Johannesburg Multi-Hospital Palliative Care Project Report

Project Name: Johannesburg Multihospital Palliative Care Project

Partner Name: Wits Health Consortium

Country: South Africa

Project Implementation Period: Start (01/07/2021) and End (30/06/2024)

Reporting period: Start (01/01/2024) and End (30/06/2024)

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Gauteng Centre of Excellence for Palliative Care

WITS HEALTH CONSORTIUM

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List of acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
CHBAH	Chris Hani Baragwanath Academic Hospital
CMJAH	Charlotte Maxeke Johannesburg Academic Hospital
HIV	Human Immuno-Deficiency Virus
HJH	Helen Joseph Hospital
MDT	Multi-Disciplinary Team
PC	Palliative Care
SCCC	Soweto Comprehensive Cancer Care Centre
WBOTs	Ward-Based Outreach Teams

EXECUTIVE SUMMARY

Introduction

The following report provides an account of the activities that have been undertaken under the Johannesburg Multihospital Palliative Care project through BMSF funding for the period of December 2023 – June 2024. Services are currently provided at Chris Hani Baragwanath Academic Hospital and Charlotte Maxeke Johannesburg Academic Hospital. This reporting period represents the last six months of the contract, which was set to end on the 30th of June 2024.

Background

The grant for the implementation of palliative care services in three tertiary hospitals, namely Chris Hani Baragwanath Academic Hospital, Charlotte Maxeke Johannesburg Academic Hospital and Helen Joseph Hospital was awarded in June 2021. Since then, palliative care services, comprising clinical, psychosocial, and spiritual care have been rendered at the three institutions. Unfortunately, services have been discontinued at HJH due to funds coming to an end in June 2023. In this report, we share the performance of the project at the two remaining institutions for the January 2024 – June 2024 reporting period (CHBAH & CMJAH).

Project goals

- ***Goal 1***: To establish PC services at CMJAH
- ***Goal 2***: To stabilize PC services at HJH
- ***Goal 3***: To strengthen PC services at CHBAH Wits Centre for Palliative Care
- ***Goal 4***: To increase access to home PC services in and around Soweto and surrounding areas
- ***Goal 5***: To train and build capacity to provide PC at all levels of healthcare
- ***Goal 6***: To provide support to patients through survivorship programs

Key achievements by objective

Goal 1: To establish PC services at CMJAH

Since receiving the palliative care grant, we have managed to successfully establish palliative care services at CMJAH through support from the BMSF. Personnel to provide clinical, psychosocial, spiritual, and case navigation were employed. From inception to date, **3391 (57%)** patients were referred for clinical care, **2966 (66%)** for psychosocial care, and **2735 (114%)** for spiritual care. Among those patients with at least one palliative care consultation, **3280 (61%)** received clinical care, **2900 (72%)** received psychosocial care, and **2595 (144%)** received at least one spiritual consultation. Because patients must be followed up to monitor treatment outcomes, the team also conducts follow up visits. The total clinical, psychosocial and spiritual follow up over the project implementation period are 5328, 4115 and 4477 respectively, bringing total consultation to **8608** for clinical, **7015** for psychosocial and **7072** for spiritual care. The hospital has also provided additional clinical staff to augment the efforts for the availability of services. Two of our clinical staff resigned as the project end date drew closer, affecting the overall number of patients receiving clinical services at the hospital during this reporting period.

Goal 2: To stabilize PC services at HJH

The project at HJH ended in June 2023. There were challenges in sustaining the project, but negotiations are ongoing.

Goal 3: To strengthen PC services at CHBAH Wits Centre for Palliative Care

CHBAH, which houses the Centre of Excellence for palliative care is a well-established center for palliative care services in Gauteng Province. With support from the hospital, clinical staff have been allocated to the Centre, and this is reflected in the number of patients who receive services monthly. There are still challenges, however, with the allocation of government-funded allied health workers such as social and spiritual workers. Since the BMSF-funded project started in June 2021 until June 2024, **4 898(136%)** patients have been referred for clinical

services, while **4847 (113%)** received at least one palliative care consultation. For psychosocial services, **3 783 (105%)** have been referred and **3 499 (108%)** have had at least one initial consultation. Among those patients who have received spiritual services, **3 191 (148%)** have been referred and **2 979 (166%)** have received at least one spiritual care consultation. Follow up visits for patients over the life of the project were 7217 for clinical, 3513 for psychosocial and 4648 for spiritual care, bringing the total visits to **12064** for clinical, **7012** for psychosocial and **7627** for spiritual care.

Goal 4: To increase access to home PC services in and around Soweto and surrounding areas

The home care component is an essential arm of palliative care service delivery to patients who cannot access the services in the hospital. Though the performance of the team, reflected in the targets is not as anticipated, several challenges were experienced, contributing to the slow start in home care service provision. The availability of a driver, as of April 2023 has greatly increased the number of patients seen at their homes due to challenges accessing the health care facilities.

Goal 5: To train and build capacity to provide palliative care at all levels of healthcare

Since our center is a center of excellence for palliative care, we are involved in providing training and capacity building to various cadres such as healthcare workers, medical students, chaplains, and ward-based outreach teams. We have managed to meet our targets for the number of health and non-health professionals receiving palliative care training.

Goal 6: To provide support to patients through survivorship programs

Throughout the life of the project, we have managed to conduct support groups and healing/bereavement services for patients and their families, in collaboration with a community-based organization. We have surpassed the targets for the number of survivorship programs throughout the lifespan of the project.

Key challenges and mitigation

We are still experiencing challenges with poor and late referrals from both hospitals. We will be creating awareness creation material to share with hospital personnel. We have also seen a slight decrease in the number of patients seen this period compared to the previous period due to some team members resigning as the project end date drew closer.

Key lessons learned

- Need for research to commence at project inception
- Collaboration with government departments and other institutions results in better sustainability of the project.

Conclusion

During the last six months of the project, we have experienced some highs and lows. We have done well in improving our service delivery model and have continually strengthened care for our patients. We have also lost a key member of our team and will continue to maintain the data standards that were established from the start of the project.

Introduction

The BMSF-awarded palliative care three-year grant officially ended on the 30th of June 2024 after three years of implementation (since July 2021). We are now on a no-cost extension and implementation will continue in two hospitals (Chris Hani Baragwanath Academic Hospital and Charlotte Maxeke Johannesburg Academic Hospital). This report is created for the January 2024 – June 2024 reporting period for the two hospitals but will also report on the overall performance of the project at the two hospitals. The structure of the report starts with an executive summary of the project and then moves on to the project performance in the past six months. The performance is reported per set goal and detailed information on the targets and actual performance, and reasons for over or under performance is shared. The report concludes by sharing the lessons learned over the reporting period, the sustainability plan, and goals and objectives for the future.

Background

The grant for the implementation of palliative care services in three tertiary hospitals, namely Chris Hani Baragwanath Academic Hospital, Charlotte Maxeke Johannesburg Academic Hospital, and Helen Joseph Hospital was set to end on the 30th of June 2024 after the project had been running since the 1st of June 2021 at CHBAH and HJH, and January 2022 at CMJAH. Implementation at HJH ended in June 2023, as per contractual obligation. Since then, palliative care services, comprising clinical, psychosocial, and spiritual care have been rendered at the two institutions. For this reporting period, our main objective was to document the work that the teams have done over the three years and increase our research output. In this report, we share the performance of the project at the two remaining institutions for the January 2024 – June 2024 reporting period (CHBAH & CMJAH).

Project performance

Overall performance

Indicators	JAN – JUN 2024 6 MONTHS PERFORMANCE			JUL 2023– JUN 2024 ANNUAL PERFORMANCE			Life of Project (LoP)	Life of Project (LoP)	% of LoP Target
	Target	Actual Performance	% of Target	Target	Actual performance	% of Target	Target	Actual	
3.1a. Number of patients who received transport support for referral to care (All 2 hospitals combined)	50	159	318%	100	324	324%	300	494	165%
3.1b. No. of patients referred for palliative care services (All 2 Hospital combined)									
3.1b(i) CHBAH	600	807	135%	1200	1936	161%	3600	4898	136%
3.1b(ii) CMJAH	1000	568	57%	2000	1697	85%	6000	3391	57%
Totals	1600	1375	86%	3200	3633	114%	9600	8289	86%
3.1c. No. of patients who received at least one session of palliative care services (Hospital, OPD & Telephone) (All 3 Hospital combined)									
3.1c(i) CHBAH	540	801	148%	1000	1922	192%	3240	4847	150%
3.1c.(ii)CMJAH	900	533	59%	1800	1654	92%	5400	3280	61%
Totals	1440	1334	93%	2800	3576	199%	8640	8127	94%
3.1d. Number of patients referred to psychosocial support services (All 3 Hospital combined)									
3.1d(i) CHBAH	600	680	113%	1200	1549	129%	3600	3783	105%
3.1d.(ii) CMJAH	750	458	61%	1500	1327	88%	4500	2966	66%
Total	1350	1138	84%	2700	2876	107%	8100	6749	83%
3.1e. No. of patients who received at least one session of psychosocial support services (All 3 Hospital combined)									
3.1e.(i) CHBAH	540	501	93%	1080	1311	121%	3240	3499	108%
3.1e.(ii) CMJAH	675	458	68%	1350	1268	94%	4050	2900	72%
Total	1215	959	79%	2430	2579	106%	7290	6399	88%

3.1f. No. of patients on ECOG 3 & 4 referred to home care services (CHBAH)									
3.1f(i) CHBAH	**300**	**235**	**78%**	**600**	**599**	**99%**	**1800**	**782**	**43%**
3.1g. No. of patients who received at least one session of homecare care services (All 3 Hospital combined)									
3.1g.(i) CHBAH	**250**	**218**	**87%**	**500**	**599**	**120%**	**1500**	**764**	**51%**
3.1h. No. of patients referred to Spiritual care, Survivorship and support group services (All 3 Hospital combined)									
3.1h(i) CHBAH	**360**	**589**	**163%**	**720**	**1127**	**157%**	**2160**	**3191**	**148%**
3.1h(ii) CMJAH	**400**	**485**	**121%**	**800**	**1023**	**128%**	**2400**	**2735**	**114%**
Total	**760**	**1074**	**141%**	**1520**	**2150**	**141%**	**4560**	**5926**	**130%**
3.1i. No. of patients who received at least one session of Spiritual care, Survivorship & support group services (All 3 Hospital combined)									
3.1i.(i) CHBAH	**300**	**555**	**185%**	**600**	**975**	**163%**	**1800**	**2979**	**166%**
3.1i.(ii) CMJAH	**300**	**459**	**153%**	**600**	**879**	**147%**	**1800**	**2595**	**144%**
Total	**600**	**1014**	**169%**	**1200**	**1854**	**155%**	**3600**	**5045**	**140%**

Table 1: Project performance (Target vs Actual)

During the reporting period, (January 2024 – June 2024), the teams managed to excel in most of the program components, except for referrals for home care and patients receiving at least one home care consultation for the life of the project. The below-average performance for home care is largely attributed to the late start of the component before a full-time driver was employed and difficulties with navigating the physical addresses of the patients in the hospital catchment area. From the other program areas, i.e., clinical, psychosocial, and spiritual in both CHBAH and CMJAH, most of the targets were met and some were surpassed. The CHBAH team met all their targets and as indicated by the green highlight. Palliative care services at CHBAH have existed for over 20 years and services have been well established in the hospital. This contributes to adequate awareness of the service by clinicians, which results in good referrals of patients to palliative care. Though CMJAH has challenges with the set targets, the numbers have greatly improved over time, indicating improved buy-in and referrals by other clinical personnel in the hospital. The total performance of the two hospitals combined reflects that the targets set for both hospitals were met.

OBJECTIVE 1: Establish Palliative Care at Charlotte Maxeke Johannesburg Academic Hospital (CMJAH)

Throughout the two and half years that services have been available at CMJAH, two professional nurses, one social worker, one social auxiliary worker, two spiritual counsellors and one case navigator, employed through the BMSF grants, have serviced the needs of palliative patients at the hospital. Management from CMJAH have also demonstrated buy-in, through providing a medical specialist, and three professional nurses. Unfortunately, no other allied health professionals have been provided by the hospital, bearing a significant impact on sustainability of services, especially now that the grant term has ended. In September 2023, one of the grant funded nurses resigned, negatively impacting the staff complement as reflected by the reducing number of patients compared to the previous reporting period.

The activities that were set for CMJAH and achievements to date are shown in the table below:

Activity	**Progress made**
Conduct baseline assessment of needs at Charlotte	Barriers and enablers study completed, awaiting submission to a journal upon review at the Wits School of Public Health.
To renovate a designated space at the hospital for palliative care staff	Furniture has been bought for palliative care staff and for the allocated boardroom. There have been delays with the allocation of space for palliative care because part of the hospital was destroyed in a fire. Based on the discussions with hospital management, space for palliative care was delayed because of other priorities, and will not be done during this project time.
To employ palliative care staff	We have managed to employ two professional nurses, one social worker, two spiritual counsellors, one social auxiliary worker, and one case navigator

To procure IT for PC ECHO	We have procured video conferencing equipment and bought furniture for the boardroom that is being used for ECHO session.

Table 2: Activities vs Progress made (CMJAH)

Clinical services

The team providing clinical services consists of a medical specialist, four professional nurses (three government-employed, and one funded through BMSF until April 2024), and a hospital-appointed assistant manager who oversees service provision at the palliative care unit. Previously, two professional nurses were funded through the BMSF grant but resigned: one in September 2023 and the other end of April 2024. The hospital also provides a Specialist Physician who supervises the team, and a medical officer on rotation after every three months. The graph below shows the performance of the clinical component vs the set targets for the reporting period.

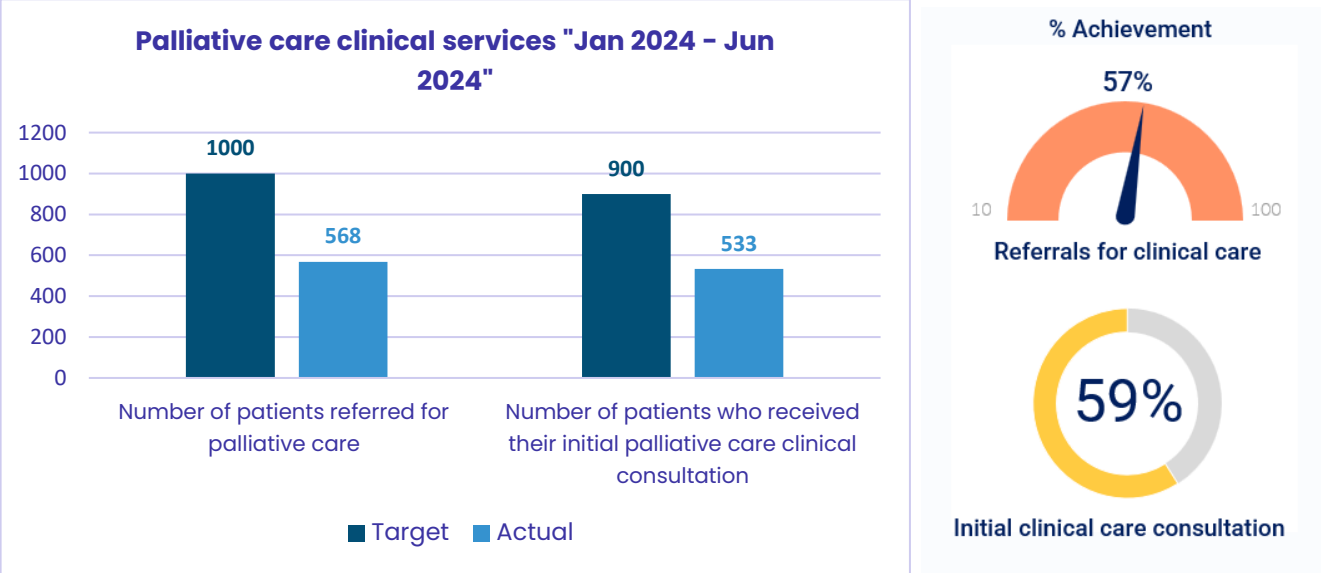

Figure 1: Actual performance vs targets (Clinical services at CMJAH)

Since the project started in June 2021, we have seen a steady increase in both referrals and patients receiving an initial consultation. For the LOP, 3 391 (57%) patients were referred for clinical services, while 3 280 (61%) patients received an initial palliative care consultation. Over the reporting period (January – June 2024), 568 referrals were referred for palliative care services out of the target of 1000 referrals. A total of 533 patients received an initial palliative care consultation, out of a targeted 900. The average performance is attributed to the high unrealistic targets that

were set for the team. In addition, two BMSF-funded professional nurses resigned as the June 30th date, when the contract was set to end drew nearer.

Psychosocial services

At CMJAH, only two personnel provide psychosocial services, i.e., a social worker and a social auxiliary worker. This has posed challenges in the capacity for psychosocial services to be available for all patients seeking palliative care services at the hospital, especially because palliative care looks at family needs as well. Despite the small team, patients still receive adequate psychosocial services at the hospital.

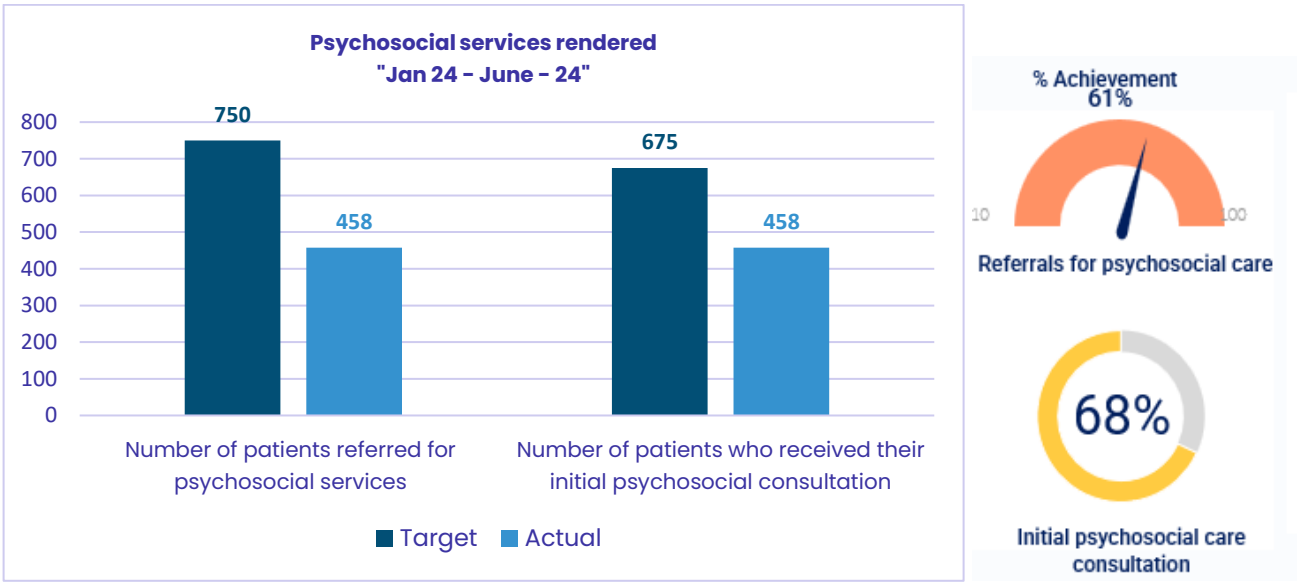

Figure 2: Actual performance vs targets (Psychosocial services at CMJAH)

On account of the high targets initially set for the team, there was an average performance recorded for psychosocial services at the hospital. The target set for psychosocial references was 750, and 458 were referred, while the target for initial consultations was 675, and 458 patients received their initial psychosocial consultation. For the Life of the Project, 2 966 (60%) patients have been referred for psychosocial services, while 2 900 (72%) patients have received at least one psychosocial consultation.

Spiritual services

Through the BMSF funding, only two trained spiritual counselors are providing spiritual services in the hospital. Despite this, the team has managed to cover the spiritual needs of palliative patients in the hospital.

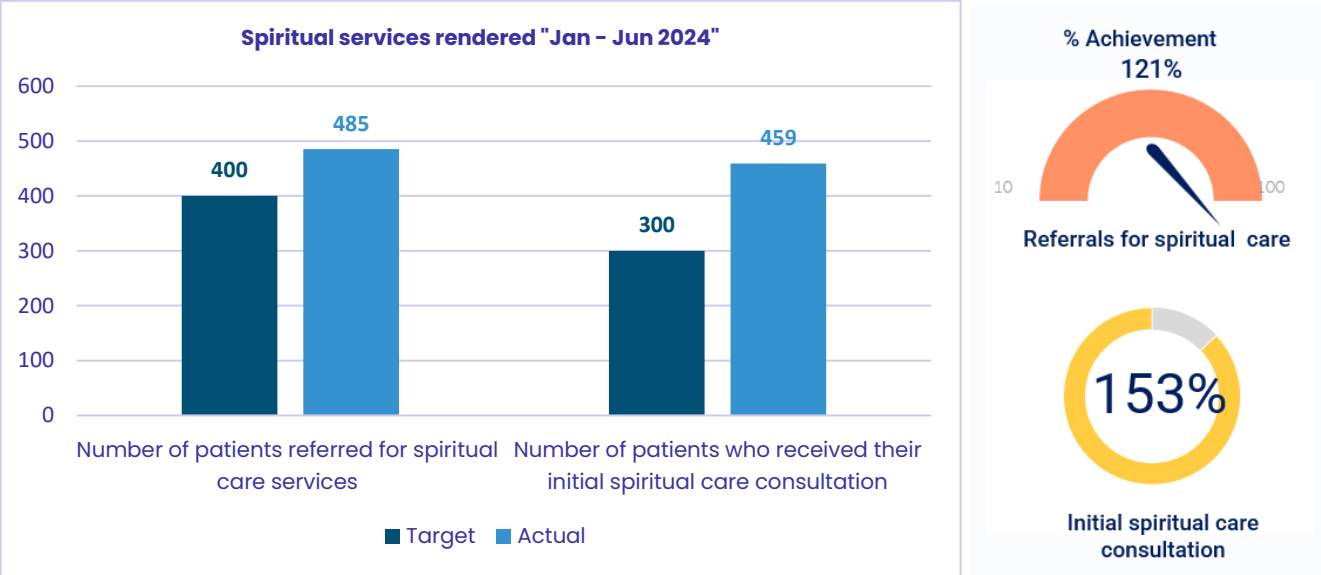

Figure 3: Actual performance vs targets (Spiritual services at CMJAH)

For spiritual services, both the targets for referrals and initial consultations were surpassed at 121% and 153% respectively. For the Life of the Project, 2 735 (114%) patients were referred for spiritual services, and 2, 595 (144%) patients received an initial spiritual care consultation. This is an indication that the spiritual component of palliative care has been well-accepted at the hospital.

OBJECTIVE 2: To stabilize PC services at HJH

The HJH project started in July 2021 and ended in June 2023. The palliative care team at HJH consisted of four personnel: a professional nurse, a spiritual counsellor, a social auxiliary worker, and a patient navigator. Despite the size of the team, they managed to achieve tremendous milestones in providing palliative care services at the hospital. Part of the activities the team conducted included health education and awareness campaigns at different outpatient clinics and formulating and printing posters to create awareness highlighting the importance of palliative care referral, with the aim of closing the care gap.

For the Life of the project, the team received 830 referrals for clinical care against a target of 2070, while 734 patients received at least one palliative care consultation against a target of 1 863. For psychosocial services, 765 patients were referred to palliative care, against a target of 2070, and 688 patients received at least one consultation against a target of 1 863. Almost similar trends were observed for spiritual services, where 853 patients were referred for spiritual care and 782 patients received an initial spiritual care consultation. The average performance on all the components of the project that were observed throughout the life of the project was attributed to the size of the team and the high targets that were initially set. Despite the moderate performance, the team

demonstrated commitment to serving their patients and consistently improved the number of patients throughout their project timeframe. At the end of the project, there were commitments by the hospital management to continue providing services through employing staff for palliative care.

OBJECTIVE 3: To strengthen palliative care services at CHBAH Wits Centre for Palliative Care

Palliative care services at CHBAH have been operational for over 20 years, but services still require strengthening because of the increasing need for palliative care, especially since the establishment of the Soweto Comprehensive Cancer Centre. There is ample buy-in from most clinicians in the hospital, though there is a need for increased awareness creation due to staff turnover. This enables improved referrals for palliative care services.

The table below represents the activities on the objective of strengthening palliative care services at CHBAH against the progress made to date.

Activity	Progress
To document the lessons learned over the years, model of care for central hospital, challenges and barriers to implementation/audit of current services	Ethical approval to conduct the study has been received. The manuscript has been approved for publication in a peer-reviewed journal.
To retain current PC staff to complement services	Staff has been retained to complement services at CHBAH Through BMSF, two nurses, four spiritual counsellors, and two social auxiliary workers have been employed Unfortunately, one professional nurse who was operating at SCCC resigned as the grant funding period was coming to an end.
To improve linkages to care (patient navigator) -to assess the impact of retention in care and QOL	We have employed patient navigators to work on this component
To evaluate the cost of PC services at different levels of care	We have re-evaluated the need and conducted the research titled “Factors associated with timely referral of cancer patients for palliative care services” instead. This research is currently under review and will be published in a peer-reviewed journal.

Table 3: Activities vs Progress made (CHBAH)

Clinical services

Over the reporting period, the team has improved in service delivery and their numbers reflect their commitment to providing relevant care for patients. Being the third largest teaching hospital globally, the hospital receives a large patient volume referred internally and from other hospitals.

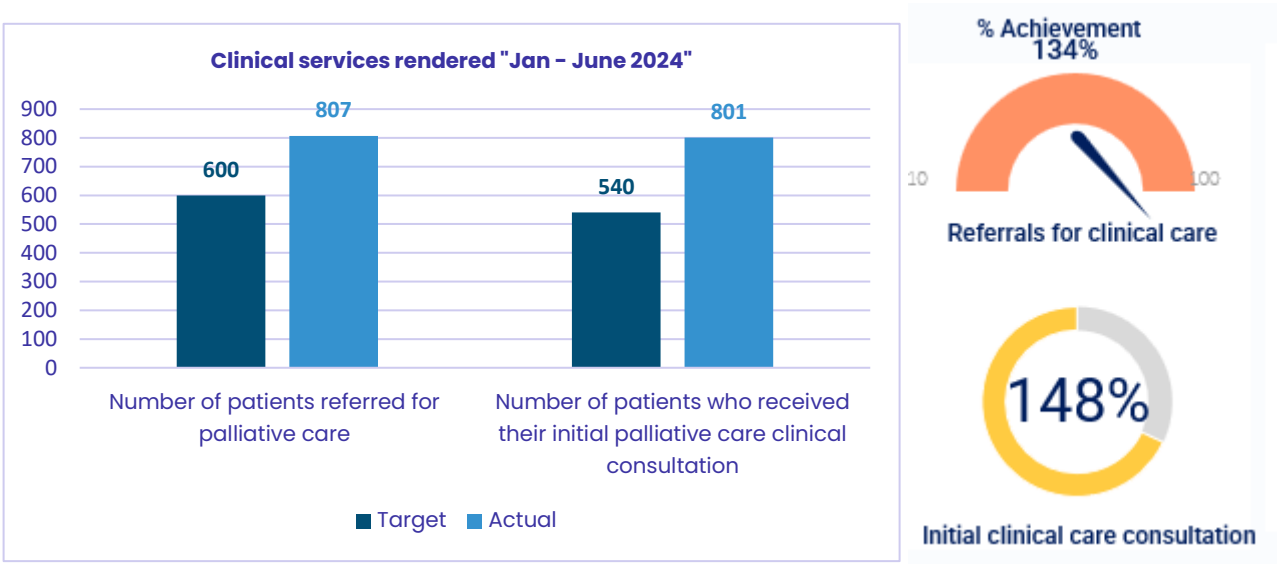

Figure 4: Actual performance vs targets (Clinical services at CHBAH)

During the reporting period, the CHBAH exceeded its targets for the number of patients referred for palliative care and those who received their initial consultation as indicated in the graph. The team has continuously demonstrated a commitment to providing clinical services to patients at the hospital. For the Life of the Project, 4 898 (136%) patients were referred for clinical care services, and 4 847 (150%) received an initial consultation. While the targets were based on existing data, we recognize that higher targets should have been set for the hospital.

Psychosocial services

The team providing psychosocial services includes one social worker (government-funded), and two social auxiliary workers. The team continues to meet its targets, which shows the shared commitment to patient care.

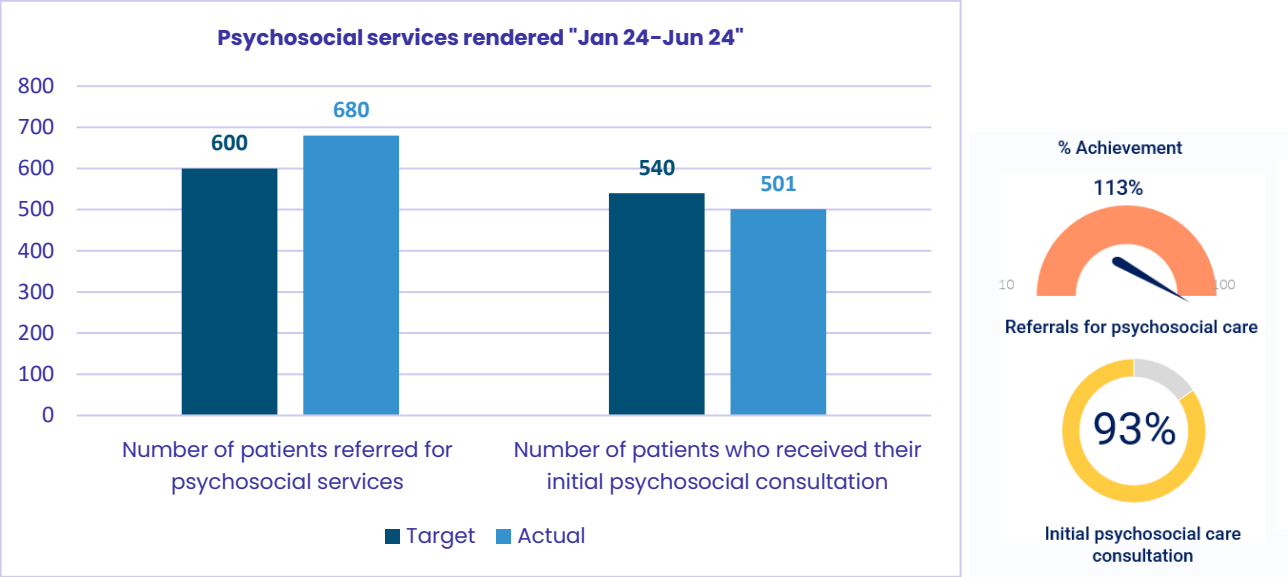

Figure 5: Actual performance vs targets (Psychosocial services at CHBAH)

During the reporting period, the team surpassed targets on the number of patients referred for psychosocial services and achieved 93% performance on the number of people who received their initial psychosocial consultation. For the Life of the Project indicators, 3 191 (148%) patients were referred for psychosocial services, while 3 499 (108%) patients received an initial consultation for psychosocial services.

Spiritual services

Spiritual services continue to be the most sought-after service at the hospital, and targets for referrals and initial consultations are consistently surpassed. For this reporting period, out of a target of 360 referrals, 589 patients were referred for palliative care. Out of a target of 300 initial spiritual consultations, 555 patients were given initial consultations for spiritual services.

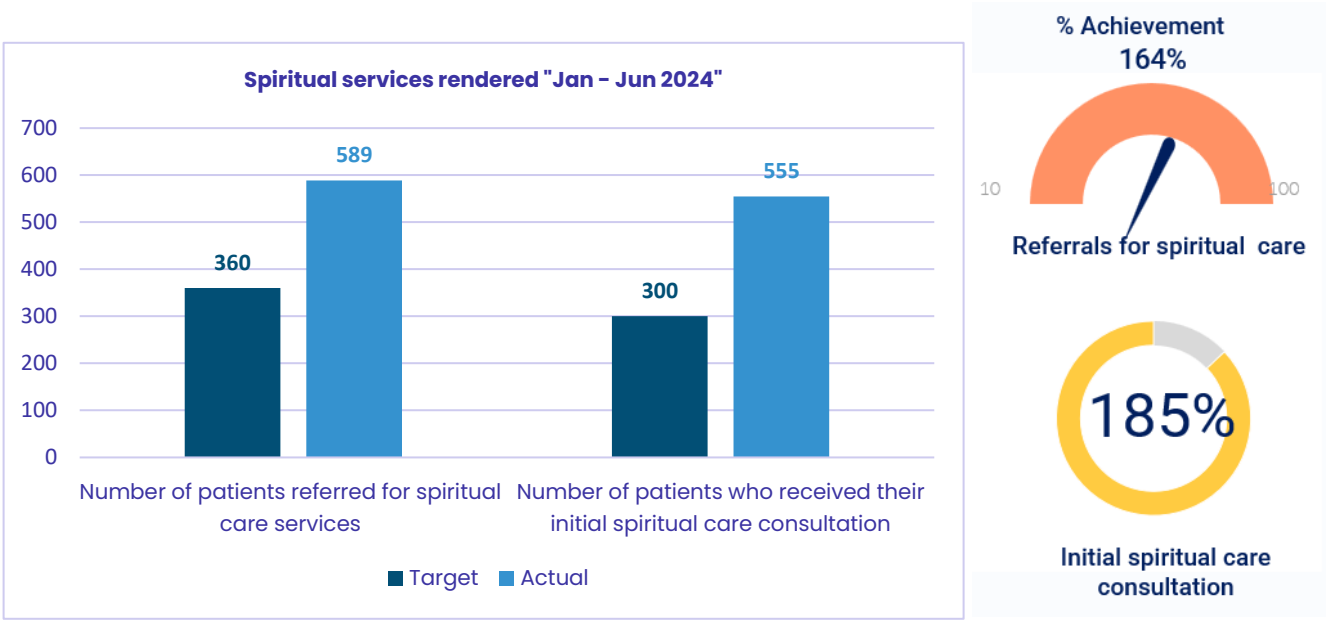

Figure 6: Actual performance vs targets (Spiritual services at CHBAH)

For the Life of the Project, 3 191 (148%) patients were referred for spiritual services, while 2 979 (166%) patients received an initial spiritual care consultation.

OBJECTIVE 4: To increase access to home PC services in and around Soweto and surrounding areas

The home care team provides clinical, psychosocial, and spiritual services in Region D & G of the city of Johannesburg. Services are provided by a team of three retired nurses, two spiritual chaplains, a driver, and social auxiliary workers (one employed through the grant, the other through Move for Transformation), and one social worker employed through Afia Tai.

The table below shows the set activities and the progress to date:

Activity	**Progress**
To develop linkages with district WBOTs	Meetings are conducted with WBOT managers every month.
To develop a model and provide home palliative care to cancer patients	There is an established home care model in place. Home care services are provided daily to ECOG 3&4 patients

To assess community awareness of PC (KAP)	Study yet to be conducted. A different study on referrals was conducted by one of the MSc students. The article will be published in due course
To evaluate funding models for home palliative care	Objective not met

Table 4: Activities vs progress (Home care)

Home care consultations

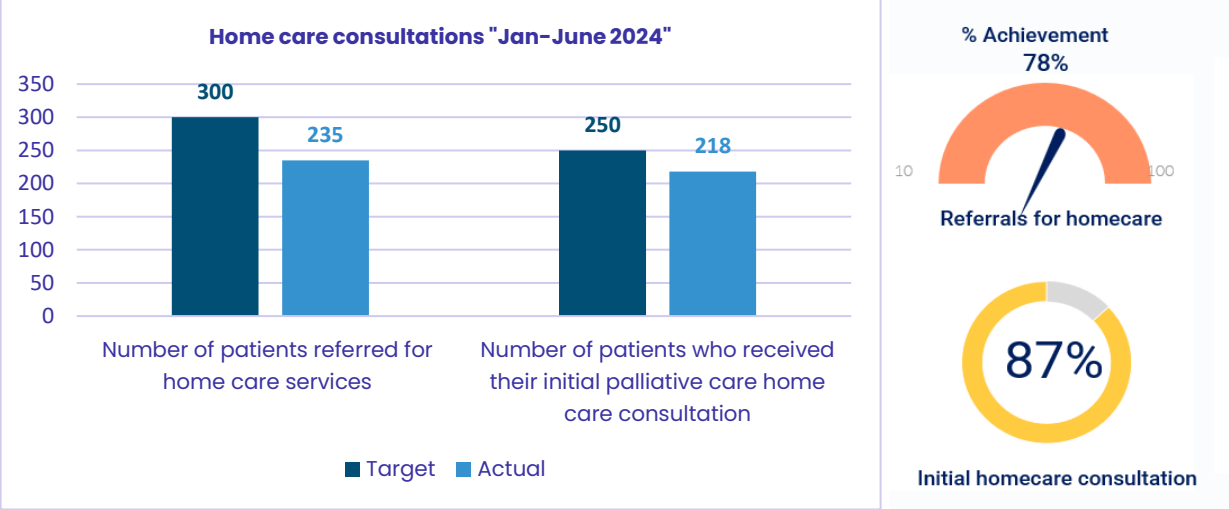

Figure 7: Home care consultations

Though the overall LOP targets for home care services have not been met due to a late start to the component and transport challenges, the team has performed optimally to meet their six-month targets. Out of a set target of 300 referrals, the team received 235 referrals during this period. The total number of patients who received their initial palliative care home care consultation was 218 out of 250. Since the inception of the home care component, 782 patients have been referred and 764 patients have received an initial home care consultation.

Patient Success Story (CMJAH)

Patient X: 50 years old male was newly diagnosed with anal SCC, stage 4, RVD positive, hypertension and worsening renal dysfunction. The patient had previously completed 6 months of TB treatment. The disease started with an anal mass that had been there for 2 years. The patient consulted the local clinic and was sent to the hospital for further assessment and management. The patient was then inserted a Stoma bag.

The patient had a partner whom he had recently paid lobola for. The patient's wish was to have a wedding ceremony before he died. He was staying in a man`s hostel with his son who worked shifts, and this was a challenge because the patient needed full-time assistance/ home care and there was no one to assist at the hostel. The patient felt embarrassed by the illness due to the smell he had from the wound and was anxious and scared of death. He was unemployed and was receiving a temporary disability grant because he could not work.

A family meeting was held with the son and the son`s concern was his father to get married before he died because that was his wish. The son asked the team to assist him so that his father`s wish would be fulfilled. During the family meeting, we advised the son to take his father back home to KZN to his wife so that she could take care of her husband and the patient could be well supported and have his wish to get married.

The patient was taken to KZN, had his wedding, and was supported by his wife and family. Unfortunately, the patient passed in February 2024. Bereavement counseling and support was provided to the patient's family. The patient`s wife stated she was at peace because the patient's wishes were fulfilled.

Figure 8: Patient Testimony

Patient success story (CHBAH)

A 20-year-old male patient was diagnosed with Right leg myxoid chondrosarcoma in 2021. He stopped school in 2021 because of disease progression. He presented with a poor quality of life as they had exhausted all measures of treatment including consulting traditional doctors. He was seen at Steve Biko Academic Hospital in 2021 where amputation was recommended, but the patient and family refused and opted to seek an opinion from traditional healers because they believed he was bewitched. He came to CHBAH casualty with severe pain. The patient was referred and seen by the palliative team. Based on the initial assessment by the interdisciplinary team, a comprehensive treatment plan was developed, which included extensive counselling for emotional, social, and spiritual pain. The patient then agreed to be amputated. The below-knee amputation

was successfully done at CHBAH in March 2024. After amputation, the patient and the family were very excited and expressed their gratitude to the palliative care team and encouraged us to continue with the good quality care we are providing.

OBJECTIVE 5: To train and build capacity to provide PC at all levels of health care

Through the Wits Centre for Palliative Care, training has been provided to medical students through the Graduate Entry Medical Program (GEMP). Postgraduate training is also offered to qualified healthcare practitioners undergoing specialist training, including registrars in family medicine and radiation oncology. In-service training is also provided to clinical and various other allied health professionals such as social workers, health promoters, and Ward-Based Outreach Teams.

The table below highlights the activities and progress to date for the training component:

Activity	Progress
To conduct KAP on palliative care for healthcare professionals	We researched factors associated with timely referral of cancer patients for palliative care services instead, upon re-evaluating project needs.
To conduct PC training for HCP across the South of Gauteng	HCP have been trained on palliative care from various institutions within the hospital.
To conduct PC training for CHW/WBOTs in Region D & G	72 Community Health Workers have been trained so far
To support Honors and Master's students at Wits University (4 students)	2 MSc Implementation Science students have been supported; awaiting results. 1 student has registered for MSc in Physiotherapy 1 student currently registered for a PhD
To provide site support and mentoring through PC ECHO	This service is being restructured

Table 5: Activities vs progress made for training and capacity building

Listed below are the trainings that were conducted during the reporting period:

- *Training for healthcare professionals and Ward Based Outreach Teams (WBOTs)*

Out of a set target of 20, nine doctors have received training. A total of 13 social workers out of a targeted 10 were trained, and 127 nurses have been trained, going well above the target of 50 set for nurses. Other categories of healthcare workers trained included Emergency Medicine Service personnel, forensic pathologists, psychological counsellor, accountants and theologians. The overall target for healthcare professionals to be trained for the life of the project is 80, and only for this reporting period, a total of 234 health care professionals have been trained. Accreditation for CPD points for training attendees has been received.

- *Introduction to spirituality and chaplaincy in palliative care training*

Figure 9: Introduction to spirituality and chaplaincy in palliative care

Through Wits Enterprise, training on the Introduction to spirituality and chaplaincy in palliative care was provided. Participants included spiritual leaders, doctors, Emergency service practitioners, Forensic Service personnel, psychologists and Gauteng Department of Health managers. Comments obtained from the training evaluation indicated how this was an eye-opener for them, and they understood how spirituality is integrated into medical care. A total of 108 people were trained in the reporting period.

Through the Gauteng Centre of Excellence for Palliative Care, training was provided to staff from the MEC of Health's office, comprising FBO leaders. The MEC for Health attended part of the training and made commitments to improve implementation efforts for palliative care throughout Gauteng Province.

Figure 10: Training for members from the MEC's office

Certification of the participants occurred during the Medical and Community National Summit that was hosted by the Wits Centre for Palliative Care at the School of Public Health, Wits University. Over 200 chaplains across South Africa attended the event, which was graced by the retired Chaplain General for the South African National Defense Force, the South Africa Police Service, South African National AIDS Council, and the MEC for Health, who was the keynote speaker.

- *Training of students at Standford University*

Dr Ratshikana visited the Stanford University School of Medicine palliative care Quality Improvement Resource Center (QuIRC), where she presented spiritual care needs and benefits among advanced cancer patients in Soweto to staff and medical students. From the visit, a collaboration between the Centre of Excellence and Stanford University was established, and currently, both institutions are working on getting ethics approval to conduct research and collaborate on sourcing future funding for the implementation of services.

Figure 11: Dr Ratshikana presentation at Stanford University

- *Community Health Care Workers training*

Training continues to happen in other districts as well outside of Gauteng Province. The Director for the Centre of Excellence for Palliative Care led the provision of training in KwaZulu Natal to teams from Zululand district. A total of 58 Community Health Workers has received training.

Other major activities during the reporting period

1. ***Medical and Community Chaplaincy Summit***

In February 2024, the medical and community chaplaincy, with support from the Wits Centre of Excellence for Palliative Care hosted a summit that was attended by government officials, including the MEC for Health and the Premier for Gauteng Province. Through this summit, commitments were made for palliative care integration in public hospitals in Gauteng Province, and especially the integration of spirituality in medical care. Various cadres who had received training on spiritual chaplaincy received their certificates.

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Former SANDF Chaplain General Monwabisi Jamangile, Gauteng Premier Panyaza Lesufi and MEC @NkomoNomantu honoured by Medical and Community Chaplaincy at Wits University School of Public Health. @eNCA @Newzroom405 @MorningLiveSABC

Figure 12: Medical and Community Chaplaincy Summit

2. Research and capacity building

For this reporting period, we prioritized research as we were in the last six months of the project. Since the project's inception, we have established a RedCap database with over 6800 patient records. This provides an opportunity for research from a robust database. Some of the research projects we have embarked on are highlighted below;

Three MSc students received bursaries and have submitted their research projects at the Wits University School of Public Health. The topics for research projects that were covered by the students are;

1. Barriers to and enablers for availability and integration of palliative care into routine services at Charlotte Maxeke Johannesburg Academic Hospital and,
2. Factors associated with timely referral of cancer patients for palliative care services at Chris Hani Baragwanath Academic Hospital, Johannesburg
3. The third MSc student has received ethical approval for a study titled "Factors influencing the integration of rehabilitation service in cancer care in a tertiary hospital, South African health workers' perspective. Data collection is currently underway.

In addition to these topics, the following research projects are currently underway;

Title	Status
Quality of life among cancer patients at three tertiary public hospitals in Johannesburg, South Africa: a case for palliative care.	Ready for submission
Tertiary Palliative Care Model in South Africa: A case of the Gauteng/Wits Centre for Palliative Care	Approved for publication
Chronic conditions, Multimorbidity and associations with the demographic profile among cancer patients, Gauteng province South Africa	In preparation
What is the functional ability of cancer patients across the 3 hospitals?	In preparation

Table 6: Research conducted during the reporting period

For the quality-of-life paper that is being reviewed for publication, results showed an improved quality of life across all domains (general, physical, psychosocial, environmental, and social health) after a palliative care intervention. This is a demonstration of the impact of palliative care on the quality of life of patients. The average time taken from intervention to follow-up was 14 days, indicating that in such a short period, patients who receive palliative care have improved outcomes.

OBJECTIVE 6: To provide support to patients through survivorship programs

Through this objective, and with assistance from Kgothatsa-Botshelo, a community-based organization, we aim to offer supportive care to patients and families through engaging in dialogue and sharing experiences. During the support groups and healing services, we offer education and awareness creation on cancer screening, caring for cancer patients, palliative care services available for patients and families, bereavement support, education on proper referral channels and encourage positive relationships among members who experience the same health conditions.

Activity	Progress
• To conduct support groups for cancer patients and their families	• Support groups have been conducted at both hospitals.

• To link patients to other services in the communities	• Through the psychosocial component, patients are being linked to other services such as hospices in the community

Table 7: Activities vs progress made for survivorship

Figure 13: Healing service at CHBAH & CMJAH

During the reporting period, 3 support groups and 3 healing services, with a total of 234 attendees were conducted.

CHALLENGES AND MITIGATION

Challenges	Mitigation measures taken
The research component of the project was delayed	The reduced research output is attributed to delays in ethical approvals and difficulty getting appointments for interviews with healthcare professionals. While this has delayed us, we have managed to get relevant ethics clearances and are set to start write-ups during the first quarter of the new year.

Insufficient morphine availability	Continue to follow up with relevant people to access morphine in the hospitals
The referral system of patients to palliative is still an obstacle	Awareness campaigns must be ongoing to educate communities about the importance of palliative care in society. Multidisciplinary health teams require ongoing health education on palliative care, the referral criteria and a clear system in terms of referring palliative to palliative. Doctors and Nurses in all facilities require education on palliative care.
Unable to register patients in CMJAH PC department especially those who have been referred from other hospitals/facilities	We have engaged with CMJAH management to discuss sustainability at CMJAH. Discussions have been escalated to the Gauteng Department of Health.
Delays in permanent space allocation for the CMJAH team have put a hold in the renovation of the space and procuring some of the equipment	• Barriers and enablers of palliative care at CMJAH study currently underway, engagement of management through the study will assist in space allocation for PC. • The team has been provided with furniture to create a more workable environment
Understaffing at both facilities	Engage with hospital management to provide staff at the palliative care unit for allied health roles such as social workers, social auxiliary workers, spiritual counsellors and case navigators

Table 8: Challenges and Mitigation

LESSONS LEARNT

- Advocacy and engagements with the MEC for health have opened potential avenues for collaboration and inclusion of palliative care on the Provincial Health budget. There is a need to continually invite the Provincial Department of Health to palliative care activities such as the Medical and Community Chaplaincy Summit to improve buy-in.
- Research is an important aspect of the project, and more time and resources are needed at the start of the project.
- Implementation of the palliative care project will be improved through collaboration and buy-in from relevant stakeholders. These include and are not limited to tertiary hospital management, heads of departments, physicians, and other sectors within public health such as physiotherapy departments.

Sustainability

- *Beneficiary involvement*

Through the palliative care project, we have managed to support our beneficiaries by creating opportunities for them to share their experiences with palliative care with other patients. We have employed palliative care patients and beneficiaries from the Soweto Comprehensive Cancer Centre in various positions, including case navigators.

- *Government involvement and support*

During this period, members from the office of the MEC attended training on the Introduction to Spirituality and Chaplaincy in Palliative Care and committed to implementing it in their various roles. The government was also involved in the certification for all chaplains that were trained on palliative care. Through continued engagements with the government, we hope to acquire some funding for palliative care and sponsoring for allied health roles that are not part of the DoH structure but are crucial for palliative care.

- *Other funding sources and support*

The team has also been involved in opportunity scanning exercises and responding to various requests for proposals from other funding agencies such as NHI. We have also established relationships with Stanford University and are working together on various research projects.
We are currently in the process of applying for ethics approval for a research project we are co-authoring titled "mHealth Promoting Access to Improve Cancer Experience (mPAICE) Project". Through this project, we will be able to have evidence of collaboration which will enable the two organizations to apply for funding jointly.

Conclusion

The last six months of the project have been a great success. Even though as a team we experienced the loss of our M&E manager, the team has managed to continue providing a great service to palliative care patients. We have noted a decrease in the number of patients seen during this period due to a reduction in our staff capacity from retirements as the project was approaching its end date. Since inception of the project, over 20,000 clinical consultations have been conducted for cancer patients in Johannesburg.

We have also improved the research output and have articles that are under review for publishing by research journals. We are excited about the results we see from our various analyses, and we hope to increase our research output in the next period.

PERFORMANCE PLANS FOR THE NEXT 6 MONTHS

For the next proposal, we plan to expand the scope of our services to at least one more university in Gauteng Province, where a comprehensive cancer center will be established, while continuing the support at the Soweto Comprehensive Cancer Centre.
Throughout the life of the current project, we have noted, through research, that there is a trend of late referrals. For the next grant, we aim to address late referrals to palliative care, using results from the research conducted at CHBAH. For CMJAH, we propose to continue providing palliative care services to allow for improved buy-in and uptake by hospital management at the institution. Though clinical staff have been provided for palliative care, crucial components such as psychosocial and spiritual care will not be available for patients when donor funding ends. We realize that three years have not been adequate to have full integration of palliative care services into routine services at the hospital, which would lead to less dependence on donor funding. An extension of the timeframe for BMSF funds to implement services may provide an opportunity for the allied services to be funded by the government, which would lead to the sustainability of the services at the hospital.

Given the high uptake of spiritual services at the institutions where palliative care services are being implemented, and the effects of addressing spiritual needs among cancer patients, we propose to integrate spiritual support as part of cancer care in the next grant.
Finally, given the experience our teams have garnered over the years, and given the impact of palliative care interventions on the quality of life of cancer patients, we propose to be given an opportunity to provide mentorship and training to other BMSF partners who are involved in cancer care.

Technical Assistance

Does your project need Technical Assistance in the next six months, if so, please select (maximum of 5) which type according to priority and describe the objective of the TA:

Type of TA	**Objective of the TA**
Community Awareness and Mobilization	
Integrating Medical Care and Community-based Supportive Services	**5**
Information Technology/Systems Management Training	**4**
Strengthening Healthcare Worker Capacity	**2**
Monitoring & Evaluation	
NGO Support and Capacity Building	**3**
Project Management	
Public Affairs	
Research and Publication Support	**1**

Table 9: TA Requirements