with eight having mixed methods and belonging to both groups overall the quantitative articles indicate that CBPC programs increase the likelihood that seriously ill patients in their community have their place of death as home, fewer hospitalization fewer emergency department visits, decreased hospital length stays, improved quality of life and lower health care cost. There was however also evidence showing un- successful in improving the stated outcomes. The qualitative studies reported positive findings and highlighted areas for future program improvement, like training staff and volunteers in communication and other skills. There was a lack of quantitative and qualitative studies investigating CBPC program low income and lower middle-income countries. In addition, there is a paucity of research examining CBPC program impact on vulnerable and key population across the globe.

Nkanasah Ehnezer Owireda-The primary goal of the study was to investigate the role of NGO’S in health care delivery in Ga east municipality using act in Africa as a case study. Toachieve this goal 10 staff and volunteers were drawn from various department of act in Africa and engaged in structured interview centering on the role and challenges faced by NGO in health care delivery. The study was revealed that in spite of re- source constraint act in Africa engages in healthcare delivery in the municipality. The study recommended that commitment to the healthcare delivery must be made to reelect through commitment of financial, human, infrastructural and technical resources. Moreso to break the vicious cycle of poor health due to poverty income generating activities must be provided for the individuals and community, to free the people of poverty and stress related to challenges and enhance their health and conditions of living.

**3.1 PALLIATIVE CARE AN OVER VIEW**

**Worldwide aspect of palliative care**

The International Symposium on Hospice & Palliative Care Conference was held in DMC, Seoul on Wednesday December 7th with many prestigious doctors and professors from around the globe to discuss appropriate palliative care policies on supporting the health system. The future plan is to transform the health system by integrating palliative care into national health system through a public health approach.

Palliative care Conferences is a multidisciplinary approach to specialized medical for people with serious illnesses. It focuses on providing patients with relief from their symptoms, and pain along with physical and mental stress. The goal of this therapy is to improve quality for life for both the patient and the family. Another aim of this care is to help people who are dying have peace, comfort and dignity. The caregivers try to control pain and other symptoms so the patient can remain as alert and comfortable as possible.

“Palliative care focuses on the person, not the disease. Physical, practical, functional, social, emotional and spiritual needs for both patients and their families.” stated Professor Mhoira E.F. Leng in her opening speech about Palliative care future goals. “It will less focus on specific diseases; highlight more primary training, urging government to fund palliative care.”

Palliative care is crucial because it will be an essential contribution to global health. There are many countries around the world that do not have access to Palliative services; about less than 10% of the population. Lower-class countries for example India and Africa have many older people and children who have chronic mental and physical health. Poverty is a major key to the reason why prisoners, sex workers and substance users are not benefited in the Health system. The current challenges are non- communicable diseases such as chronic lung diseases, diabetes and cardiovascular dis- eases. All of these combined are rising fast among lower and middle-income countries.

**Hospice and Palliative Care services in Australia**

MS Liz Callaghan, CEO of Palliative Care Australia started her speech by explaining that Australia has similar issues with the age demographic situation with South Korea which faces the problem of a rapidly aging population. In fact, the speed of aging in Korea is unprecedented in human history, 18 years to double aging population from 7 – 14% (least number of years), overtaking even Japan.

The leading cause of death in Australia is coronary heart disease following Dementia and Alzheimer disease, compared to Korea which is Cancer. Palliative care in Australia is funded by both private companies and the government and patients request that the care is provided in the patient’s homes rather than in hospitals. Because of this, the program regularly asks patients where they would like to die. But death is often sudden and quick so the Palliative care provides a choice to have a right place at the right time with the right people.

How the Australian government invested in the Palliative Care program is to improve access to and the equality of palliative care: to provide research and drug trails, funding for research and education programs. Their strategy was made in 2010 and will be updated once more next year 2017. Their goal will be to try to make a framework where there can have a health system equally around Australia to make it available to all of their citizen

**Hospice and Palliative Care in Taiwan**

The next presenter was Doctor Daniel Fu-Chang, Professor in the National Tai- wan University College of Medicine who represented for Taiwan.

“The goal of the care is to help people who are dying have peace, comfort and dignity. The cost of dying is high. It ranges from 10,223 for sudden death, 36,652 for terminal illness such as Cancer and 39,937 for organ failure. 70% of the costs for terminal illnesses are due to hospitalizations. You need to have good policy, to train your staff with important education and implementation and Medicine availability.”

Taiwan’s quality of End-of-Life care is ranked number 14 in the world, the first in Asia. One of the main reasons why this is the case is community engagement; in particular to break down cultural taboos against discussing death has been a focus in Tai- wan. They have introduced discussions of life and death into the education system from primary school through university and by changing the mindset of patients. But their flawed system is about healthcare spending, the capacity to deliver palliative care and shared decision making between the patient and families.

The Taiwan Hospice Organization called the act a major step forward as the act applies to the terminally ill, patients in a coma or vegetative state, and patients with advanced dementia or incurable diseases. The Patient Self-Determination Act was introduced to Taiwan in May of 2015. Under this, these patients have the right to accept or deny medical treatment, provided that they have signed a legal document called an advance healthcare directive. The Ministry of Health and Welfare pronounces that since the act aims to offer patients the opportunity to accept or deny medical care, medical institutions and doctors involved will not face criminal or administrative liability for their actions unless there is ill intent and there are major medical mistakes.

Currently in Taiwan, they are providing for old age and early stage of organic psychopathic diseases, brain deterioration, chronic obstructive pulmonary diseases, acute renal failure, lung diseases, chronic liver diseases and heart failure. Among this, a pro- gram called ‘Truth-telling’ is about cancer disclosure to patients. This avoids futile med- ical care, ensures the dignity of the terminal ill, respect the rights of patients to know and their right to choose. The program organizes the training professional medical staff to enhance their skills of truth-telling. This allows the awareness of palliative care to in- crease with ‘Truth-telling’ as the first step.

The 4 essential components for Palliative Care development in Taiwan is Gov- ernment, National Health Insurance, NGO and Academic Association. Dr. Daniel Fu- Chang stresses that the Government should provide policy and funded programs to hospitals and that Academic Association is important for communities it requires to change the cultures norms about death.

**Hospice and Palliative Care in United States**

Dr. David Hui from Texas, U.S.A, Professor at the MD Anderson Cancer Center Associated describes American Palliative care particularly for US Cancer Centers. They do provide home palliative care programs but patients must go back and forth to the hospital for treatments or when they are too weak. In the program, America categorizes their patients: Early disease (years-decades) Advanced disease (months-years) and Impending death (days-hours). Dr. David Hui believes that Palliative Care should begin earlier with inpatient programs because every patient life expectancy depends on their needs and the timing.

“American Hospice care is the patients understanding and agreeing to forego cu- rative therapy. 2 physicians must declare the prognosis in 6 months if they can for their patients. Cancer is 37% while 63% are non-cancer such as heart disease, kidney disease, liver diseases, stroke and coma and HIV diseases.”

The challenges with Prognostication in America are that non-cancer diagnoses are highly inaccurate. The prediction of survival often overestimates and the eligibility criteria underestimate. Also, hospice referral can be delayed to 17 days. Cancer patients are good candidates if they have more than a year to live and have been diagnosed in 3 months.

Doctor David Hui believes that America specifically would like to improve the clinical structure and collaborate, improve the education to palliative care specialists and selecting the right policies.

In many cases, patients will benefit from specialized palliative care because many hospital-based integrated palliative care programs for patients with chronical diseases have been shown to improve symptom management and quality of life for patients and their families. In addition to helping with pain, other aims of care are improving the quality of end-of-life care for patients. With the future goals to develop Palliative care, countries can end extreme poverty and fight inequality throughout the health system.

**PALLIATIVE CARE IN INDIA**

India, being home to one –sixth of the world’s population has a huge burden of suffering from life limiting diseases. It is estimated that in India the total no. of people who need palliative care (PC)is likely to be 5.4 million people a year. Though PC was introduced nearly 30 years ago, it is still in its infancy with less than 1% of patients having access to PC. India ranks at the bottom of the Quality Of Death Index in overall score. Obstacles are too many and not only include factors like population density, poverty, geographical density, restrictive policies regarding opioid prescription, workforce development at base level but also limited national PC policy and lack of institutional interest in palliative care. However there has been a steady progress in the past few years through community owned PC services. South Indian state of Kerala which has 3% of Indian population, stands out in terms of achieving coverage of palliative care. On the national level recent years saw several palpable changes including the creation of a National Programmed for Palliative care and also the Parliament amended India’s cumber- some Narcotic Drugs and Psychotropic Substances Act (NDPS) thus overcoming many of the legal barriers to opioid access.

Initially WHO and now the IAPC has taken over the responsibility of spreading the message of palliative care in India, but we still have a long way to go. Education of the professionals and sensitization of the public through awareness campaigns are vital for improving access to PC in India. Process of implementing PC plan into action re- quires strong Advocacy, political support and integration across all levels of care.

India with a 1.2 billion population has a huge burden of suffering from life limiting diseases. Less than 1% of its population has access to pain relief and palliative care. The ‘Quality of death ‘index measures the current end-of –life care environments across 40 countries. The report identifies poor access to pain relief, a lack of palliative care at national level and cultural taboos as the main barriers to countries providing a good ‘Quality of death ‘and thus a good quality of life at the end of life. India ranks at the bottom of the Quality of Death Index in overall score and scores badly on many othe indications. Furthermore, India ranks poorly regarding the knowledge of existence of hospice care, reflecting a general lack of awareness.

**Need of Palliative Care in India**

It is estimated that in India the total number of people who need PC is likely to be 5.4 million people a year, stressing on the need to expand the coverage of PC services and integrate services.

Late diagnosis and inadequate pain relief: It is estimated that in India around 1 million people are diagnosed with cancer every year with over 80% of cancer presenting at stage when treatment is less effective and palliative care becomes absolutely essential. There is also a sizable number of patients with HIV/AIDS. It has been estimated that 60% of the people dying annually will suffer from prolong illness. That means there will be a sizable number of aged who will be needing palliative care. In fact, that according to WHO, there were 60 million people above 65 years of age in 2010 in our country and that this figure will increase to 227 million by 2050 constituting 20% of the total population. Non-communicable diseases (NCD) including injuries account for 62% of disease burden as on 2004 and contribute to half (50%) of all mortality in india. Long-term care for such patients is emerging as a major health care issues in India. So, all of them are in dire need of palliative care. Less than 3% of India cancer patients have access to adequate pain relief.

Lack of palliative care facilities: In India the coverage of PC services is extremly patchy, services being concentrated in large cities and regional cancer centers with exception of Kerala, where the services are more widespread. The problem of inadequate pain relief is owing to the poor availability of morphine, lack of skills among professionals to prescribe morphine, fear of side effects and a fear of addiction of morphine among professionals, patients and their family.

Poor quality of death index: The economist intelligence unit has given India the lowest ranking in end-of –life care across the world among 40 countries. In India there is very little awareness about palliative and end-of life care which is complicated by the perception that Hospice care is often associated with giving up.

Lack of medical infrastructure: The majority of the urban poor to rely on government run hospitals, which are overcrowded and is the least of their priorities. It is natural that they would devote their limited resources to patients who can be cured. Again, In the rural areas, the doctor and hospitals are few and far apart. The vast distance and poor transportation facility prevent these patients from getting medical relief.

**History of Palliative Care**

Hospices were originally the places of rest for the travelers/pilgrims in 11 the century. In 17th century a religious order established hospices for the dying poor, where they offered food, clothing, shelter as well as minimal medical care. Modern hospice is relatively a new concept but originated and gained momentum in UK after the foundation of St. Christopher's hospice in London in 1967

Dame Cicely Mary Saunders is the founder of modern Hospice movement, who revolutionized PC in India and helped people to die with dignity free from fear and pain. She was originally a medical social worker, then she became a registered nurse, finally advanced her carrier to become a palliative care physician. She got inspired by a polish patient David Tasma who was dying from cancer to open St. Christopher's hospice. She had three aims for foundation of hospice: to provide care in both hospice and patient's home, to encourage teaching and training of doctors/nurses to promote research and in to the care and treatment of the dying. In 1986, Prof. D'Souza opened the first hospice in India 'Shanti Avedna Ashram'.

**Current Facilities and Provisions**

In a study published in 200813 MC Dermott E et al, identified 139 palliative care services in India serving 1.2 billion people out of which 83 centers in Kerala which con- tains 3% of India's population. These services are usually concentrated in large cities and regional cancer centers with the exception of Kerala where it is more widespread. As of 2014 in Kerala, more than 170 institutions stock and dispense morphine. NNPC in Kerala is often cited as only "beacon of hope" contributing to two third of India's palliative care services and one of the largest networks in the world. India has a huge burden of suffering from life limiting diseases. It is estimated that 5.4 million people in a year are in need of palliative care in India.

Future scope for PC in the country lies in the provision of facilities and medi- cines, sustainability of services, support from the community, government, media and team building for palliative care. Recent declaration by the WHA (World Health Assem- bly) asking all member states to integrate PC with routine health care comes as a major tool in advocacy and hopefully will boost the current efforts.

**PALLIATIVE CARE IN KERALA**

Pain and Palliative Care Society (PPCS), Calicut formed in 1993 is one of the pi- oneer organizations in palliative care in the Developing World. It is the first charitable society in palliative care in India. Since its inception, PPCS has acted as a facilitator for a large number of community-based initiatives in palliative care in Kerala). It was founded by some of the doctors of Calicut Medical College, under the guidance and leadership of doctors M.R. Rajagopal and Suresh Kumar. It started with a capital of Rs.1500 and a primary focus on palliative care for cancer patients. It grew and flourished quite fast and in 1995, it was recognized by the World Health Organization.

As the organization grew, they trained thousands of volunteers who later spread out to start palliative care units in their own local communities. They have also given guidance and support to palliative care units in neighboring countries like Thailand, Bangladesh, and Sri Lanka. Dr. Suresh Kumar himself had been to other parts of India like Puduchery and Arunachal Pradesh to help train volunteers and set up palliative care units there. In January 2020, about 30000 people attended a fund-raising event organized in Kozhikode. It was a carnival that featured art, literature, music and food, with palliative care patients themselves having made many handicraft items and savory dishes that were sold at the function (Manoj, 2020).

There has been a lot of debate about and study of its organization and function and the reasons for its achievements since the establishment of the NNPC (Neighbor- hood Network in Palliative Care). Relying too much on the all-encompassing word 'NNPC' is a mistake that is sometimes made. It is incorrectly used to refer to a homogeneous, centralized entity dedicated, according to its own established principles, to the development of identical satellite centers. The units covered by the umbrella term of the NNPC vary greatly depending on their organization, the priority of services, the availability of services, and the types of persons making up the unit. Some centers are run al- most entirely by a single entity, such as a religious association. A second category of established group is created by individuals from various organizations. To become formed, to recognize leaders and to work as a team, these groups need more time. Then, the final form of center is made up of people not affiliated with any organization. They also work in the area of health or social work independently. This group's initiation process is also challenging because they are only joined by the geographical region and require more time to grow as a group.

According to Zaman et al, (2017), the “NNPC is an attempt to facilitate a sustain- able, community-led service capable of providing palliative care to all those in need, with limited resource”. This model is based on the idea that untreatable medical conditions are social problems albeit containing somemedical components and definitely not a solely medical problem. The basis of this theory is the Declaration of Alma Ata of 1978 which emphasizes the obligation of “all governments, all health and development work- ers, and the world community to protect and promote the health of all the people of the world”. It was co-sponsored by WHO and emerged as a major milestone in the public health field of the 20th century. The Millennium Development goals of the United Na- tions in the year 2000 brought the focus back on the essence of this declaration. “The NNPC is an example of the revival of Alma Ata ideas and has in turn been acknowledged by WHO as a demonstration project”. According to the authors, it is a highly progressive measure, though it elicits a crucial question about the way in which welfarist ideas are incorporated into a neo-liberal state.

As part of the expansion of the services, new initiatives are started like ‘Tracks we leave’ to organize mass public support by accepting small donations for bedridden patients. The Footprint Rehabilitation Project, initiated by the Institute of Palliative Med- icine, Kozhikode, is a project that aims to incorporate chronically sick, bedridden and chronic psychiatric patients back into the community by teaching them new crafts / skills. A project that focuses on the ‘elderly’ - ‘Kiran Living with Dignity’ is an India- based project that proposes to integrate the care of aged together with palliative care. This five- year project began on November 1st, 2007. ‘Caring 4 Childhood Cancer & Chronic Illness’ is a new project that supports children with cancer and other chronic ill- ness. The only state with an NRHM palliative care program me is Kerala. The project, which began in 2008, has been working towards implementing the Government of Kerala's Palliative Care Policy.

Kerala’s palliative care units are functioning well because there are lots of volunteers in these units besides health care professionals. The volunteers work not only at the institutes but also participate in home visits and even participate in emergency night visits which are coordinated by the city’s administration. The local community plays a strong part in these involvements because many people join the initiative as they see it as a venture of their community, whether bonded on religious grounds or on ideological grounds.

Dr. Suresh Kumar, the doyen of palliative care in Kerala even welcomed the en- try of political parties into the sacrosanct arena of palliative care. In answer to a question about political parties entering the hallowed grounds of civil society, Dr. Kumar said that political workers were also part of civil society and that he was glad to see some of them trying to claim the social space they were entitled to According to him, the entry of such major players into the world of palliative care in the state is a “success of the sensitization and advocacy campaign for palliative care in the state” because the message being delivered all along has been that palliative care is everybody’s business.

This initiative could persuade the State to replicate this model and incorporate it in the health delivery system of the government. Such a scenario will make “Kerala the first in India with an official palliative care policy and statewide support system in place”. Kerala’s community-based palliative care units are local manifestations of neoliberalism in an only-one-of-its-kind socio- political setting. Kerala’s unique socio- historic context has expedited this participation of civil society organizations in welfare programs in association with the State.

**Table 4.1**

**Age structure of the respondent**

|  |  |  |
| --- | --- | --- |
| Age | Number | percentage |
| Below 70 | 16 | 32 % |
| 70-80 | 8 | 16 % |
| Above 80 | 26 | 52 % |
| Total | 50 | 100 |

Source : primary data

**Chart 4.1**

**Age structure of the respondents**

**Interpretation**

Table 4.1 shows the age profile of the respondents. Out of 50 respondents 32 per- cent fall in the age group below 70 and 16 percent come under the age group 70 to 80 and remaining 52 percent under the age group of above 80.

**Gender distribution of the respondents**

The gender wise classification of the sample population is important to under- stand whether male or female are mostly preferring palliative care services. The gender wise classification of the survey data shown in the following table.

**Table 4.2**

**Gender distribution of the respondent**

|  |  |  |
| --- | --- | --- |
| Gender | No .of Respondent | percentage |
| Male | 14 | 28% |
| Female | 36 | 72% |
| Total | 50 | 100 |

Source : primary data

**Chart 4.2**

**Gender distribution of the respondent**

**Interpretation**

It is clear from the Table 4.2 there exist a smaller number of males in the sample data. It is an important thing that mostly females are receiving palliative care services in their old age and illness. Out of 50 respondents 72 percent females and 28 percent males.

**Table 4.3**

**Marital status**

|  |  |  |  |
| --- | --- | --- | --- |
| Marital status | Female | Male | percentage |
| Married | 15 | 13 | 56% |
| Unmarried | 0 | 1 | 2% |
| Widow | 21 | 0 | 42% |
| Total | 36 | 14 | 100 |

Source : primary data

**Chart 4.3**

**Marital status**

**Interpretation**

Table 4.4 there are 50 respondents, out of 50 respondents 56 percent are married, 12 males and 15 females, 2 percent of male unmarried and 42 percent females are widows. The study examine that in the old age life majority of women are widows, therefore they have to lead a lonely life because husband died and children are working far away. Most of the females are widows in this age due to increase in the life expectancy of women and men marry women in their younger age

**Table 4.4**

**Income category**

|  |  |  |
| --- | --- | --- |
| Income Category | Number | percentage |
| APL | 28 | 56% |
| BPL | 22 | 44% |
| Total | 50 | 100 |

Source : primary data

**Chart 4.4**

**Income category**

**Interpretation**

Table 4.5 shows Out of 50 respondent 28 respondents are under APL category 22 in the BPL category. The study examines that 56 percent are the richer section of the society.

**Table 4.5**

**Status of Monthly Income**

|  |  |  |
| --- | --- | --- |
| Income | No.of Respond- ent | percentage |
| Below 20000 | 21 | 42% |
| 20000-30000 | 25 | 50% |
| Above 30000 | 4 | 8% |
| Total |  | 100% |

Source : primary data

**Chart 4.5**

**Income category**

**Interpretation**

Status of the monthly income of the respondent in the Table 4.6 shows that out of 50 respondents 42 percent below 20000 as their income 50 percent are under 20000 to 30000 category 8 percent above are in 30000 categories. . Survey results shows above 30000are consider as high income families. And there is no patient suffer any economic problems. People who are in old age difficult to approach hospitals and therefore they receive palliative services.

**Table 4.6**

**Distribution on The Basis of Type of Disease**

|  |  |  |
| --- | --- | --- |
| Disease | No .of Respond- ents | percentage |
| Cancer | 7 | 14% |
| Diabetes | 18 | 36% |
| BP & Stroke | 37 | 74% |
| Heart disease | 4 | 8% |
| Neurology | 2 | 4% |
| Peripheral Vascular disease | 1 | 2% |
| Paraplegia | 3 | 6% |
| Kidney disease | 4 | 8% |
| UTI | 1 | 2% |
| Mental problems | 1 | 2% |
| Spinal code damage | 2 | 4% |

Source : primary data

**Chart 4.6**

**Distribution on The Basis of Type of Disease**

Source : primary data

In the table 4.6 shows that out of 50 respondents, the BP Patient also suffer other type of disease. There are number of diseases affected one patient. 37 respondents suffer BP, 7 have Cancer, 18 are diabetic, 4 of them are suffering from heart disease, 2 of them have neurology problem, 1 respondent have peripheral vascular disease, 3 of them have Parapligia, 4 of them are suffering from kidney disease, 1 have UTI problem, 1 patient is suffering from Mental problem, 2are suffering from Spinal code damage.

In current situation the people suffering different types of diseases. Most of the disease is from the daily life of persons. There was increase in the non-communicable diseases like BP, CANCER, etc. the study reveals that most of the palliative care receiv-ers suffering this types of non-communicable diseases. And people suffer this type of disease in the early age but it was high in their old age period. The figure 3.3 shos the different types of diseases affected in the old age life of patient.

**Table 4.7**

**Years of Receiving Palliative Service**

|  |  |  |
| --- | --- | --- |
| Years | No.of Respond- ent | percentage |
| Below 1 Year | 2 | 4% |
| 2-3 Year | 2 | 4% |
| 3-4 Year | 7 | 14% |
| 4-5 Year | 16 | 32% |
| Above 5 Year | 23 | 46% |
| Total |  | 100 % |

Source : primary data

**Chart 4.7**

**Years of Receiving Palliative Service**

**Interpretation**

Table 4.7 interpret that out of 50 samples, 2 patients are receiving Palliative care service less than 1 year, 2 Patients are receiving the service from 2 to 3 years, 7 Patients are re- ceiving service under 3 to 4 years, 16 Patients are receiving service under 4 to 5 years and 23 Patients are receiving Palliative service above 5 years. Here out of 50 respondents more than 20 patients are receiving palliative care service above 5 years. . This shows the efficiency of palliative care units. Because above 5 years a patient and their family de- pending palliative care it shows palliative care units are providing good service.

**Table 4.8**

**Distribution on the basis receiving health care services**

|  |  |  |  |
| --- | --- | --- | --- |
| Sl .No | Availability | No of Respondents | percentage |
| 1 | Fully available | 44 | 88 |
| 2 | Partially available | 6 | 12 |
|  | Total | 50 | 100 |

Source : primary data

**Chart 4.8**

**Distribution on the basis receiving health care services**

**Interpretation**

Table 4.8 shows that out of 50 respondents (46)88 percent patients fully gets their demanded services. Only 12 percent patients partially available their demanded services.

**Table 4.9**

**Unnecessary hospital admissions**

|  |  |  |  |
| --- | --- | --- | --- |
| Sl.No | Hospital Admit | No of Respondents | percentage |
| 1 | Completely reduced | 43 | 86 |
| 2 | Partially reduced | 7 | 14 |
|  | Total | 50 | 100 |

Source : primary data

**Chart 4.9**

**Unnecessary hospital admissions**

**Interpretation**

Table 4.9 shows out of 50 samples 43 patients (86%) have completely reduced unnecessary hospital admissions. And remaining 7(14%) patients have partially reduced hospital admissions. The surveyed information clearly provide us the information that the palliative care units are playing an important role in improving the health conditions of the people of the society. Old age people have difficulties in going hospital, so in this occasion the activities of Palliative care units definitely provide a support and care to them. Similarly people with handicaps by birth or accidents are also receiving greater support from these units.

**Table 4.10**

**distribution on the basis of getting enough medical support**

|  |  |  |
| --- | --- | --- |
| **Sl no** | **Availability of medical support** | **percentage** |
| 1 | Fully available | 99 |
| 2 | Partially available | 1 |
|  | Total | 100 |

Source : primary data

**Chart 4.10**

**distribution on the basis of getting enough medical support**

**Interpretation**

Table 4.10 shows that out of 50 samples 99 percent patients get enough medical facilities. Remaining 1 percent or 1or 2 cases like kidney disease, cancer patients do not get enough medicines from palliative care services.

**Table 4.11**

**Satisfaction from palliative service**

|  |  |  |  |
| --- | --- | --- | --- |
| Sl. No | Satisfaction level | No of Respondents | percentage |
| 1 | Satisfied | 45 | 90 |
| 2 | Highly satisfied | 5 | 10 |
|  | Total | 50 | 100 |

Source : primary data

**Chart 4.11**

**Satisfaction from palliative service**

**Interpretation**

Table 4.11 shows that out of 50 respondent 90 percent patients are satisfied from palliative care services. And remaining 10 percent patients are highly satisfied with palliative care services. The satisfaction is assessed on the basis of the way of communication, In health care system the treatment from same nurse and doctor will helpful for the patients. They made a communication with the health practitioner in a smooth man- ner. In palliative care system there is the same nurse will provide care to the patients. It will help the patients and family members talk to them as a family member.

**Table 4.12**

**Reasons to Approach palliative services**

|  |  |  |  |
| --- | --- | --- | --- |
| Sl .NO | Reasons | No of Respondents | percentage |
| 1 | Financial problem | 9 | 18% |
| 2 | Nobody to help | 2 | 4% |
| 3 | Efficiency | 10 | 20% |
| 4 | Home Care | 29 | 58% |
|  | Total | 50 | 100% |

Source : primary data

**Chart 4.12**

**Reasons to Approach palliative services**

**Interpretation**

Table 4.12 interpret that out of 50 samples 18 percent patients are approaching palliative care facing financial problems, 4 percent patients are due to nobody to help, 20 percent patient approach palliative care due to the efficiency of palliative services, and remaining 50 were approach palliative care for home care.

**Table 4.13**

**Physical condition of the respondents.**

|  |  |  |  |
| --- | --- | --- | --- |
| Sl.No | Physical Condition | No of Respondents | percentage |
| 1 | Bed ridden | 21 | 42% |
| 2 | Aged | 9 | 18% |
| 3 | Normal | 15 | 30% |
| 4 | Difficulty in Walking | 2 | 4% |
| 5 | Others(Chemo, Dialysis) | 3 | 6% |
|  | Total | 50 | 100 |

Source : primary data

**Chart 4.13**

**Physical condition of the respondents.**

**Interpretation**

Table 4.13 shows that Out of 50 samples 21 patients are in bedridden, 24 patients are aged but in normal condition, 2 patients are difficulty in walking and 3 patients are cancer and dialysis patients. Most of patients are bedridden and they need palliative care service.

# Table 4.14

# Support for physical care

|  |  |  |
| --- | --- | --- |
| Sl No | Supporting System | No of Respondents |
| 1 | Wheel chair | 10 |
| 2 | Urinary Tubes | 2 |
| 3 | Walking stick | 4 |
| 4 | Air bed | 7 |
| 5 | Crutches | 1 |
| 6 | Walker | 8 |
| 7 | Water bed | 4 |
| 8 | Commode chair | 1 |
|  | Total | 37 |

Source : primary data

**Chart 4.14**

# Support for physical care

Table 4.14 interpret that out of 50 samples the support servicesare provided to the needy people. Here 10 patients have got wheel chair, 2 get urinary tubes ,4 get walk- ing stick, 7 get air bed, 1 get crutches, 8 receive walkers, 4 got water bed and 1 person got commode chair. Most of the patients need wheelchair. Out of 50 respondent 37 pa- tients get additional supporting system for their disease.

**5.1 FINDINGS**

The following are the important findings of the study

* Palliative care units and palliative care receiver explains the role and satisfaction level of palliative care service.
* Majority of the respondents are females and they are aged, there is decrease in the aged population of males.
* Fifty two percentage of the respondents are aged above 80 years.
* Forty two percent of female respondents are widows.
* Fifty six percent of respondents are in APL category.
* 50 percent of the respondents status of monthly income is between 20000-30000 it implies most of the respondents have fair income to meet their own basic needs.
* The respondents are suffering from different types of diseases, and out of this seventy percent of the respondents suffering BP and Diabetic problems.
* Forty six of the respondents receive palliative care more than 5 years, it shows the efficiency and need of palliative care service.
* 99 percent of the respondents get adequate medical support from palliative care, in some exceptional case they cannot provide medicine for respondents.
* The attending health care practitioner (nurse) is enough for the patients who need care.
* All palliative care receivers are comfortable with the visiting time of palliative care units.
* Almost all patients and family members get psychological support from pallia- tive care units.
* Eighty eight percent of respondent get their demanded services.
* Eighty six percent of respondents completely reduced unnecessary hospital ad- missions.
* The total respondents are satisfied with the way of communication palliative care workers.
* Care from the same health care practitioner will helpful for the patients and the communication between them in a smooth manner.
* There is no fee charge to the palliative care receivers for the service of palliative care units.
* Ninety percent of respondents completely satisfied with the palliative care ser- vices.
* Fifty eight percent of respondents approach palliative care service for home care because this service mostly wanted aged persons. And most of them are bedrid- den.
* Palliative care units provide different type of supporting system to the respond- ents.

**5.2 SUGGESTIONS**

* There are various services (medical and non-medical) provided by the palliative units support to the needy. To conduct an Awareness campaigns on the types of services offered by palliative care units it will help to opt the services they actu- ally require.
* Since the units offer economic support as free medicines, wheel chair, waterbed, airbed and provisions for the needy, but it did not get completely as they de- manded, to improve the provisions to the increase number of supporting system.
* As the contributions of volunteers in the team are revealed to be important in the non-medical services like social and psychological support, more philanthropic individuals should come forward to improve the palliative care units services.
* To initiate students involvement in Palliative Care to enhance the volunteer sup- port. Palliative Care students and unemployed volunteers should be motivated by grace marks, weight age points, etc. at the time of admission for higher studies and even for job recruitment and it will improve the service orientiveness of stu- dents.
* Since the numbers of the chronically ill and aged are increasing day by day, exist- ing units of palliative care may be insufficient. It would be more successful if Palliative Care could be considered essential by the Private Health Care institu- tions also.
* As the joint family system is disappearing from our society, the caring of a disa- bled member is also becoming difficult to manage by the family itself. Though there will be external support from agencies like palliative care, the young family members should be trained physically and mentally for the same.

**5.3 CONCLUSION**

In conclusion Palliative care is essential care for people in the community with serious or life-threatening illnesses. For ethical, public health and financial reasons, pal- liative care must be considered an essential integrated service within PHC. Interest in palliative care has been intensifying recently among health care professionals, motivated by the welfares to patients, the necessity to engross patients earlier in the course of their illnesses, and the effective reduction in cost by reducing hospitalizations, repeated ad- missions and causality visits. Palliative Care is proposed to get rid of and preclude suf- fering for patients with terminal illness or disability. For such patients, Care which in- cludes, medical, nursing, psychological, socio-cultural and spiritual aspects is required. Principles of Palliative Care include caring attitude, commitment, consideration to indi- viduality, cultural considerations, consent of patient and choice of site of care. Commu- nication among health care professionals and with patient and family also become the indispensable aspect of Palliative Care. Palliative Care principles insist comprehensive and multidisciplinary care with excellence and co-ordination. It should also be assured that the care is having continuity and it supports the care givers also. The study was an attempt to analyze the role of palliative care units and the service orientiveness of pallia- tive care units and the study will help full to know the importance of palliative service. This study reveals that majority of respondent satisfied with the service of palliative care units and they have a role in supporting health care.

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**APPENDIX**

**QUESTIONNAIRE**

Section 1 - Palliative Care Receivers

1. Name:

2. Age :

3. Gender :

4. Marital status :

5. Income category :

• APL

• BPL

6. Monthly income of your family?

7. Do you suffering which type of diseases?

• Cancer

• Diabetics

• Blood pressure

• heart disease

8. How many years of receiving palliative services?

• Below 1 year

• 2 to 3 years

• 3 to 4 years

• 4 to 5 years

• Above 5 years

9. Distribution on the basis receiving health care services?

• Fully available

• Partially available

10. Does the service reduce unnecessary hospital admissions?

• Completely reduced

• Partially reduced

11. distribution on the basis of getting enough medical support

• Fully available

• Partially available

12. Are you satisfied with the service from palliative care workers?

• Highly satisfied

• Satisfied

13. Why did approach this palliative care?

• Financial problems

• Nobody to help

• Efficient

• Homecare

14. Which are the physical condition of the respondent?

• Bedridden

• Difficulty in walking

• Normal

• Aged

15. Which are the support service provide for physical care?

* Wheel chair
* Urinary Tubes
* Walking stick
* Air bed
* Crutches
* Walker
* Water bed
* Commode chair