Community-based Palliative Care in Malappuram, Kerala: A Case Study of Selected Units with Reference to Care, Support, and Service Delivery

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ABSTRACT

This study examines community-based palliative care in Malappuram, Kerala, through a case study of selected units, with particular reference to care, support, and service delivery. Adopting a mixed-methods approach, the research analyses the operational efficiency of these units and explores the support systems that enhance patients' quality of life. The findings indicate that the effectiveness of the selected units is largely sustained through strong community participation, involving families, volunteers, and local organizations. Care practices extend beyond medical treatment to include emotional and social support, reflecting a holistic and patient-centered approach. Despite limited direct governmental funding, the model demonstrates sustainability through cost-effective strategies and active community involvement. The study further highlights the capacity of these units to deliver inclusive and accessible services tailored to the needs of patients and caregivers. It concludes that community-based palliative care units in Malappuram offer a viable model, emphasizing the critical role of community engagement in strengthening care, support systems, and service delivery.

Keywords: Community-based palliative care, Service delivery, Support systems, Community participation, Malappuram

INTRODUCTION

Palliative care plays a crucial role in improving the quality of life of patients suffering from life-limiting illnesses, chronic conditions, and terminal diseases (Azeez & Anbuselvi, 2021). In this context, it represents a significant shift in healthcare practice, moving away from a predominantly disease-focused approach toward a more holistic and patient-centered model (Kilbertus et.al 2022). This shift is further reflected in its core objective of improving the quality of life of patients and their families who are facing the challenges associated with life-threatening illness (WHO, 2012). By prioritizing care over cure, palliative care extends beyond clinical treatment to address the physical, emotional, and social dimensions of well-being, thereby placing the individual and their lived experience at the centre of healthcare delivery.

Within this framework, community-based palliative care has emerged as an important model that situates care within the everyday environments of patients. The concept of "community" here encompasses the various settings in which individuals live, work, and interact, including both stable and transitional spaces (Kamal et al., 2013). By embedding care within these social contexts, community-based models strengthen support systems, improve accessibility, and enable continuity of care. Such programs have also been found to enhance patient outcomes and caregiver experiences in a cost-effective manner, making them both socially and practically significant.

Existing studies on community-based palliative care highlight the interdependent roles of doctors, nurses, and volunteers in ensuring comprehensive care delivery. These actors collaboratively engage in patient care, mentorship, training, and advocacy, with volunteers often functioning as crucial intermediaries between families

and the care system (Philip et al., 2019). Caregiving within such settings is predominantly undertaken by women, who frequently experience significant physical strain, psychological stress, and social constraints. However, structured support mechanisms within palliative care programmes, including training and guidance, have been found to ease caregiving responsibilities and enhance their effectiveness. Patients with long-term illnesses also report improved independence and self-reliance as a result of sustained engagement with these services. Furthermore, the active involvement of the local community—through financial contributions and practical assistance—plays a vital role in sustaining these programmes, reinforcing the collective and participatory nature of community-based palliative care (Philip et al., 2019).

Kellehear (2005) marks a significant shift in the understanding of end-of-life care by moving beyond the limitations of conventional medical interventions. While the emergence of hospice and palliative care introduced a more holistic approach focused on improving the quality of life for patients and their families, Kellehear extends this perspective further by proposing a public health model of end-of-life care. This approach emphasizes the role of communities in supporting individuals facing death, loss, and bereavement. By advocating for "compassionate communities," the work highlights the importance of collective responsibility and social engagement in care practices, thereby reframing end-of-life care as not solely a medical concern but a broader societal obligation.

Kerala's experience with community-based palliative care is widely recognized as a sustainable and effective model (Azeez & Anbuselvi, 2021). The model reflects a broader commitment to collective care, where the well-being of vulnerable individuals becomes a shared social responsibility. This orientation is further reinforced through state initiatives such as the "Pariraksha" scheme, which demonstrate how community-led efforts can shape and influence public policy. As a result, palliative care in Kerala has evolved through a dynamic interaction between grassroots participation and institutional support.

A key milestone in this development was the introduction of Kerala's palliative care policy—the first of its kind in Asia—which formalized government involvement and strengthened community-managed initiatives. This policy has played a crucial role in expanding access to care and integrating palliative services into the broader health system. Despite these advances, there remains limited engagement with how such models contribute to wider development concerns, including their relevance to the Sustainable Development Goals (Gowri & Abdul Azeez, 2025).

The effectiveness of Kerala's model is closely tied to the active involvement of community-based organizations, including religious and voluntary groups, which contribute through volunteer mobilization and resource generation. This collaboration between civil society and the State has enabled the delivery of care that is not only accessible but also responsive to the needs of patients and their families. It highlights how networks of care and support can be built and sustained within communities, particularly in contexts where institutional resources alone may be insufficient.

Against this backdrop, the present study focuses on Malappuram district to examine how community-based palliative care is organized and delivered at the local level. Using a mixed-method approach, the study analyses the operational efficiency and service delivery mechanisms of selected palliative care clinics, while also exploring the nature of care and support systems sustained within the community. By doing so, it seeks to provide a detailed understanding of how community-based palliative care functions in practice and how it addresses the needs of patients and caregivers in a specific regional context.

MATERIALS AND METHODS

Research Design

The study adopted a mixed research design to examine the functioning and sustainability of community-based palliative care services. This design enabled the collection of both quantitative and qualitative data concurrently, providing a comprehensive understanding of the organizational, financial, and social dimensions of community-

based palliative care. Quantitative data were obtained from clinic records and structured schedules, while qualitative data were gathered through interviews, observations, and case studies.

The quantitative and qualitative data were analysed independently and integrated during the interpretation of findings through triangulation. While the quantitative data identified patterns related to patient profiles, service delivery, and clinic resources, the qualitative findings provided deeper insights into patients' lived experiences, volunteer engagement, and the community-based nature of care. The integration of both datasets enhanced the validity of the findings and offered a holistic understanding of the effectiveness and sustainability of the selected palliative care model.

Study Area and Selection of Units

The study was conducted in Malappuram district of Kerala, focusing on four selected community-based palliative care units located in Trikkalangode Panchayath: Elankur Palliative Care Clinic, Shappinkunnu Palliative Clinic, Amayoor Palliative Clinic, and Thrikkalangode Palliative Care Clinic. These units were purposively selected to capture variations in service delivery and organizational practices within community-led palliative care.

Sampling

A purposive sampling technique was employed for the selection of both the palliative care units and the study participants, as the research sought to generate an in-depth understanding of women's experiences within community-based palliative care settings. The sampling strategy was guided by the objectives of the study rather than statistical representativeness. For the selection of palliative care units, the inclusion criteria required that the centres had been operating continuously for a minimum of three years to ensure organizational stability, continuity of service, and sufficient experience in delivering community-based palliative care. The study primarily focused on non-governmental and community-led palliative care units, as these institutions play a significant role in the provision of home-based and community-oriented palliative services. To capture variations in service delivery and organizational practices, clinics with different service orientations were intentionally included. Based on these criteria, four palliative care units were selected: Elankur Palliative Care Clinic, Shappinkunnu Palliative Care Clinic, Amayoor Palliative Care Clinic, and Thrikkalangode Palliative Care Clinic.

Data Collection Methods

The study is based on field-level investigation involving both primary and secondary data. Primary data were collected through in-depth interviews with key stakeholders, including administrators, physicians, nurses, coordinators, and healthcare volunteers involved in the management and functioning of the units. In addition, interviews with patients and family members were conducted to understand their experiences and perceptions of care and support systems. Secondary data were gathered from institutional records, reports, and documents available at the selected palliative care units, which supported the analysis of operational efficiency and service delivery patterns.

Tools and Techniques

The primary tool for data collection was a semi-structured interview schedule, designed to capture both factual information and subjective experiences. Observational insights from field visits also supplemented the data, enabling a contextual understanding of care practices and interactions within the units.

Method of Analysis

The study employed a mixed-method approach for data analysis, in which quantitative and qualitative data were analysed separately and subsequently integrated during the interpretation stage. Quantitative data collected from

the selected palliative care clinics, including patient records, clinic documents, and structured schedules, were analysed using descriptive statistical techniques such as frequencies, percentages, averages, and tabular presentation. These analyses were used to examine patient distribution, disease patterns, clinic resources, service delivery, and financial sustainability.

Qualitative data obtained through case studies and observations. The interview transcripts and field notes were coded systematically to identify recurring themes related to community participation, volunteer engagement, psychosocial support, patient experiences, and the sustainability of community-based palliative care. The case studies were analysed narratively to capture the lived experiences of patients and to illustrate the broader social and emotional dimensions of palliative care that could not be adequately explained through quantitative findings alone.

Theoretical Framework

The concept of social capital, as developed by Pierre Bourdieu (1986), provides a useful lens for understanding the functioning of community-based palliative care. Bourdieu defines social capital as the aggregate of actual and potential resources embedded within networks of relationships, which can be mobilized to achieve collective or individual benefits. In the context of community-based palliative care in Malappuram, this perspective helps to explain how care, support, and service delivery are sustained through dense social networks involving volunteers, community-based organizations, and local institutions. These networks facilitate not only the provision of material resources, such as financial assistance and medical support, but also intangible forms of care, including emotional support, trust, and a sense of belonging. The active participation of community members reflects the conversion of social relationships into functional support systems, thereby enhancing the accessibility and effectiveness of palliative care services. Furthermore, such collective engagement resonates with broader public health approaches that emphasize the role of communities in end-of-life care (Kellehear, 2005), while empirical evidence from Kerala demonstrates how community mobilization significantly contributes to the success and sustainability of palliative care initiatives (Kumar, 2007). Thus, social capital operates as a crucial underlying mechanism through which community-based palliative care is organized and delivered, highlighting the importance of social networks, reciprocity, and shared responsibility in addressing the complex needs of patients and their families.

Analysis

Patient Distribution across Palliative Care Clinics

The study examines the number of patients registered at four different palliative care clinics. It provides a comparative overview of patient load at each clinic, highlighting Elankur Palliative Care Clinic as the facility with the highest number of patients. The total patient count across all clinics is also summarized to give a comprehensive view of the overall service demand.

Table 1: Number of patients at different Clinics

Name of Clinics	Number of Patients
Elankur Palliative Care Clinic	300
Shappinkunnu Palliative Clinic	260
Amayoor Palliative Clinic	254
Thrikkalangode Palliative Care clinic	250
Total	1064

Source: Primary Data

According to the data collected from all the clinics, the total number of patients across the clinics is 1,064 , an average 266 patients for every clinic. The highest number of patients was recorded from Elankur Palliative Care Clinic with 300 patients followed by Shappinkunnu Palliative Clinic with 260 patients. Amayoor Palliative Clinic has 254 patients and Thrikkalangode Palliative Care clinic has 250 patients

Healthcare Services and Support provided by the Clinics

This study analysed the healthcare services and support systems delivered by community-based palliative care clinics. The services are categorized into four main areas: Home Care Services, Mental Health Support, Volunteer Programmes, and Administrative Meetings. Each category includes specific interventions aimed at addressing the comprehensive needs of patients and ensuring effective clinic operations. The table reflects the clinics' holistic and integrated approach to care, emphasizing both medical and psychosocial dimensions. The comprehensive healthcare services and support provided by the clinics are given below in the table No.2

Table 2: Healthcare Services and Support provided by the Clinics

Areas of Services/Support	Nature of Services
Home care Services	Daily Home Care
	Doctor's Home Care
	Night Home Care
	Physiotherapy
Mental Health Support	Psychiatric OP
	Counselling
	Day-care Service
	Peer group Meeting
Volunteer Programmes	Home Visits
	Volunteer Training
	Family Training
Administrative Meeting	Team Meeting
	Activity Review
	Administrative Committee Meeting

Source: Primary Data

The table highlights the multi-dimensional care model adopted by the palliative care clinics, which extends far beyond basic medical treatment. Under Home Care Services, the inclusion of daily visits, doctor's home care, night care, and physiotherapy illustrates a strong focus on continuity of care and patient comfort within their own homes—central to the philosophy of palliative care. This also reduces the need for hospitalization and improves quality of life.

The Mental Health Support section is particularly notable, as it demonstrates recognition of the psychological burden faced by patients and their families. Services such as psychiatric outpatient care, counseling, and peer group meetings indicate that emotional and social well-being are treated as integral components of health.The Volunteer Programmes show the clinics' deep engagement with the community, training and mobilizing volunteers and families to become active participants in care. This not only addresses staffing challenges but also builds social capital and sustainability by making care a shared community responsibility. The inclusion of Administrative Meetings—such as team discussions and activity reviews—signals a commitment to coordination, accountability, and continuous improvement. These meetings are essential for maintaining quality,

evaluating outcomes, and planning effectively. Through these core services, community-based palliative clinics in the Trikkalnagode Panchayath of Malappuram aim to provide holistic support to our patients and their families, ensuring that they receive the best possible care and resources**.**

Distribution of Major Illness in Palliative Clinics

The most prevalent diseases identified in patients who visit palliative care clinics are broken down categorically in this table. A clear distribution of diseases is provided by listing the conditions in decreasing order of prevalence. It facilitates the analysis of patient care requirements and resource planning in palliative care settings.

Table 3: Distribution of Major Illness in Palliative Clinics

Order of Prevalence	Nature of Illness
1	Cerebrovascular Accidents
2	Cancer
3	Chronic Kidney Disease
4	Coronary Artery Disease
5	Dementia/Alzheimer's
6	Chronic Obstructive Pulmonary Disease
7	Others

Source: Patient records

According to the data regarding illness distribution in the palliative care clinics, Cerebrovascular Accidents (CVAs) are the most common condition, followed by Cancer (CA), Chronic Kidney Disease (CKD), and the fourth most common illnesses among patients in the palliative care clinics are cardiovascular conditions such as Coronary Artery Disease (CAD). Following these illnesses are neurodegenerative diseases (such as Dementia) and respiratory diseases (such as Chronic Obstructive Pulmonary Disease or COPD).

The relatively high prevalence of CVAs and CAs indicates a large burden of non-communicable disease (NCD) among the patients seen in these clinics. CKD and CAD are examples of some of the challenges that accompany lifestyle disease, and their increasing prevalence demonstrates the necessity of considering integrated approaches to healthcare while working in a palliative care setting. Others category includes less frequently reported but still significant life-limiting or chronic conditions that require palliative care. These are typically conditions that do not appear among the top major categories but still contribute to the overall caseload.

Patient Classification and Care in the Clinics

The classification framework adopted by the selected palliative care units to organize patients based on their level of need and corresponding care requirements are given in the table. It reflects the structured approach followed by the clinics in delivering differentiated and need-based services within a community-based care model.

Table 4: Patient Classification and Care in the Clinics

Categories	Nature of care Provided
Category A	Doctor Consultation, Nursing Home Care (NHC), Volunteer home care (VHC), Psychosocial Support

Category B	Guidance from Clinic Doctors, Nursing Home Care (NHC), Volunteer home care (VHC), Psychosocial Support
Category C	Distribution of Medical kits, Example: Dialysis kits

Source: Primary Data

The table presents the classification of patients in the selected palliative care units and the corresponding nature of care provided under each category. The categorization reflects a graded and need-based approach to service delivery, ensuring that patients receive care according to the severity of their condition and level of dependency.

Category A represents patients with the highest level of need, requiring comprehensive and continuous care. These patients receive regular doctor consultations, along with Nursing Home Care (NHC) and Volunteer Home Care (VHC), indicating a coordinated model involving both professional and community-based support. The inclusion of psychosocial support highlights the emphasis on addressing emotional and mental health concerns alongside physical illness, reflecting a holistic approach to care.

Category B includes patients who require moderate levels of care and supervision. While they may not need frequent direct medical intervention, they continue to receive guidance from clinic doctors, along with nursing and volunteer-based home care services. The continued provision of psychosocial support suggests that emotional well-being remains a key concern even at this intermediate level of care. This category demonstrates the system's ability to maintain continuity of care while optimizing resource allocation.

Category C comprises patients with relatively lower levels of dependency, where care is primarily focused on the provision of medical supplies, such as dialysis kits and other essential materials. This indicates a more targeted and need-specific intervention, where direct caregiving may be minimal but support is still extended to ensure treatment continuity and basic health maintenance.

The classification system reflects an efficient and stratified care model, enabling the palliative care units to allocate resources effectively while ensuring that patients across different levels of need receive appropriate medical, psychosocial, and material support. It also highlights the integration of professional healthcare services with community participation, which is central to the sustainability and effectiveness of community-based palliative care.

Economic Sufficiency of the Clinics

The palliative care units studied were involved in providing a wide variety of services for a large number of patients. These service deliveries incur potential costs to palliative care units. Most palliative care in the region, except for the government-run, is a function of community-owned projects. Although there are no fixed sources of funding for these organizations, they reach a large number of patients every year with comprehensive care. The expenses include fuel for vehicles, salaries for employees, costs for medicines, and expenses for medical equipment.

All the studied palliative care programs were reported to be financially sustainable in a way that they could meet all the expenses of the palliative care operations from the funds they received from different sources. Currently, these four community-based clinics do not receive any government support. They primarily rely on micro funding as their main source of income. This includes small contributions collected from donation boxes placed in houses and shops, special occasion donations, annual one-day collections, and Ramadan collections. All expenses for the month could be met by these means. The annual expenditure of the clinic is given in the table no 5

Table 5: The Annual Expenditure of the Clinic

Name of the Clinics	Expenditure
Elankur Palliative Care Clinic	30 lakhs
Shappinkunnu Palliative Clinic	30 lakhs
Amayoor Palliative Care Clinic	25 lakhs
Thrikkalangode Palliative are Clinic	22 lakhs
Total	107 Lakhs

Source: Financial records kept at Clinic

The table provides a detailed breakdown of the clinic's annual expenditure. It includes various cost components associated with the delivery of palliative care services, such as medical supplies, staff salaries, operational costs, and patient support services. The overall total expenditure for all four clinics is 107 lakhs, with an average expenditure of 26.75 lakhs per clinic. The expenditures for Shappinkunnu Palliative Clinic and Elankur Palliative Care Clinic are the highest, at 30 lakhs each, and Thrikkalangode Palliative Clinic is comparatively the lowest at 22 lakhs. The differences in expenditure may be influenced by patient load, costs of operation, and sources of funding.

Resources available at Palliative Care Clinics

The key resources owned and utilized by the palliative care clinics to support their operations and patient care services are listed in the Table No.3.7. It includes physical infrastructure, such as buildings and vehicles, as well as human resources like doctors, nurses, physiotherapists, and social workers. The data provides an overview of the clinics' capacity to deliver effective palliative care across their service areas.

Table 6: Resources available at Palliative Care Clinics

Category	Number
Own Building	1
Own Vehicle	12
Home care units	10
Doctors	3
Regular Nurses	10
Physiotherapists	4
Social Workers	4

Source: Primary Data

According to the data provided it is clear that with 12 own vehicles, 10 home care units, 10 regular nurses, and a multidisciplinary team, palliative care clinics are comparatively well-equipped in terms of human resources and mobility. Regular nurses (at least two), Doctors, and medical practitioners (part-time or full-time) were available in all studied care units. All units had permanent drivers. All were appointed part-time physiotherapists for service delivery and qualified social workers. However, the fact that only one clinic owns its building highlights a significant infrastructure limitation. Using rented facilities for the majority of operations may limit

long-term planning, make it more difficult to customize spaces for optimal care, and make operations more vulnerable. With more than 1,000 patients served, the clinics nevertheless exhibit a strong outreach capacity, which is crucial for community-based palliative care. Service quality may be raised by increasing infrastructure ownership while preserving efficient home-based and mobile services.

Volunteer Engagement

Across all the palliative care units examined in the study, volunteerism was the most important component for providing sustainable operational capacity, as every activity of palliative care was performed by volunteers. Volunteers were key to patient identification, need assessment, resource mobilization, and coordination of overall palliative care services. All palliative care units highlighted the importance of volunteers in the continuity of palliative care and the effectiveness of services. Public acceptance of palliative care services shows strong social consensus on the need and value of their services.

Clinical survey data showed that the volunteers' ages ranged from 8th-grade students to 72-year-old individuals. Volunteers are an important part of fund mobilization, identifying patients who may need care, and mobilizing resources; they are the foundation of community-based palliative care. The majority of volunteers received training that included training on the psychosocial needs of patients and their families to encourage the achievement of service delivery objectives. Training and awareness seminars were held at the district level for new volunteers and staff to learn new essential skills, such as communication skills and basic patient care. This volunteer workforce similarly included a range of experiences from young people, professionals, retired people, students, NSS members, and other members of the community. The volunteers formed a community-led palliative care model together. Community-based palliative care has shared the social obligations of care, rather than being specifically assigned as caring in a professional service sense.

To further strengthen palliative care initiatives, district-level awareness seminars and training programs were conducted across Kerala. The seminars and training were aimed at building basic awareness, communication skills, and fundamental caregiving skills for volunteers. The volunteers represented a diverse group that included students, professionals, retired government officials, members of the National Service Scheme (NSS), and members of the general public who came together for a common cause. Their collective contribution made a major difference not only in patient care but also in the finances and viability of community-supported palliative care models.

Case Studies

Case 1: The life of this patient has been filled with tremendous hardships, from losing their father at a young age, being placed into an orphanage as a child, and then getting married in the ninth grade at age 15. Marital life is extremely traumatic for the patient, in part due to their husbands' drinking problems, which contributed to prolonged physical and emotional abuse. This prompted the patient to attempt suicide and subsequently led to their introduction to the palliative care clinic. The use of holistic care led by nurses and volunteers, as well as psychosocial models of care, allows for patient recovery. Over time, the patient's mental health improved and they regained stability. The most remarkable aspect of this case is the patient's transition from a care recipient to an office staff member at the same clinic, which aided in their recovery. This shows how a community-based palliative care model can be life-changing and empower patients, not just with medical care but through meaningful involvement in community life.

Case 2: In this case the patient has been receiving care from a community-supported palliative care clinic since 2017. After experiencing divorce more than 20 years ago, the patient faced emotional challenges and loneliness. Over time, the patient has successfully rebuilt a stable life and lives comfortably with their children. The role of the clinic has been instrumental in patients' emotional recovery and reintegration into family life. A prominent feature of this case is patient's ability to sustain positive social connections. Volunteers and health providers working with the patient regularly use the word' model behavior as well as noting the patient's openness to experience the assistance. The patient is proactive in working with their caregivers and other patients to support a warm relationship in the community-based palliative care system. Regular follow-ups are a principle of the

clinic's approach to patient care, ensuring that the patient's emotional well-being is monitored at all times. The clinic provided care during COVID-19 when many patients did not have access to healthcare, but the COVID CARE clinic reflected both the resilience of palliative care and the persistence of volunteers in support of the community's healthcare needs.

Case 3: This patient has been under the care of the palliative care clinic since 2013. This patient experienced severe familial and emotional challenges. He is alienated from his wife and children, suffers severe emotional pain, and experiences social isolation. The absence of a home-based support system has intensified his mental distress, and he is relying on the social presence provided by palliative volunteers even more. The aspect of living without a caregiver has added considerable solitude. Cancer is a complex health issue, and this patient requires medical and emotional support to assist with coping. This case illustrates the importance of palliative services not only for addressing physical health issues but also for managing psychological and social issues. Despite all these challenges, community-based volunteers and healthcare providers have provided the patient with a feeling of belongingness and respite from the burden of isolation. The palliative volunteers visited him routinely, and the visits ensured that they were not completely isolated. The act of listening and providing emotional support matters and has a positive impact on the patient's well-being while giving credence to the value of palliative care services beyond medical treatment, reflecting the need for organized emotional support for patients receiving palliative services who lack familial relationships. The case also highlights the power of volunteers to offer sorely-needed psychological comfort to those receiving terminal care.

Case 4: This patient became part of the community-based palliative care system in 2015. Unlike other cases, this patient preferred to be alone in the beginning and did not engage with other people in social contexts. The refusal to engage with the caregiver and other patients complicated the patient's care process related to psychosocial disconnect in palliative care. At the early point of treatment, the patient avoided interactions and was not cooperative. Subsequently, through hard work by nurses and volunteers, the patient began to change. The repeated, structured, and person-centred engagement facilitated some trust by the patient in the caregivers, and the patient started to engage socially. Eventually, as the patient was more accepting, the patient's health began to improve with the willingness to engage with caregivers, engage in conversations, and participate in social activities organized by the palliative care clinic. This case illustrates the importance of patience, long-term engagement, and targeted psychosocial strategies in community-based palliative care, emphasizing how effective community-based palliative care and structured emotional support in a caring environment can improve patients' general mental and social well-being. Finally, this case elucidates that effective palliative care goes beyond the medical treatment of the patient to address emotional and psychological barriers to recovery in the patient's health trajectory.

Case 5: This case highlights the comprehensive support of community-based palliative care for a multi-problem family. They had a student in the 9th standard with blood cancer, a 9-year-old child with muscular dystrophy, and their mother, who was afflicted with a psychiatric disorder. Their situation worsened because their father left them, and their eldest brother, a Plus One student, had to look after them all by himself. The responsibility of looking after the family and providing medical care forced the eldest child to leave school to accompany the 9th-grade sibling to the hospital for treatment. The patient was referred to a palliative care service by a doctor at a medical college, resulting in immediate intervention. Four years of rent was provided to the family to attain housing stability, prevent displacement, and ensure a safe living situation. Educational support was also organized so that the eldest child could pursue school education, thus bringing relief for caregiving and ensuring their future. Medical, food, and basic household expense support was also given by volunteers to ensure that the basic needs of the family were met. Psychosocial interventions were also a priority, where volunteers engaged 9th-grade sibling in recreational activities to maximize their quality of life. The child died peacefully after receiving treatment for three years. Palliative care services; nevertheless, continued to assist families in rebuilding their lives. The family was given a house, and a 9-year-old child with muscular dystrophy continued to receive therapy for body rehabilitation and movement support. The mother, who was under psychological treatment, exhibited spectacular improvement with unbroken care and mental attention. Consequently, the family entered a settled and rewarding life, illustrating the effectiveness of palliative care within a community setting over both medical and socioeconomic challenges.

Case 6 highlights the impact of a community-based palliative care program supporting individuals with serious health and social vulnerability. The family included a mother living with advanced dementia and her 21-year-old son who had sustained a spinal cord injury from a fall and had previously worked as a painter. The father left shortly after the son was born, and the son and mother were left without apparent family or support after the abandonment. As the mother progressed further into her dementia diagnosis, she was no longer able to perform basic day-to-day activities, and her cognitive abilities decreased, making her unable to live independently. They did not have any means to bring in a caregiver, so palliative care volunteers stepped in and began to provide 24-hour-a-day assistance to keep the mother safe and healthy. While their actions assisted the mother physically, along with being patient-centred in intent as a caregiver, their commitment was to the levels and processes of compassion, care, and patient-centeredness, which further positioned them to respond to the mother's emotional and psychological needs. The unwavering commitment of the volunteers was so profound that when a doctor witnessed their work, he stated, "*Palliative care has taught me the real meaning of humanity.*" This case demonstrates how palliative care exists outside traditional medicine through a holistic approach to support dignity and quality of life.

Case 7 demonstrates that community-based palliative care can transform mental health recovery. This patient experienced significant mental health challenges, leading them to separate the marital bond. Her child (who was also diagnosed with ADHD) added another layer to the challenges. After separating from their spouse, she and her child were placed with her elder brother. Eventually, a palliative care service entered the scene to provide one-on-one assistance and counselling. Volunteers appeared to visit the clinic too often as highly distressed, was able to work toward stability with the on-going support of palliative care services. With encouragement from caregivers, she pursued educational opportunities, eventually completing a bachelor's and a master's degree in psychology. She is presently working in Dubai as a psychologist and is rebuilding their life and career. Eventually, the couple was able to reunite, and both showed significant improvements in mental health, such that everyone involved was able to discontinue psychiatric methods. Her child receives the support they require. This example demonstrates the on-going benefits of sustained community

The above case studies collectively highlight the multidimensional impact of community-based palliative care in addressing not only medical needs but also the complex social, emotional, and economic challenges faced by patients and their families. Across diverse contexts—ranging from mental health struggles, social isolation, and family disintegration to chronic illness and economic vulnerability—the selected cases demonstrate that palliative care extends far beyond symptom management. The consistent involvement of volunteers, nurses, and community members emerges as a central feature in sustaining care, fostering trust, and ensuring continuity of support.

A recurring theme across the cases is the role of sustained interpersonal engagement in facilitating recovery, reintegration, and improved quality of life. Whether through emotional counselling, regular follow-ups, or assistance with basic needs such as housing, education, and caregiving, the palliative care units effectively mobilize community resources to respond to patient needs in a holistic manner. The transformation of patients—from states of distress, isolation, and dependency to stability, participation, and even empowerment—underscores the significance of community-driven care models.

Furthermore, these cases illustrate the importance of long-term commitment and patient-centered approaches in overcoming psychosocial barriers, building resilience, and restoring dignity. The integration of medical care with psychosocial and material support highlights the adaptability and responsiveness of community-based palliative care systems. Overall, the cases reaffirm that such models are not only effective in managing life-limiting conditions but also play a crucial role in strengthening support systems, enhancing social connectedness, and enabling meaningful improvements in patients' lives.

DISCUSSION

The research on community-based palliative care services highlights a viable, patient-centred model that has proven successful and sustainable, particularly in Kerala, even in the absence of direct governmental funding. By emphasizing a community-driven structure that integrates emotional, medical, and social support, the

findings demonstrate the development of a self-sustaining system that functions effectively within its local context and addresses the long-term needs of patient. Even during the COVID-19 pandemic, the clinics continued home care with the consent of the patients, ensuring patient safety. This dedication led people from different places to contact and visit these clinics for outpatient services during that time, and it became highly recognised and appreciated.

The remarkable part of the study was the high-level of satisfaction from patients. They expressed a strong emotional interest toward their caregivers that extended beyond "medical support". The elimination of professional distance was an important factor in establishing meaningful relationships, not just treatment where realistically no one cares. The movement from clinical to a home-based care was a fundamental factor in how patients perceived and experienced the care.

The program operates outside the traditional palliative care system. It functions through active community engagement and funding, without reliance on government resources. The initiative is managed by four clinics, each led by a 33-member committee responsible for governance, funding decisions, resource allocation, and service monitoring. Regular community meetings bring local members together, strengthening participation and accountability. Community fundraising efforts, voluntary service, and in-kind contributions ensure the program's sustainability. This model represents a community-rooted structure that is independent of hospitals and firmly embedded in local networks.

A key element of this care model is its reduced hierarchy. Nurses and doctors purposefully take off their professional coats when interacting with patients to ensure a more equal and personal interaction. This deliberate action removes traditional power dynamics and promotes a trusting relationship between caregivers and patients. Home visits by doctors further personalize care, allowing medical interventions to be delivered in a familiar setting and strengthening the bond between doctor and patient. The approach is designed to be relational rather than purely clinical.

Case study analysis proved that the patients are well satisfied with the services provided by the palliative care units. Case study demonstrates that community-based palliative care can transform social, emotional, physical health outcomes.

CONCLUSION

The study concludes that the community-based palliative care system is indeed sustainable. Community Palliative care exists outside traditional medicine through a holistic approach to support dignity and quality of life. By working closely with cultural and social values, community-based palliative care has provided essential programs such as home care, mental health therapies, and physiotherapy, despite challenges related to infrastructural capacity, reliance on community funds, and lack of government support. An improved collaboration between government services, NGOs, and communities will improve delivery and enhance sustainability and long-term impact, ensuring the long-term success of community-based palliative care. This model can be effectively replicated in other states to promote a more inclusive and sustainable approach to healthcare and community well-being

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