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Outcomes of interprofessional oncology rehabilitation seminars in South Africa

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Background: Individuals living with cancer require oncology rehabilitation (OncR) to address functional and emotional impairments contributing to reduced quality of life (QOL) limitations.

Aim: Oncology rehabilitation education, required to advance a healthcare workforce to superintend the cancer treatment adverse effects, therefore improving QOL, was explored in South Africa.

Setting: Underserved rural and urban hospitals in three provinces received OncR education seminars focused on identifying and mitigating adverse effects of cancer treatment and palliative care.

Methods: Participants completed a retrospective survey including demographic data, experience with OncR, and seminar experience.

Results: Health professionals (n = 81) from rural a urban hospitals engaged in the retrospective study. Participants (17%) stated that the most helpful feature of this seminar was the appreciation and importance of an interprofessional team in cancer care. Fifty-nine per cent identified the least helpful feature as time constraints in clinical practice. Post seminar, 23% enhanced their rating of knowledge, although, 26% did not feel confident designing an exercise prescription for cancer survivors. Seventy-eight per cent were confident in identifying impairments and functional limitations resulting from cancer treatments; 88% and 68%, respectively, were able to identify one evidence-based measurement tool to assess pain and cancer-related fatigue.

Conclusion: The need for increased OncR education to equip the healthcare workforce, streamline connection to community oncologic services, and interprofessional presence is imperative to improve QOL for people diagnosed with cancer.

Contribution: The lack of education and funding, as well as resources and policy in rural areas in South Africa, requires distinctive strategies to enhance clinical knowledge and confidence in culturally relevant OncR assessment and intervention.

Keywords: oncology rehabilitation; physical therapy; interprofessional education; cancer rehabilitation; interdisciplinary education.

Introduction

Cancer diagnosis and survivorship continue to be an ongoing threat to the global society as disparities in cancer diagnosis, access to effective medical treatment and rehabilitation services impact individuals around the world as they live with cancer and the sequelae of adverse effects from treatment. Although emerging technology and new research indicate progress towards resolving some of these disparities, some countries are unable to address the burden at the forefront through prevention and education. Globally, 70% of all cancer deaths and 40% of all new cancers worldwide occur in low and middle-income countries, similar to those populations in South Africa. South African statistics reported that in 2015, neoplasms caused 41 799 adult deaths.[1] Cancer incidence was reported to be 61 957 in 2019, a figure that is projected to double to 120 969 by 2030 because of the high human immunodeficiency virus (HIV) prevalence, ageing population and poor access to timely healthcare. This projected increase in cancer cases highlights the need to strengthen prevention efforts of non-communicable diseases (NCDs) and cancer support throughout the journey of cancer illness.

Efforts are underway to provide life-sustaining care; however, many of these attempts remain ineffective. A majority of this problem stems from delays in cancer screening and treatment, and the scarcity of appropriate resources related to cancer prevention and education. The lack of proper equipment and staffing, as well as delays in treatment, create an added challenge,

especially for those who do not have financial resources. It is important to examine why nations like South Africa are falling behind in attempts to provide effective cancer care, inclusive of all key stakeholders, to foster momentum and optimise existing resources to upscale education and comprehensive healthcare services.

Oncology rehabilitation (OncR) has been a growing speciality in recent years because of the concern for the ageing population and the rise in cancer prevalence, with a focus on supporting successful survivorship. In South Africa, the median age at diagnosis is 59 years for women and 64 years for men. The median age at death because of cancer was 62 for women and 64 for men.[2] The literature highlights the need for early detection, diagnosis and early intervention to successfully manage individuals diagnosed with cancer.[2] All medical treatments for cancer have the potential for an array of adverse effects that can have a detrimental impact on quality of life (QOL). It is important to note that each individual's experience is unique, and as this population begins to live longer owing to medical advancement, access to timely and effective interprofessional rehabilitation is imperative.

Physical therapy students and clinicians in various regions of South Africa have disparate opportunities to partake in OncR programmes. Since 2017, curricula at the University of the Witwatersrand have integrated OncR education and illuminated cases through several interprofessional experiences, including simulation exposure. Other universities, such as the University of Cape Town, offer continuing education units on palliative care training in the field of oncology. It consists of a 12-month online course with a total of 62 h of self-directed study to help equip healthcare and counselling professionals to effectively communicate with individuals diagnosed with cancer and their families along the continuum of cancer care.[3] While these are substantial steps in the right direction, there is a need for continuing professional education throughout South Africa to decrease access disparity and address the lack of resources.

Although this area of work has been growing, the Commission on Accreditation of Physical Therapy Education (CAPTE) still does not provide requirements or direction for programmes to include curricular content pertaining to OncR in the United States (US).[4] A lack of a strong foundation in entry-level physiotherapy curricula may impede the development of clinical skills applied in this population. There is growing concern over the ability of entry-level physiotherapists (PTs) to capably manage individuals with a cancer diagnosis because of inadequate curricular content and a lack of opportunities for clinical training.[4] Cancer prevalence and the need for effective OncR services are outpacing the growth of the workforce in this domain.[4] Efforts to evaluate the effectiveness of increased OncR education and the effect on knowledge and confidence in treating this population are ongoing in the US. Although some entry-level Doctor of Physical Therapy (DPT) programmes have implemented OncR content throughout their curricula or offered the content in an 'elective' course format, it remains unclear how other programmes, specifically those which are international, are addressing the content gap.[4]

Looking beyond the scope of physiotherapy, caring for individuals with a cancer diagnosis spans the entire healthcare continuum, and there is a call to increase interprofessional education. The Interprofessional Education Collaborative (IPEC) is a group formed in 2009 to emphasise and encourage efforts that advance interprofessional learning experiences to help future health professionals enhance a team-based practice to improve health outcomes.[5] In the years since its creation, the IPEC has become a national representative coalition of 22 health profession organisations all with the shared vision to ensure health professionals are prepared to work in an interprofessional, collaborative practice model.[5] Interprofessional education can be defined as 'occasions when two or more professionals learn with, from, and about each other to improve collaboration and the quality of care'.[6] Studies have shown that interprofessional education enhances the delivery of safe, high-quality care for patients, in addition to allowing learners the ability to react positively to collaborative perceptions and note improvements in knowledge and skills overall.[6] To improve health outcomes among individuals with a cancer diagnosis, the interprofessional team needs to proactively monitor and manage their functional needs, and work with one another to arrange for therapeutic interventions that support overall well-being.[7] In some areas of South Africa, indigenous healers have become the primary healthcare providers for oncology patients, and they are the first to be consulted following a cancer diagnosis.[8] In countries where traditional indigenous healers play a vital role for individuals seeking care, it is essential that they also become a part of the interprofessional team. Honouring cultural and spiritual nuances stands to impart opportunities for improved access at an earlier point in the trajectory of care, as well as confidence in the healthcare team, and optimise opportunities for better outcomes.[9]

According to the South African National Cancer Strategy Framework, rehabilitation care should be an integral part of the cancer continuum of care.[1] While OncR is mentioned several times in this framework, rehabilitation clinicians may not feel equipped to render optimal care in the prevention and management of cancer treatment-related adverse effects. A lack of awareness of OncR among different health professionals is one of the barriers to integrating rehabilitation into cancer care.[10] Ensuring that health professionals are skilled in chronic care is one of the elements of chronic care models.[11] Regular training and education sessions can enhance awareness and clinical competency. The goal for the evaluation of OncR training is to garner the impact of this education on knowledge and confidence, and rehabilitate patients who are experiencing adverse effects from the treatment for cancer in a South African context. This provides global utility in education

strategies to upscale knowledge and clinical practice to enhance care for cancer survivors. The purpose of this article, therefore, was to evaluate outcomes in knowledge and confidence following participation in a modular foundational OncR seminar in South Africa.

Methods

Module development

Content experts, members of the research team, constructed modules based on the entry-level doctor of physical therapy programme curricula's needs in the US. Another content expert and member of the research team upscaled the modules to meet the curricula and community needs in South Africa and delivered presentations to students and clinicians in several regions in the country.

Sampling criteria

Education seminars were held at Charlotte Maxeke Johannesburg Academic Hospital, Tshwane Rehabilitation Hospital, Polokwane Hospital, Tshilidzini Hospital, Letaba Hospital, Tintswalo Hospital and Sefako Makgatho Health Science University and University of the Witwatersrand, located in Gauteng, Limpopo and Mpumalanga, respectively. The participants were healthcare professionals and students from the surrounding areas. The focus was to offer this OncR training to under-resourced provinces in South Africa. All attendees and participants were provided with continuing professional development (CPD) points for attending. Continuing professional development points refer to the process of tracking and documenting training hours and skills, knowledge and the experience one acquires beyond on-the-job training received at places of employment in South Africa. Participants were English-speaking South African-based interdisciplinary clinicians.

Methodology or protocol

Participants received a 2–3-h OncR lecture and discussion. The two main lectures presented at all locations were *Managing Side Effects of Cancer Treatment* and *Palliative Care/Grief Process*. Rehabilitation throughout the stages of survivorship and care for the caregiver were additional themes that were emphasised. Special topic areas included: use of specific outcome measures to manage impairments inclusive of pain, neuropathy, fatigue, chemotherapy-induced cognitive decline, compromised function, sarcopenia and psychosocial needs. Additionally, evidence for exercise, motivation for patient participation to improve QOL, and mechanisms and importance of OncR referral were also topic areas of emphasis. The discussion portion of the lecture included case studies, demonstrations and experiential small group interaction. Following the lecture, the retrospective participants were asked to complete a digital survey that included questions on demographic data, knowledge of OncR and questions about the lectures provided (See Table 1).

TABLE 1: Demographics.

Sample characteristics	*n*	%
Clinical practice		
Nursing	16	19.80
Physiotherapy	12	14.80
Occupational therapy	12	14.80
Speech therapy	4	4.90
Dietician/Nutritionist	8	9.90
Social worker	9	11.10
Psychologist	1	1.20
Physician	7	8.60
Audiologist	0	0.00
Other	12	14.80
	81	100.00
Years of clinical practice		
1–5	18	22.20
6–10	17	21.00
11–15	12	14.80
16–20	10	12.30
21–25	12	14.80
26–30	6	7.40
31–35	2	2.50
36-40	3	3.70
41–45	0	0.00
> 46	1	1.20
	81	100.00
Work setting		
Primary health clinic	19	24.40
District hospital	25	32.10
Tertiary hospital	25	32.10
Private practice	2	2.60
Academia	7	9.00
	78	100.00

Data analysis

The data from the survey were analysed using Microsoft Forms Windows 11 (2023), Redmond, Washington, United States. Descriptive statistics were generated for demographic and outcome variables. Qualitative data were coded and analysed for frequency of responses. Members of the research team independently reviewed responses to identify common themes, and interpretations were then discussed in small groups to achieve an 80% kappa coefficient.

Ethical considerations

An application for full ethical approval was made to the University of the Witwatersrand Human Ethics Committee (Medical) on 11 August 2023. The ethics approval number is M230772 MED23-07-048. A survey was designed to capture knowledge, attitudes and feedback regarding education training needs. A retrospective review of response items was analysed via descriptive statistics.

Results

Of the 361 clinicians who participated in the education modules, 81 participants responded to the survey, with 20% nursing respondents and 15% from physiotherapy and occupational therapy. Additional participants that took part in the education sessions included speech language pathologists (5%), dietitians and/or nutritionists

(10%), social workers (11%), psychologist (1%) and physicians (9%). Twenty-two per cent of these participants reported 1–5 years of clinical practice experience, followed by 21% clinicians who reported having 6–10 years of clinical experience. Thirty-two per cent of participants reported working in a district hospital, and 32% reported working in a tertiary hospital. The remaining 36% of participants reported working either in a primary health clinic, private practice or academia. Table 1 provides a summary of the demographic data of the participants.

In response to additional survey questions, 98% of participants either agreed or strongly agreed with the importance of advocacy for the cancer population. Seventy-eight per cent of participants either agreed or strongly agreed with being able to identify impairments and functional limitations. Eighty-four per cent of participants either agreed or strongly agreed with the importance of working with an interprofessional team. Moreover, 93% of participants either agreed or strongly agreed that they understood how to receive continuing education following the seminar. Eighty-eight per cent of participants were able to identify one evidence-based measurement tool to quantify pain, and 68% of participants were able to identify one evidence-based measurement tool to measure cancer-related fatigue. Seventy-four per cent of participants were able to work with an interprofessional OncR team to establish and execute an appropriate plan of care. Figure 1 provides a visual depiction of survey data.

Qualitative findings

Participants reported the three most helpful features of the course were exercise and rehab (20%), palliative care (17%) and involvement with a multidisciplinary team (17%). Their comments reflected these themes, including the following examples:

> '[*The*] importance of rehab to cancer survivors.' (participant 7)

> '[C]hanging perception of death and dying [in] palliative care.' (participant 21)

and

> '[*A*]ppreciation of the importance of an interprofessional team on the care of patients with cancer.' (participant 22)

In terms of the least helpful features of the course, 29% stated the need for more training/education for OncR, with one participant stating:

> 'Profession specific training will really boost my confidence in treating cancer patients.' (participant 50)

Another 20% reported a lack of resources and time constraints as their concern. Furthermore, 11% of participants shared that the venue and/or environment was the least helpful, stating:

> '[*needing a*] bigger accommodation venue to have other disciplines to present.' (participant 36)

Thirty-five participants reported in the 'other' category for the most helpful and least helpful features about the

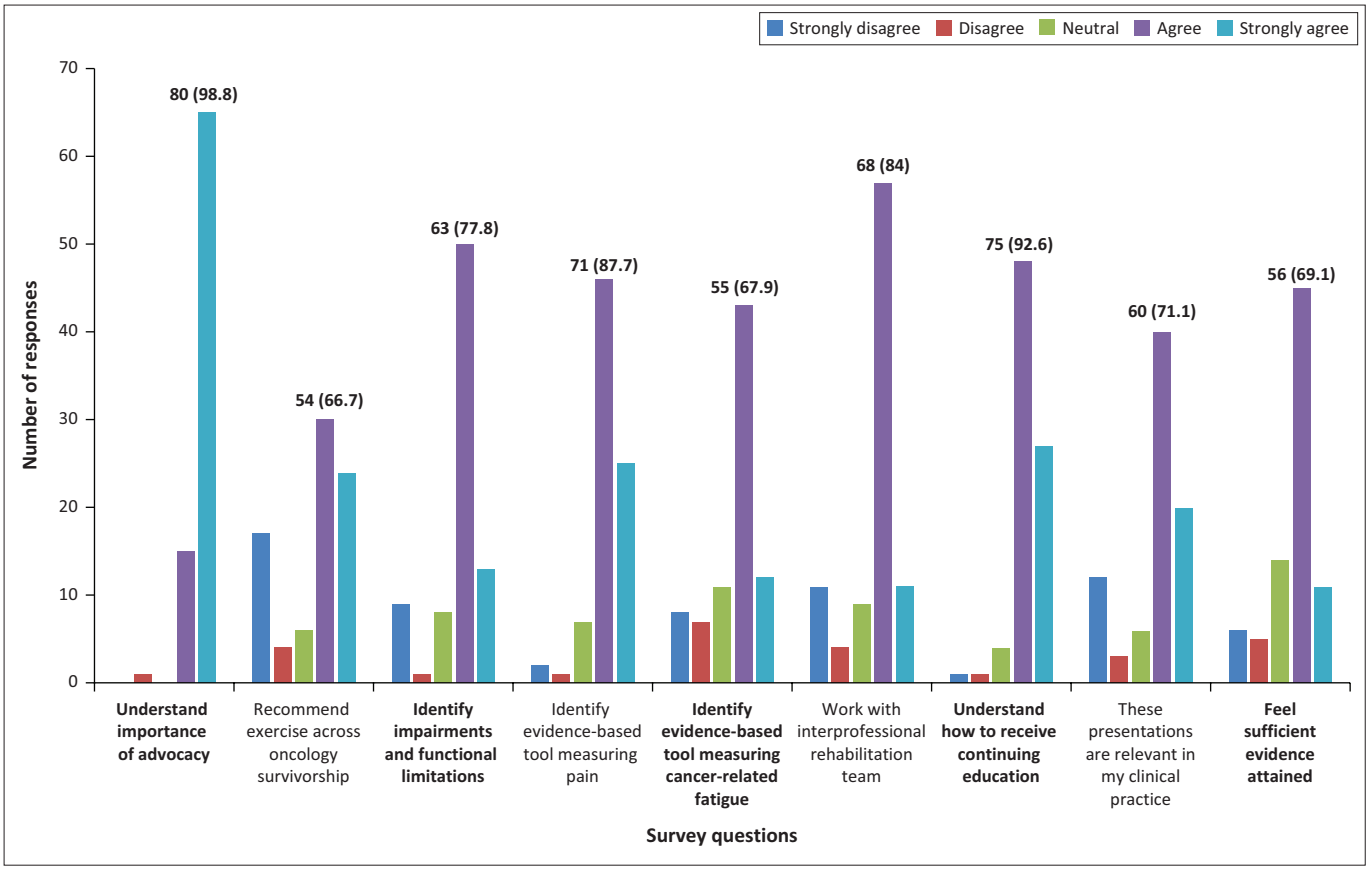


FIGURE 1: Survey responses.

course, further expressing opinions on their overall perceptions, including applying the seminar information in various cultural contexts, and topics to include in future workshops.

The most common themes identified in the 'additional comments' included an informative discussion on the presenters, followed by more presentations needed, and an increasing awareness to foster recognition of key stakeholders. One participant stated:

> 'I suggest that the information need to be presented on media such as our local radio stations not excluding schools since our children engage into sexual activities at an early age, to be able to reach more people who need to learn about carrying and supporting their family members who are suffering from cancer.' (participant 65)

A review of how the information learned will be applied in various cultural contexts revealed that most respondents recommended various forms of education and awareness. One respondent stated:

> 'I will avail myself and do all I can to understand the patient and also educate them based on their condition and also communicate with other multidisciplinary teams in order to help patients cope with their condition.' (participant 39)

Participants also suggested that cultural sensitivity needs to be incorporated, as evidenced by the statement:

> 'One would need to be culturally sensitive and competent then this can enable one to know how to apply the information and the policy with a sensitive and holistic approach because it is a sensitive topic.' (participant 63)

Lastly, when reviewing the topics individuals would desire in future workshops, the most frequent responses centred around three areas of need:

1. *Education on multidisciplinary*

Education on multidisciplinary teams. Two memorable quotes include:

> 'How to build a cancer patient team. I feel like oncology already has enough to worry about since they treat the patient. A team of 1 of all professions which only works with cancer patients. I think we will be able to have a better inter-connected medicine approach.' (participant 71)

and

> 'I learned a lot. I will educate my colleague about what I learned. Let's make a multi-disciplinary team work together, then we will change patients' lives'. (participant 52)

2. *Nutrition*

An example from one respondent is:

> 'Nutrition management of cancer patients undergoing rehabilitation. More to do nutritionally to avoid malnutrition'. (participant 33)

3. *Palliative care*

The following quote sums it all up:

> 'The presentation helped me gain more confidence in treating patients in palliative care and it made me realise that my knowledge and skills can make a significant change in the palliative care unit. I am very grateful for the presentation, it was exceptional.' (participant 77)

Discussion

The primary purpose of this article was to evaluate outcomes in knowledge and confidence following participation in modular foundational OncR seminars in South Africa. This project is the first interdisciplinary OncR seminar in South Africa, which focuses on increasing awareness of cancer-related impairments and various rehabilitation strategies for implementation. Following the educational seminars across various provinces, survey responses noted gaps in knowledge relative to the rehabilitative management of oncologic patients. A study conducted in 2021 found that a key barrier in health services included having inadequate knowledge regarding cancer and a need for the availability of treatments for lung cancer management in South Africa.[12] Oncology rehabilitation education is essential at both the entry and post-professional levels to address the identified knowledge gaps and ultimately improve the quality of care delivered to all persons living with and beyond a cancer diagnosis. Increased time and resources focused on OncR education are needed to ensure a comprehensive approach for successful care delivery to all people with cancer. Efforts towards this end in the US have culminated in the development and recent dissemination of entry-level competency guidelines.[13] Improving OncR provider knowledge and skills has the potential to improve care delivery and thus outcomes, and help raise awareness of these benefits among individuals and caregivers navigating a cancer diagnosis.

The qualitative data highlight the need for more education on palliative and hospice care strategies because of the high prevalence of late diagnosis in the region examined. There are a number of challenges to providing equitable access to quality palliative care, and available resources and supportive existing legislation policies are imperative to implement an effective palliative care strategy. It is also essential that healthcare professionals provide proper referrals in a timely fashion during various stages of recovery to leverage effective care, healing and promote optimal outcomes.[14] A patient may be identified at any stage of survivorship as requiring a palliative care referral to the appropriate level of care, which may be a down-referral from hospitals to clinics, or to home for ongoing treatment. In the National Policy Framework and Strategy on Palliative Care (2017–2022), there is an overall referral pathway for a palliative care patient from the community to the tertiary hospital.[15] However, a more widespread referral pathway from primary and secondary prevention throughout the treatment trajectory must be established to direct persons with cancer to the appropriate healthcare provider for treatment and to mitigate the issue of late diagnosis and subsequent

potentially avoidable tertiary rehabilitative management (tertiary prevention). Patient education related to lifestyle modification and healthy behaviour changes, that is, primary prevention, and efforts to prevent the adverse effects of the disease and its medical management (secondary prevention), are indeed within the scope of practice of the rehabilitation clinician. Rehabilitation clinicians are essential and well positioned to address impairments and optimise survivorship outcomes across the continuum of care.

The study findings also support the importance and presence of engaging and empowering the interprofessional team in South Africa to deliver high-quality care. To foster optimal recovery, healthcare professionals must be able to leverage their strengths and empower each other through support and effective communication. This study included nurses, PTs, occupational therapists, speech therapists, social workers, nutritionists, physicians, dentists and orthotists and prosthetists. Most participants felt confident in working with an interprofessional OncR team to execute a plan of care following the seminar. However, a need to provide a deeper appreciation within each respective profession and, similarly, an appreciation for what other professions can bring to the interprofessional team was elucidated. Interprofessional education curricula are foundational and essential components of holistic and patient-centred care delivery. Interprofessional collaboration is a key component in establishing goals that manifest improved QOL and reduce symptom burden for people living with a cancer diagnosis. Pornrattanakavee et al. reported that individuals with an advanced cancer diagnosis who were managed with a team-based approach had significantly improved scores of subjective well-being, as well as decreased readmission rates at seven days of hospital discharge.[16] Additional evidence supports the importance of interprofessional collaboration for enhancing QOL and overall care in patients with chronic conditions.[17]

Qualitative data revealed a need for more culturally relevant OncR and resources to improve the cultural competence and knowledge of healthcare professionals to ensure the population served receives optimal care. Curating resources provided relative to professional preparation and educational background aims to improve the overall understanding of OncR to ensure all disciplines have an equal understanding of competency. Inclusive teaching strategies enhance seminar delivery as well as optimise the learning experience for all participants, especially related to varied learning styles. Providing a streamlined connection for all available oncology resources within a respective community is essential. Additionally, limiting the steps that need to be taken prior to accessing proper OncR care can help improve outcomes and QOL in a timely manner.

Study limitations

This is a retrospective study with a small sample size. Of the 81 participants, 60 were from the same location at Tshwane Rehabilitation Hospital, located in Gauteng, which limits the generalisability of the results. As a result of this methodology, we are unable to delineate public versus private nor province-to-province participant responses, as we did not collect participant location variables. Decreased representation of PTs in the sample is a notable limitation, as they represented 15% of all participants. The lack of PT representation may have skewed the data, as PTs have a rehabilitation background and may have responded differently regarding their knowledge of OncR. Finally, the limited duration of the seminars could have impacted the ability of the participants to acquire and retain the information from the seminar.

Future research

Future research could embrace additional stakeholders, including indigenous healers, community workers and homoeopathic practitioners as a part of the interprofessional team. Goals may include identifying needs, garnering stakeholder support, implementing education, utilising existing resources and providing a sustainable dialogue for the continued advancement of OncR education and patient services in the region. Additionally, future work must assure and ensure the provision of foundational knowledge in respective entry-level interdisciplinary curricula to adequately prepare a workforce capable of addressing the growing need for quality and competent cancer care. Further, participant location variables should be accounted for in the data collection process.

Conclusion

A lack of resources, funding and education in rural areas in South Africa requires unique strategies to upscale clinicians' knowledge and confidence in OncR assessment and intervention. Feedback from participants indicates enhancement of knowledge and identification of barriers; however, inclusive interprofessional education is essential to optimise impact through culturally relevant OncR services. Increased OncR education is needed to equip the healthcare workforce, especially in low-income countries, to streamline connection to oncologic services in the community. Continued interprofessional presence is imperative to move towards improved QOL for all individuals diagnosed with cancer.

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Competing interests

Lori E. Boright and Deborah Doherty are co-editors and co-authors of the textbook, 'Oncology Rehabilitation:

A Comprehensive Guidebook for Clinicians'. The other authors have no financial or personal relationships that may have inappropriately influenced them in writing this article.

CRediT authorship contribution

Lori E. Boright: Conceptualisation, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Resources, Supervision, Writing – original draft. Sonti Pilusa: Data curation, Formal analysis, Funding acquisition, Investigation, Project administration, Resources. Timothy Blaney: Data curation, Methodology, Writing – original draft. Brianna Breedy: Data curation, Writing – original draft. Rachel Cook: Data curation, Writing – original draft. Sidney Crick: Data curation, Writing – original draft. Deborah Doherty: Conceptualisation, Data curation, Formal analysis, Investigation, Methodology, Project administration, Resources, Supervision, Writing – original draft. Mary Lou Galantino: Conceptualisation, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Resources, Supervision, Writing – original draft. All authors reviewed the article, contributed to the discussion of results, approved the final version for submission and publication, and take responsibility for the integrity of its findings.

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Data availability

The data that support the findings of this study are available on request from the corresponding author, Lori E. Boright.

Disclaimer

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