

**Special Article**

# Promoting the Integration of Quality Palliative Care—The South African Mentorship Program

Kathleen M. Defilippi, RN, Dip Nurse Ed, and Sue Cameron, MA (Unisa)  
*Hospice Palliative Care Association of South Africa (K.D., S.C.), Pinelands, South Africa*

---

**Abstract**

*This article provides a brief outline of the HIV/AIDS situation in South Africa and the development of the Hospice Palliative Care Association (HPCA) as the background to an exploration of the changing face of palliative care in light of the demands of HIV/AIDS. It describes the South African Palliative Care Mentorship Program, including a description of the Integrated Community-Based Home Care (ICHC) model and its promotion of collaboration with the formal health care sector and other networking partners. The role mentorship played in its application to HPCA member hospices in response to the increasing demands of HIV/AIDS is outlined. The article also focuses on the development of provincial and regional mentorship capacity, the establishment of provincial palliative care development teams, the development of comprehensive palliative care standards, and the link between mentorship and accreditation. The key results of the promotion of the ICHC model and the effects of the mentorship program are highlighted, including possibilities for the expansion of the model beyond its original context in South Africa. The difficult issue of sustainability within an African context is also mentioned. In conclusion, there is a challenge to readers to explore the use of mentorship within their own palliative care settings. J Pain Symptom Manage 2007;33:552–557. © 2007 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.*

**Key Words**

*Mentorship, palliative care, standards, accreditation, development, sustainability, capacity building, cascade, quality*

---

**Introduction**

In South Africa, a country with a population of 45 million, over 320,000 people died of AIDS during 2005 (about 890 each day).<sup>1</sup> While antiretroviral treatment is now officially

available, poverty and the lack of infrastructure mean treatment remains beyond the reach of many who need it. Currently, the 76 hospices that are members of the Hospice Palliative Care Association of South Africa (HPCA) are the key providers of palliative care in a country with 174 health subdistricts. The need far outstrips their resources.

To make optimal use of these scarce palliative care resources, HPCA introduced a mentor program. While the concept of mentorship was well discussed in academic and business fields, a search of the literature<sup>2–4</sup> revealed

---

*Address reprint requests to:* Kathleen M. Defilippi, RN, Dip Nurse Ed, Hospice Palliative Care Association, P.O. Box 218, Anerley, 4230, KwaZulu-Natal, South Africa. E-mail: [kath@hpca.co.za](mailto:kath@hpca.co.za)

*Accepted for publication: February 14, 2007.*

that there was no reference to mentorship in palliative care. Although many of the concepts identified in the available literature, for example, mentor roles, phases of mentorship and characteristics of a successful mentor, and are generic, the experience of applying these concepts within a palliative care context is the focus of this article.

In 1979, a lecture tour by Dame Cecily Saunders was the catalyst for the establishment of hospice programs in South Africa. These early programs were based on the United Kingdom model of hospice care and focused almost exclusively on patients with advanced cancer.

In 1988, the 14 existing hospices formed a national association. By 1998, the impact of HIV/AIDS threatened to overwhelm hospice programs and challenged the way care was being delivered. Huge numbers of young adults were facing the stigma of HIV/AIDS, the ravages of poverty, and the added emotional burden of caring for both infected and affected children. The magnitude of the need for palliative care in South Africa was such that HPCA member hospices would never have the capacity to meet this need on their own. It was obvious that the focus of care needed to be broadened in scope and provided over a longer period of time to help hospices to cope with

the seemingly impossible challenge of increasing coverage without compromising quality.

## Methods

### *Integrated Community-Based Model*

In response to these challenges, in 1996 South Coast Hospice developed a model for palliative care that relied not only on the hospice resources but included all relevant community service providers, particularly government hospitals and clinics. It became known as the Integrated Community-Based Home Care (ICHC) Model (Fig. 1). The link between care, prevention, and more recently, treatment of HIV/AIDS, including palliative care, is a key focus of the model.<sup>5</sup> It allows for referral between all partners as trust is built and it develops palliative care capacity in all partners. It ensures that community caregivers are trained, and then supervised and supported. The diagram below illustrates the central position of the person living with HIV/AIDS, the family and the small group of people around the patient. This small group is supported by a large and growing network of services and the community in which the patient lives.<sup>6</sup>

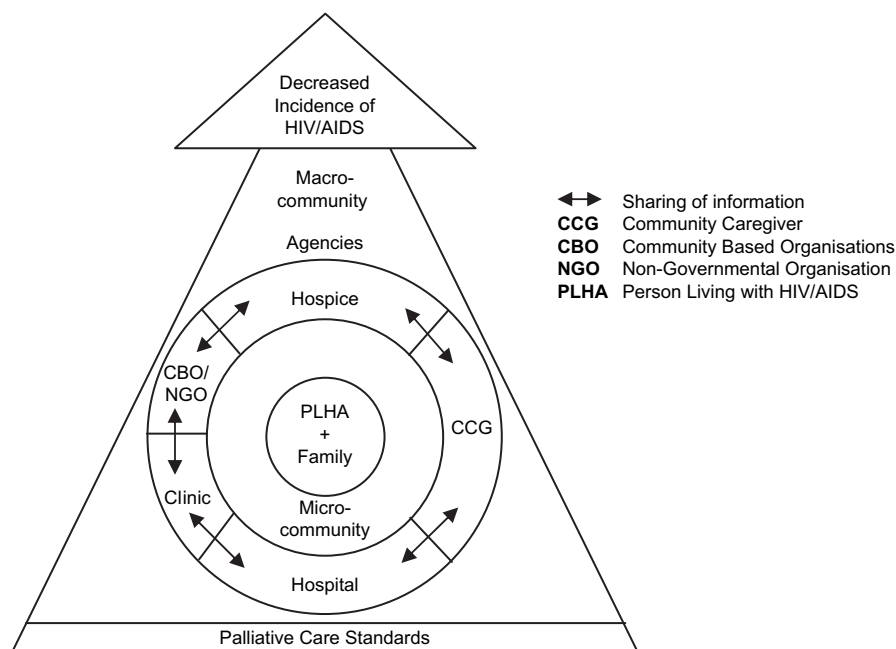


Fig. 1. The ICHC model. From Ref. 6, page 6.

### *First Phase Mentorship*

In 2001–2002, based on research conducted by the University of KwaZulu-Natal<sup>7</sup> that demonstrated the model's replicability in rural, urban, peri-urban, and metropolitan settings, HPCA adopted the ICHC Model and developed the first phase of a mentorship program to implement in 28 HPCA member hospices. The aim was to encourage hospices to reach out into local communities and to provide quality palliative care to the growing number of HIV/AIDS patients.

Those hospices with well-established ICHC programs became the "mentor hospices." They provided structured support to hospices implementing the model (identified as development sites). Supported by a core of qualified and experienced HPCA personnel, mentor hospices facilitated a situational analysis at each development site, followed by strategic planning involving all key players both within the hospice and the local community. In addition, to build capacity, a number of regional workshops were conducted during the first two years.

An external survey evaluated the program on two levels:

1. Mentor hospices assessed the impact of the ICHC model on the quality of care delivered by the development sites.
2. Development sites evaluated the quality and impact of the mentorship provided to them by the mentor hospice.

### *Expanded Mentorship*

Following the success of the initial phase of the mentorship program in 2003, HPCA expanded its mentorship strategy. That same year, the development of two significant parallel processes occurred due to the expansion.

1. *Provincial Mentorship Teams:* Full-time coordinators were established in eight of South Africa's nine provinces. Their primary focus was on providing mentorship to selected development sites, with a view to enable the development sites to meet the criteria for HPCA membership. In addition, HPCA created part-time mentor positions in the majority of hospices that had functioned as mentor hospices during the first phase of

mentorship. These hospice-based mentors were responsible for strengthening the capacity of their own hospices to provide mentorship and promoting compliance with standards.

2. *Palliative Care Standards:* In conjunction with the Council for Health Service Accreditation of Southern Africa (COHSA-SA), comprehensive palliative care standards were piloted that expanded on existing HPCA standards. In 2004, COHSASA trained a group of 20 hospice and HPCA staff as surveyors and during the first year of the accreditation process, 47 baseline surveys were jointly conducted by an HPCA/COHSASA survey team. To achieve full accreditation, a hospice needs to score at least 80% in all the relevant service elements listed in Table 1.

To support and empower hospices to comply with the requirements of the standards, HPCA appointed five regional part-time mentors in 2004. However, it soon became evident that the growing number of hospices, vast distances between hospices, and limited time made it unrealistic to expect these mentors to take sole responsibility for this mentorship function. In 2005, HPCA trained 30 HPCA mentor surveyors to be involved in surveys and the follow-up mentorship process at hospices within their own geographic area. On receipt of a hospice's survey report, both the regional mentor and the mentor surveyor work with key members of the hospice staff to analyze the results and compile a development plan to address criteria identified as partially or noncompliant in terms of the

*Table 1*  
**Service Elements of HPCA/COHSASA  
Palliative Care Standards**

---

SE1 Governance & Leadership
SE2 Human Resource Management
SE3 Administrative Support
SE4 Risk Management
SE5 Quality Improvement
SE6 Access to Care & Admissions
SE7 Patient Rights
SE8 Interdisciplinary Team
SE9 Holistic Patient Care
SE10 Medication Management
SE11 Support Services
SE12 Education and Research
SE13 Fund Raising

---

standards. A section of an HPCA development plan is included in Fig. 2.

**Results**

The most important lesson learned was that mentorship works! The growth of HPCA member hospices has increased from 50 in 2004 to 76 in 2006 and continues to grow. Regional teams are currently mentoring 60 development sites, many of which have the potential to meet the requirements for HPCA membership.

*Implementation of the ICHC Model*

The ICHC model is firmly established in all HPCA member hospices except two that currently focus only on inpatient care. The ICHC model has strengthened links with the formal health care sector at local, provincial, and national levels and contributed to positioning HPCA and its member hospices as key national palliative care resources.

*Centers for Palliative Learning*

The mentorship approach was also successfully used in the development of Centers for Palliative Learning (CPL). Tutors from a well-established training center provide structured guidance and support to an emerging CPL. Today, nine hospices have accredited CPLs which collectively offer accredited HPCA palliative care training courses for community caregivers, nurses, and social workers, and provide clinical placements for doctors doing either a degree or diploma in palliative medicine.

*Hospice Palliative Care Standards/ Accreditations*

A significant parallel achievement was the development and circulation of the first edition of the comprehensive Hospice Palliative Care Standards in August 2005. A second edition is anticipated during 2007.

Mentorship played a key role in accelerating hospices' ability to comply with the standards and work towards accreditation. The COHSA-SA accreditation process is now well established

**HOSPICE DEVELOPMENT PLAN  
(SE 6 PATIENT RIGHTS)**

<b>Name of Hospice</b>			
<b>Plan developed by (Hospice)</b>		<b>Mentor/s:</b>	<b>Date:</b>
<b>Approved by (Hospice):</b>			
<b>Hospice person/s overseeing implementation:</b>			
<b>SE &amp; STANDARD</b>	<b>ACTIVITIES/ACTION PLAN</b>	<b>COMPLETION DATE</b>	<b>PERSONS RESPONSIBLE</b>
<b>6.1.1 Management creates an environment that supports the implementation of patient rights and empowers the patient and family</b>	1. Get patient rights documents		
	2. Policy/procedure on how the rights will be made known to patients		
	3. Train all staff in patient rights		
	4. Document implementation in patient files		
<b>Date</b>	<b>PROGRESS REPORT</b>		

Fig. 2. Section of HPCA Hospice Development Plan.

and survey results indicate a significant improvement in the quality of service delivery in all HPCA member hospices. To date, 11 South African hospices have been awarded full accreditation, for two years, by COHSASA. New hospices are committed to having a baseline survey within six months of being granted HPCA membership.

### *HPCA*

There have also been significant beneficial effects on the national association. The development of the linked mentorship and accreditation programs has resulted in the acquisition of a wide range of additional skills by HPCA personnel.

Competent HPCA surveyors are now able to conduct surveys independently and only refer to COHSASA for an external survey when hospices are assessed as likely to achieve full accreditation.

### *Wider Application*

The African Palliative Care Association has started to apply the principles of mentorship developed by HPCA across Africa, particularly in its activities with the recently established national palliative care associations in Zambia, Tanzania, and Kenya. An exciting new application of the mentorship process will be piloted in 2007. It will involve a hospice-based, palliative care-trained nurse supervising community caregivers in local home care programs, which presently have no access to professional palliative care expertise. This model has the potential to dramatically improve the quality of care delivered by community-based home care programs.

### *Discussion*

For a mentorship program to succeed, it is important that mentors are motivated and have the skills needed to assist others in a positive, culturally sensitive, and constructive manner. In resource-constrained settings, it is also important for mentors to have the experience and willingness to involve a wide range of networking partners in the mentorship process. The aim is not to foster dependency but rather to encourage hospices to grow and take responsibility for their own development.

Setting up mentorship and accreditation programs involves both individuals and organizations to change which often meets with initial resistance. Necessary skills include patience, perseverance, and the maturity to deal with criticism constructively.

### *Conclusion*

In the South African context, where the demand for palliative care far outstrips available resources, there is an urgent need to strengthen existing hospice programs and develop new ones. HPCA's vision is to have all member hospices serving as palliative care resources, with a strong mentorship role that influences all relevant government, community, and faith-based organizations in health districts throughout the country. Expertise from fully accredited hospices further strengthens regional mentorship programs. There is already evidence of the effectiveness of the cascade effect. Many of the hospices mentored during Phase I of one mentorship strategy are now providing mentorship to new and potential HPCA members in their geographic area.

The success of the mentorship process has depended largely on funding from external donors. In South Africa, where human and financial resources are limited and where the average income is less than the per capita expenditure on health in the United States, this dependence will continue for many years.<sup>8</sup> Considering that South Africa is the best resourced country in Africa, donor expectations of sustainability of African programs, such as the one outlined in this article, are often unrealistic.

The HPCA experience has shown that mentorship can be widely applied if the necessary infrastructure is sustained. It is anticipated that the HPCA mentorship program will continue to provide significant, long-term benefits for growth and development of palliative care for both individuals and organizations across South Africa, Africa, and potentially worldwide.

### *Acknowledgments*

The authors wish to thank the Open Society Institute, the Elton John AIDS Foundation,

and the President's Emergency Plan for AIDS Relief for funding the HPCA mentorship and accreditation programs. The authors also acknowledge the help and support of the HPCA management team.

### **References**

1. Geffen N. What do South Africa's AIDS statistics mean? A TAC briefing paper. Available from <http://www.tac.org.za/aidsstats.html> 2006.
2. Galbraith MW, Maslin-Ostrowski P. The mentor facilitating out-of-class cognitive and affective growth. In: Bess JL, Associates, eds. *Transforming the structure of teams for teaching*. San Francisco: Jossey-Bass, 2000:145–148.
3. Mason MK. The debate over coaching and mentoring in today's workplace. Available from <http://www.moyak.com/researcher/resume/papers/var20mkm> 2006.
4. Freeman M. The mentoring relationship. Available from <http://www.sonic.net/~mfreeman/mentor/relation.htm> 1997.
5. Defilippi K. Implementing integrated community-based home care. In: Uys L, Cameron S, eds. *Home-based HIV/AIDS care*. Cape Town: Oxford University Press, 2003:23–24.
6. Uys LR. A model for home based care. In: Uys L, Cameron S, eds. *Home-based HIV/AIDS care*. Cape Town: Oxford University Press, 2003:5–6.
7. Uys LR. Evaluation of the integrated community-based home care model. *Curationis* 2001;24:75–82.
8. van Niekerk JP. Editorial. *SAMJ* 2003;93:305.