PSYCHOSOCIAL CARE AND SUPPORT STRATEGIES FOR IMPROVING CANCER SERVICES AT THE HOSPITALS IN LIMPOPO PROVINCE

BY

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Thesis Submitted in Fulfilment of the Requirements for the Degree:

Doctor of Philosophy (Health Studies)

Department of Advanced Nursing Sciences

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University of Venda

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February 2021

DECLARATION

I Neo Jacqueline Ramutumbu hereby declare that the thesis *"**Psychosocial care and support strategies for improving cancer services at the hospitals in Limpopo Province** "*submitted by me, has not been submitted previously for a degree at this or any other university, that is my own work in design and in execution and that all reference material contained herein has been duly acknowledged.

Signature: Ramutumbu NJ   Date: 26 February 2021

DEDICATION

This thesis is dedicated to my late father Rev Nathaniel Musundwa Nengovhela and Mother Mrs Dikeledi Catherine Nengovhela who have supported me unconditionally and believed in me. All gratitude's goes to my family, my daughters, and all participants to this study. Thank you for your support and motivation throughout the duration of this study.

ACKNOWLEDGEMENTS

I would like to extend my sincere gratitude to the following people and institutions that contributed to the success of this study.

- My promoter, Prof DU Ramathuba, for her consistent support and guidance. I appreciate her patience and warmth as a supervisor. I cannot express how thankful I am that you were always there to help and guide me, listened, for your patience and for always standing behind me. You are a true inspiration.
- My co-promoters, Prof SM Maputle and Dr ND Ndou for their feedback and consistent support, guidance, and encouragement
- The University of Venda department of research and innovation for granting me permission to conduct the study.
- Department of Health Limpopo Research office for granting me permission to conduct the study in the Province.
- District Offices of health in Limpopo of the hospitals for permitted me to use their facilities.
- Participants who participated in all the phases of the study
- My children Pfarelo and Mudzunga for your support and encouragement
- My friends Kate Booi, Takalani Rafundisani and Tshifhumulo Tshikovhele for your support
- My dear supporter Bontie Molefe for her time and energy to arrange the list of sources in this study, thank you so much.
- My brother Nkhanedzeni Baldwin Nengovhela for your support in this journey, thank you.

LIST OF ACRONYMS

ACA	American Cancer Association
ACS	American Cancer Society
HPCSA	Health Professional Council of South Africa
SA	South Africa
SANC	South African Nursing Council
SSA	Sub-Saharan Africa
WHO	World Health Organisation

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ABSTRACT

The prevalence of psychological distress in cancer patients is reported to be above 30%. Yet, the psychosocial needs of cancer patients may be overlooked by health care providers who possibly prioritise medical needs. Physicians may overlook the psychosocial needs of cancer patients due to the high physician-patient ratio and poor patient referral systems, delaying diagnosis and coordination of oncology services**.** **The purpose** of this study was to develop psychosocial care and support strategies to improve the cancer services at the hospitals in Limpopo Province.

Methods: A qualitative research design which was exploratory, descriptive was used for phase one and the findings formed the basis for strategy development to improve psychosocial care and support services at hospitals in Limpopo Province. The target population were health care professionals who expressed the challenges they experience in rendering the psychosocial care and support needs and cancer patients who described their experiences of psychosocial care needs**.** Five focus group discussions were conducted at the hospitals and eleven cancer patients where interviews were conducted at the hospitals.

Findings: Health care professionals reported shortfalls of human resource in oncology care poor patient administration and support in cancer services, poor co-ordination of cancer care services, concerns relating to conflicting values and norms concerns with disclosure of their diagnosis and observance of maladaptive personality traits affecting mental health-related quality of life. The cancer patients perceived a lack in emotional support, a lack of timeliness of care and co-ordination, and a lack of education on their treatment.

Strategies yielded, informed the study that: recruitment of skilled health care professionals, improving and structuring oncology services, decentralizing treatment centers (oncologist out-reach services), patient navigation and cancer survivorship programmes. The draft strategies were verified by panelists of experts and the refined strategies have been drawn following three rounds of e-Delphi and the final strategies have been drawn. The important contribution of the study was outlined, the suggestions for further studies about the patients; maladaptive personality traits affecting mental health-related quality of life.

Conclusion: providing psychosocial cancer care to patients and families as part of standard care in reducing distress and psychosocial morbidity associated with cancer and in fostering a better quality of life during and after treatment, increases survival.

Keywords: cancer care guidelines, navigators, survivorship programme, resource

CHAPTER 1

OVERVIEW OF THE STUDY

1. INTRODUCTION

This study is focused on exploring the care and psychosocial support needs of the cancer patients in the hospitals of Limpopo Province. Understanding, screening, and providing resources for quality-of-life factors and psychosocial distress have become an important area of focus in cancer care. Negative consequences of poor quality of life and psychosocial distress is of concern to the researcher.

1.1 Background

Cancer poses a major threat to public health worldwide, and incidence rates have increased in most countries since 1990. The trend is a threat to developing nations with health systems that are ill-equipped to deal with complex and expensive cancer treatments (Fitzmaurice, Dicker, Pain, Hamavid, Moradi-Lakeh, Macintyre, Allen, Hansen, Woodbrook & Wolfe, 2015). The World Health Organization, Bray Ferlay, Soerjomataram, Siegel, Torre, and Jemal (2018) indicated that cancer is the second leading cause of death globally and responsible for an estimated 9.6 million deaths in 2018.

The World prevalence's of cancer indicated that new cancer cases are still found in Africa, Asia, and South America. The American Cancer Association (2014) has estimated that there will be 1,665,540 new cases diagnosed in the United States in 2014 and an increased number of deaths from cancer. Nigeria had 100,000 new cases and Malawi had 18,946 new cases (Msamboza, Dzamala, Mdokwe, Kamiza, Lemari, Dzowela & Kathyola, 2012). South Africa had new cases of about 30,461 that were reported in 2007(ACA, 2014). In Sub-Saharan Africa (SSA), cancer and other non-communicable diseases are a burden to the low and middle-income countries. There is a projection that cancer in Sub-Saharan Africa (SSA) carries 80% of the total or more of the global cancer burden (Olsen, 2015). It is also indicated that many patients diagnosed with cancer in these countries are unable to access comprehensive cancer care due to their location concerning the treatment centres. Longevity and the challenges, old age contributes to more cancers and increases the psychosocial support needs. An increase in cancer survival rates has prompted a greater need for widely accessible patient-centred support services that are integrated (Robson, 2018).

The health care professionals and the health care systems are obliged to attend to the challenges to make sure that the quality of life is improved. Therefore, the primary caregiver who in this case is the nurse should be able to assess the patient in totality to achieve and improve quality of life and good health outcomes. The cancer diagnosis has many implications on the patient and family, the patient should be assisted in the appraising of the challenges the individual patient is faced with. The nurse as the initial caregiver should be able to assess the patients in totality to know how to provide nursing care and psychosocial support. Initiating direct communication with the other team members involved in the treatment of the cancer patients has a positive impact on the vulnerable patient's wellbeing and health. Holistic care is a system of comprehensive or total patient care that considers the physical, emotional, social, economic, and spiritual needs of the person or their response and the effects of the illness on the ability to meet self -care needs.

The use of nursing process in assessing patient needs is employed in the total assessment of the patients (Watson, 2006; Obioma, 2017 & Miskir , 2018).The purpose of assessment is to organize a database regarding a patient’s physical, psychosocial and emotional health, to identify health promoting behaviour and actual and potential health problems (Mamseri.2012; Ngao, 2015) Holistic approach to the patient assessment means that the patient is assessed for physical, social and psychological challenges. The following guidelines are assessed under each challenge as adapted from the National Cancer Survivorship Resource Centre (ACS, 2009).

Table 1: National Cancer Survivorship Resource Centre Guidelines (ACS, 2009).

Physical	**Social**	**Psychological**	**Spiritual challenges**
Fatigue and sleep	Roles and relations	Anxiety states	Religiosity

Overall physical health	Affection and sexuality	Depression	Transcendence
Fertility	Appearance	Fear of recurrence	Hope
Pain	Isolation	Cognition /attention	Uncertainty
	Finances and employment		Inner strength

This study is more concerned with care and psychosocial support; however, it is exceedingly difficult to separate the psychosocial support of the individual from the holistic being. Watson (2006) has indicated that a plan of action (nursing process) should be undertaken to assist as much as possible to alleviate the problems. For the cancer patients, the challenges could be treatment related and or disease related that brings about the social and psychological challenges. The plan may include family therapy and referral to the other members of the oncology team and other health professionals involved in their care. The relevant support groups and other agencies that may assist the patient to achieve an equilibrium. At evaluation if an emotional is appraised the need for psychosocial support becomes eminent to assist the patient and family to cope with the circumstances. Coping with disfigurement and losses like hair loss, side effects of chemotherapy.

Psychosocial distress as defined by Ross, Rottmann, Andersen, Hoybye, Johansen and Dalton (2015) are ranging from common normal feelings of vulnerability, sadness, and fears to problems that can become disabling, such as depression, anxiety, panic, social isolation, and existential and spiritual crisis. Psychosocial distress has indicated to have a significant impact on poor quality of life in the cancer patient population and the family. The family as the immediate support system in the home front are greatly affected as they should take part in the care. Elevated levels of psychosocial distress increase the risk of developing depression, anxiety, immune suppression, and may lead to high levels of stress. There is an association between increased psychosocial distress levels, relapse, treatment and healing outcomes, and survival rates (Ross, et al. 2015).

Balasubramanian (2012) has indicated in his study that the burden of having cancer must be well understood and that there is a need to develop systems and services appropriate for the concerns and challenges of the individuals and society. Health professionals caring for cancer patients need to be prepared to decide, in consultation with the patient the therapeutic measures to cure or prolong life with knowledge, to assess the psychological distress that the patient might be experiencing. Physical and psychosocial support is essential for people living with and beyond cancer.

The psychological distress of the patients is sometimes not evident to the health care team as they are not effectively communicated. Heckle, Fennell, Morhebi, et al. (2017) indicated that Australia has developed a strategy whereby they use telephone-based communications to give psychological support to the patients who may not want to communicate about their distress, as such. Knowledge of such services is given to the patients by the associating health professionals.

England (NHS/2015-2020:2015) have developed a strategy based on six principles: Spearheading a radical upgrade of the services in the prevention and managing cancer treatment; and driving the national ambition to achieve early diagnosis. The approach is meant to support people living with and beyond cancer and establishing patient’s experiences to be on par with clinical effectiveness, necessary investments required to deliver a modern, high quality services and ensuring commissioning provisioning accountability processes. The England strategy has achieved that fewer people getting preventable cancers, more people surviving for long and with positive experiences and long-term quality of life. Their strategy is worth learning from and may assist in the development of the intended psychosocial support strategies and implementation.

In the United States and Canada their strategy pioneered the use of the patient navigator programmes their aim was to reduce cancer disparities by informing cancer and the availability of cancer services and addressing cultural, educational, language barriers to screening and treatment through community outreach programmes by the health care workers (Paul, Hall, Oldmeadow, et al., 2017) Cancer control policies and programs vary greatly now and are evolving in the US and around the world.

Sub- Saharan Africa (SSA) policies are dwelling much on the initiation of cancer registry so that there could be a plan to finance cancer services (Olsen, 2016). South Africa does not have clear cut strategies for cancer care however it has a guideline for the physical management of different cancers like breast cancer and cervical cancer. Many people in the world population will eventually need psychosocial support for cancer, health care delivery and medical insurance systems that have a major effect on diagnosis and treatment of cancer. Spirituality impacts patient Quality of Life (QoL) and provides a context in which to derive hope and meaning to cope with illness.

This is the point that the researcher believes that the care and psychosocial support is greatly needed by the patients and their family, to provide and improve the QoL and hope in patients with cancer, in addition to exploring the importance of spiritual issues both for patients and family. A strong spiritual wellbeing decreases symptom severity, the level of hopelessness and the desire for hastened death in cancer patients. However, in the medical setting the provision of spiritual care remains poor, although patients, especially at the end of life, would like their spiritual needs to be addressed as part of the global care. Care for cancer patients goes beyond just caring for the person's body. Care and psychosocial support in nursing is part of the fundamental nursing science which can be discussed by the aid of Watson’s theory as discussed by Park & George (2013). Coping with the adverse effects of being diagnosed with cancer according to Folkman and Greer (2000). The researcher is driven by the unmet psychosocial needs of the cancer patient believing that the strategy will enable them to cope with the illness better with the assistance of the health professionals.

1.2 Problem statement

Cantril and Haylock (2013) have reported that health care systems and cancer care delivery throughout the world are quite often fragmented**,** inaccessible and are associated with high levels of psychosocial distress related to unmet informational needs, inadequate support, and communication failures; all of which negatively affect the quality of life and increase the burden of suffering throughout the cancer experience. Ramutumbu (2016) in the study undertaken in the Vhembe district also highlighted the unmet psychosocial care needs for cancer patients.

The relevant referral services in the hospitals to the communities and the treatment centres are not well defined and patients are not navigated along the journey of their cancers on their specific care and support services. Patients miss appointments and end up missing treatment and having complications related to treatment, some are never traced through the treatment registry. The most distinctive gap in Limpopo Province is the unavailability of a discharge plan for the continuity of care at home and a well explained follow up care at the hospitals and the communities. The unavailability of support structures in the community and rehabilitation centres impacts negatively on the quality of life of cancer patients. Due to lack of care and psychosocial support the researcher sought to develop strategies to improve care and support services for cancer patients in Limpopo Province.

1.3 Purpose of the study

The purpose of this study is to develop psychosocial care and support strategies for cancer patients at the hospitals in Limpopo province.

1.4 Research objectives

The study will be conducted in phases.

Phase 1(a)

- Explore the psychosocial care and support needs of the cancer patients at the hospitals in Limpopo Province.

- Describe the psychosocial care and support needs of the cancer patients at the hospitals in Limpopo Province.

Phase 1(b)

- Identify the challenges faced by the health care professionals in rendering psychosocial care and support need at the hospitals in Limpopo Province.

Phase 2

To develop psychosocial care and support strategies for improving cancer services at the hospitals in Limpopo Province

Phase 3

To validate the psychosocial care and support strategies for improving cancer services at the hospitals in Limpopo province.

1.5 Research questions

The following research questions guided the study.

- What are the psychosocial needs expected by the cancer patients at the hospitals in Limpopo?
- What are the challenges experienced by the health care professionals regarding providing psychosocial care and support for the cancer patients at the hospitals in Limpopo?
- What are the psychosocial strategies that can improve psychosocial care and support for the cancer patients at the hospitals in Limpopo Province?

1.6 **Significance of the study**

The study findings assisted in identifying addressing the care and psychosocial support needs of the patients and the identification of the challenges encountered by the health care professionals in rendering care and psychosocial support needs of the cancer patients.

The study findings contributed to the body of knowledge by informing the health care professionals about the cancer patient's care and psychological support needs and the challenges they face while visiting the services. Relations amongst health professionals and cancer patients could improve when working as a team.

The findings may contribute to improving the collaborative care with families for improving the psychosocial support of the patient and family.

It is anticipated that health care professionals must improve their care through a co-ordinated approach in referring the patient according to their needs (holistically).

The study findings serve as a guideline to improve the services in the hospitals in Limpopo Province. It may enhance the quality of life of the patients to the better and positively.

1.7. Definition of concepts

Care

Care in health care is directed at those who are ill and at those who are ill and at those who are at risk of becoming ill. Kraus and Boldt (2018) imply that caring for a patient means curing that person, restoring health in situations such as chronic disease to the end of life. Caring involves maintaining and improving the well–being of the patient to the extent which is still possible.

In this study, care shall mean finding a balance between optimal care for cancer patients and family on the demands of providing physical, psychological, spiritual care over a long period.

Strategy

The pattern of decisions in a company that determines and reveals its objectives, purposes, or goals, produces the principal policies, and plans for achieving those goals and defines the range of businesses the company is to pursue, the kind of economic and human organization it is or intends to be, and the nature of the economic and non-economic contribution it intends to make to its shareholders, employees, customers, and communities (Andrews,1980).

In this study a strategy shall mean a plan of action geared towards improving the psychosocial care and support services for the cancer patients in Limpopo province. These strategies shall assist in achieving the set of objectives set to improve the services involving short-term goals and long-term goals.

Support

Support means comfort, strengthening, maintenance, and advocacy often a basis for individualised care of patients in a variety of contexts (Graham-Wisener & Dempster, 2017). In this study, support will be an essence of strengthening cancer services to provide expected care in cancer services.

Psychosocial

It is one part of the general well-being of the person, relating to the interrelation of social factors and individual thoughts and behaviour (Wang, He, & Daddialla, 2014)

In this study, psychosocial support would mean strengthening social networks such as family and community functioning. The cancer patient’s psychosocial strength will be built through inner capacity by facilitating mental processes.

Health professional

Health professional is a person that maintain the improvement of health via the prevention, diagnosis, and treatment of disease, illness, injury, and other physical and mental impairments in human beings (Nxumalo, 2013). It includes work done in providing primary care, secondary care, and tertiary care, as well as in public health. The health professionals are trained and skilled in the work they do.

In this study the health care professional shall imply nurses, doctors, oncologists, social workers, and psychologist. Health care professionals are positioned to create a link between coordinated services that can ensure this comprehensive approach and underserved communities who are less likely to reach those services. They have the potential to provide greater community outreach services that address the social determinants of health and strengthen comprehensive PHC (Nxumalo, 2013).

1.8 PARADIGMATIC PERSPECTIVE

1.8.1. Meta-theoretical assumptions

The researcher believes that cancer patients can be assisted to maintain the quality of their lives even beyond cancer through a concerted effort of the multidisciplinary team as well as the network of family and community services. The holistic approach to care and support can improve the cancer services in Limpopo Province. In the realisation of the unmet psychosocial care needs the researcher believes that if the cancer patients themselves are part of the drawing of the care and support strategies together with the health professionals the cancer patient’s plight and journey with cancer can be lessened from the stressors they are encountering presently.

1.8.2 Theoretical framework

Watson’s human caring theory (George, 2011) and a theoretical model of appraisal and coping process (Folkman and Greer, 2000) will be equally applied in this study. Watsons' theory endorses the nursing professional’s identity within the context where human values are questioned. Upholding the theory allows the oncology health care professional to practice the art of caring and provide compassion to ease patients' and families' suffering and to promote their healing in dignity.

This theory addresses the care given to the cancer patients to find solace and comfort from the care provided by the health professionals. According to Watson (2007) caring is grounded on a set of humanistic-altruistic values including caring with kindness empathy concern and love. The assessment and managing the cancer patients according to the nursing process as outlined by Watson concur with Folkman's and Greer model of appraisal of the harm, the treats and the challenges and coping process, the characteristic, be it social, physical, psychological, and spiritual same as the holistic approach in the nursing process in Watsons theory.

Patient assessment of coping with cancer should be assessed because cancer diagnosis can be a traumatic experience. In cases where a negative outcome is observed and maybe verbalised, the individual is further re-assessed for re planning and further referred or supported. Supporting of the cancer patient is important to deal with emotional and psychosocial setbacks to assist the patient's distress and vulnerability, to cope with their circumstances addressing their psychosocial care needs to bring about a positive outcome.

The patient should be encouraged to attach meaning to own life and as in Watson theory of human caring. The health professionals should nurture faith and hope and the deep belief system of oncology patients by encouraging them to adhere to medical regimens, provide counselling and support. The positive outcome would indicate that the patient is starting to cope with the cancer diagnosis and should be sustained (Folkman & Greer, 2000). Psychosocial support should be a continuous process throughout when needed as cancers may return or new challenges may arise.

Table 2: Key elements of the theories and their effect on the patient

Watson and the nursing process	**Folkman and Greer Appraisal and coping**	**Patient effect**
Assessment /holistically Physical, psychological, social, and spiritual	Event occurring	At diagnosis, triggers a reaction/character. Physical,

		psychological, social, and spiritual
Planning for the perceived problem	Appraisal of threat/harm and challenge	Identification of the problem and acknowledge need to resolve the problem/emotional or problem focused
Implementation	Problem outcome	Strive to positive outcome/negative outcome
Evaluation: negative outcome calls for re-planning and intervention	Coping/positive and negative	Positive /sustained coping Negative calls for re=evaluation of emotional outcome

Source: authors own table

1.9 RESEARCH METHODS AND DESIGN

This study was conducted in three phases and each phase is discussed in terms of the research design and methods used to address the specific objectives. Research design is the plan for addressing a research question, including specifications for enhancing the study's integrity (Polit & Beck, 2014). Table 3. provides a summary of the research design and methods.

Table 3: Summary of research methods and design .Source: Author's own table

	PHASE 1: Situational analysis	**PHASE 2: Strategy development**	**PHASE 3: Validation of strategy**
SETTING	Hospitals in Limpopo Province		

POPULATION	**1(a)** Cancer patients **1(b)** Health care professionals	**Thematic**	-Cancer patients -Multidisciplinary team
SAMPLING METHODS	Non- probability purposive **1(a)** Convenience **1(b)** Snowball		Purposive
DATA COLLECTION	Face to face individual interview		E-Delphi technique
DATA ANALYSIS	Thematic Analysis		Consensus

1.9.1 PHASE 1: EXPLORATIVE DESCRIPTIVE SURVEY

According to Polit and Beck (2014), a qualitative research design is described as an investigation of phenomena in an in-depth and holistic fashion, by using a flexible research design and through the collection of rich narrative materials. A qualitative, exploratory, descriptive, and contextual design was used to get an in-depth understanding of the experiences and challenges inherent in the provisioning psychosocial care and support needs of the cancer patients at hospitals in Limpopo Province. A qualitative approach used assisted to acquire in-depth content and information using individual interviews. The qualitative data obtained was analysed and the results formed the basis for strategy development.

1.9.2 PHASE 2: DEVELOPMENT OF PSYCHOSOCIAL CARE AND SUPPORT STRATEGIES FOR IMPROVING CANCER SERVICES AT THE HOSPITALS IN LIMPOPO PROVINCE

Thematic analysis was approached inductively resulting in data driven themes as the researcher was actively involved in the data analysis process. The researcher's involvement commenced during data collection at which the initial data coding started. The researcher transcribed all data sets upon which the researcher's involvement with the was data expanded. The strategies were developed from the merged themes of both the focus group discussions with the health professionals and the and the face- to face interviews with the patient's participations of this study.

1.9.3 PHASE 3: VALIDATION OF PSYCHOSOCIAL CARE AND SUPPORT STRATEGIES FOR IMPROVING CANCER SERVICES AT THE HOSPITALS IN LIMPOPO PROVINCE

Delphi is a technique used to achieve a common viewpoint from experts using questionnaires to gather information of interest, which was the development of psychosocial and support for cancer patients. The experts, the multidisciplinary team were consulted to input and ensured that consensus is reached.

In the e-Delphi process, reaching consensus by experts cannot be resolved in a once-off discussion. As an iterative process, e-Delphi involves a chance for initial feedback, collation of feedback and distribution of collated feedback to participants for further review. Depending on the number of research questions and available time to reach consensus, the e-Delphi process includes three rounds, to prevent exhaustion and attenuation (Green, 2014).

1.10 MEASURES TO ENSURE TRUSTWORTHINESS/ VALIDITY AND RELIABILITY

Trustworthiness or rigor of a study refers to the degree of confidence in data, interpretation, and methods used to ensure the quality of a study (Pilot & Beck, 2014). In each study, researchers should establish the protocols and procedures necessary for a study to be considered worthy of consideration by readers (Amankwaa, 2016; Connelly, 2016). Ensuring trustworthiness entails taking measures to make sure that the research findings are worth paying attention to and taken into consideration. In this study, trustworthiness was obtained by using multiple methods of data collection methods such as the interview, focus group discussion, audiotape, and field- notes to ensure credibility and confirmability. Dependability was achieved by using a detailed description of the data collection method and the use of an independent coder. Transferability was achieved through the thick and dense description of the sampling method and the methodology.

1.11 ETHICAL CONSIDERATIONS

Ethical guidance governing research will be considered before commencing with the study, the researcher guaranteed the protection of participants by adhering to the principles on which the standards of ethical conduct in research are based, namely: informed consent, autonomy, beneficence and maleficence, confidentiality, and justice (Polit & Beck, 2012). The ethical considerations used in this study will be discussed in more details in chapter 2.

1.12. ORGANISATION OF THE THESIS

Chapter 1 Orientation of the study

Chapter 2 Research methodology

Chapter 3 Presentation and interpretation of qualitative results

Chapter 4 Contextualisation of a theoretical framework

Chapter 5 Development of strategies

Chapter 6 Validation of developed strategies

Chapter 7 Limitations, recommendations, and conclusions of the study.

1.13 CONCLUSION

This chapter gave an overview of the research study. It provided background information for the topic being examined, the problem statement, purpose and objectives of the study sets out the main research question which drives this enquiry. It further addressed the scope of the study the conceptual framework, definition of the concepts and the research approach and the organisation of the study chapters. The following provides a detail description of the method that the researcher has used in this study.

CHAPTER 2

RESEARCH METHODOLOGY

2.1 INTRODUCTION

The purpose of the research method is to inform the readers of how the study was conducted, what the researcher intended to solve the research question and responds to the research questions**.** The researcher has used a qualitative ,explorative, descriptive and a contextual design to collect the data to answer the research questions and to achieve the set objectives.

2.2. STUDY AIMS AND OBJECTIVES

The purpose of this study is to develop care and psychosocial support strategies for the cancer patients at the hospitals in Limpopo province.

Phase 1(a)

- Explore the psychosocial care and support needs of the cancer patients at the hospitals in Limpopo Province.
- Describe the psychosocial care and support needs of the cancer patients at the hospitals in Limpopo Province.

Phase 1(b)

- Identify the challenges faced by the health care professionals in rendering psychosocial care and support need at the hospitals in Limpopo Province.

Phase 2

To develop psychosocial care and support strategies for improving cancer services at the hospitals in Limpopo Province

Phase 3

To validate the psychosocial care and support strategies for improving cancer services at the hospitals in Limpopo province.

2.3. STUDY DESIGN AND METHOD

The study was conducted in three phases, each with its own different design and methods suitable to answer the overall research question and to address the objectives of the study. Triangulation in research is the use of more than one approach to researching a question. The objective is to increase confidence in the findings (Heale & Forbes, 2013). Therefore, the study used different designs and the combination of findings from two or more rigorous approaches provides a more comprehensive picture of the results than the use of one approach.

Phase 1 A qualitative, exploratory, descriptive, and contextual design was used to get an in-depth understanding of the experiences and challenges inherent in the provisioning psychosocial care and support needs of the cancer patients at hospitals in Limpopo Province.

Phase 2 Development of the psychosocial care and support strategies for cancer services in Limpopo province

Phase 3 Validation of the psychosocial care and support strategies for cancer services in Limpopo province using e-Delphi consensus method. Individual phases will be discussed in terms of the research design and methods here under.

2.3.1 PHASE1 (a): EXPLORATIVE, DESCRIPTIVE AND CONTEXTUAL DESIGN

Qualitative research

In this study, a qualitative, exploratory, descriptive, and contextual design was used to get an in-depth understanding of the phenomena (Brink, Van der Walt, and Van Rensburg,2014) The approach assisted in understanding the meaning that the individuals ascribe to a social problem. Face to face interviews of the psychosocial care and support needs of the cancer patients in the hospitals.

- **Exploratory**

An explorative design was aimed at exploring the dimensions of the phenomenon, the way it will show and the other factors that are related (Polit & Beck, 2012; Brink, 2012). The explorative study assisted in enlightening how the psychosocial care and support needs can be improved in hospitals in Limpopo province.

- **Descriptive**

Descriptive research aims at exploring, describing phenomenon in real situations, discovering new meaning, and determining the frequency with which something occurs (Grove, 2013; Brink et al., 2014). In this study the researcher described the psychosocial and support needs of the cancer patients as described by the patients without manipulating their narrative.

2.3.2 Phase 1 (b) Focus group discussions with the health care professionals.

- **Qualitative research**

In this study, a qualitative, exploratory, descriptive, and contextual design was used to get an in-depth understanding of the phenomena (Brink et al., 2014). Focus group discussions were convened, focus group comprised of small groups of participants led through a discussion by a skilled moderator, the group were enough to generate rich discussions and not large to leave other participants out. The approach assisted in understanding the meaning that the individuals ascribe to a social problem.

- **Exploratory**

An explorative design was aimed at exploring the dimensions of the phenomenon, the way it will show and the other factors that are related (Polit & Beck, 2012; Brink, 2012). Participants discussions were facilitated by the questions that were initially predetermined questions to make the discussions free flowing. Participant's comments stimulated and influenced the thinking and sharing of the others. The explorative study assisted in enlightening the challenges encountered by the health care professional in rendering psychosocial care and support needs of the cancer patients and how they could contribute to the improvement of the psychosocial care and support needs of the cancer patients improved in hospitals in Limpopo province. The discussions lasted for 45 to 60 minutes to make them productive with probing questions (ANNEXUE A) comprising of engagement questions, exploratory questions and exit questions.

- **Descriptive**

Descriptive research aims at exploring and describing phenomenon in real situations as generated by the focus group, discovering new meaning, and determining the frequency with which something occurs (Grove, 2013; Brink et al., 2014). In this study the researcher described the narratives from the focus group discussions without manipulating the narratives that were about the challenges experienced by the health care professionals in rendering psychosocial care and support for the cancer patients in the hospitals.

- **Contextual**

In qualitative research, the meaning of social action depends on the context in which the study is taking place. Contextual describe the uniqueness of the research setting (Brink et al., 2014). In this study, the context was community hospitals in Limpopo that are responsible for the cancer care services in the Districts and the Provincial hospital which is a treatment centre for all patients in the Limpopo province.

2.4. STUDY SETTING

The study setting refers to the physical location and conditions in which data collection takes place (Polit & Beck, 2012). Limpopo province is situated in the North East of South Africa, it borders with Botswana on the north east, North West Province in the borders on the South West Gauteng on the South and Mpumalanga on the south east. There are five districts which are Vhembe, Mopane, Capricorn and Waterberg and Sekhukhune. Limpopo province has 5.7 million residents, accounted for 10%of South African population in 2014/2015. Vhembe, Capricorn, and Mopani district are rural districts where the study was undertaken. The tertiary hospital, Polokwane was included in the study as it is the one that have oncologists and specialised services for the oncology patients. It is the main treatment centre for cancer patients in the province. The following is the map that indicates the 5 districts in Limpopo Province of which the researcher has used 5 hospitals from the 3 districts in this map being Mopane,Capricon and Vhembe district.

Figure 1: Map of districts in Limpopo Province

2.5. POPULATION SAMPLE AND SAMPLING

A population is the whole group of people that is of interest to the researcher or that meet the criteria that the researcher is interested in studying (De Vos, 2011; Brink et al., 2014). The target population in phase 1(a) were cancer patients and for phase 1(b) the health care professionals (doctors, professional nurses, social workers, psychotherapists) that had experienced the psychosocial care and support of the patients at the hospitals. A sample is a subset of a population that will be selected from the study population to participate in the study (Brink et al., 2014).

2.5.1. Sampling of districts and hospitals

Sampling is the process of selecting the sample from the population to obtain information regarding the research question and the whole phenomenon under study (Brink et al., 2014). A non-probability purposive sampling was used for selection of three districts, namely: Mopani, Vhembe, and Capricorn districts for their cultural diversity and four hospitals.

Table 4: **Sampling of the districts and hospitals**

District	Municipality	Hospital
Vhembe	Thulamela	Siloam
	Collins Chavane	Malamulele
Mopane	Greater Giyani	Nkhensani
Capricorn	Polokwane	Seshego and Pietersburg

2.5.2. Sampling of participants

Sampling indicates the process by which the researcher chooses a sample from the population to get information about the reality in a way that represents the population that the researcher is interested in (Brink, Van Der Walt & Rensburg, 2012; Brink et al., 2014). The reason was that a probability sampling recruitment enhances each element an equal opportunity of selection independent of any other event in the selection process (Husley, 2011).

In phase 1 (a), a non-probability purposive sampling was employed by using the researchers' judgement of selecting the patient participants that are of interest to the study who provided rich and valuable information regarding the psychosocial care and support needs at the hospitals in Limpopo province and were able to enlighten the researcher on how these psychosocial care and support can be improved at the hospitals.

In phase 1(b) focus group discussions, the health care professionals were sampled using the snowball sampling technique and the patients were reached through a convenience sampling technique.

- **Inclusion criteria**

The inclusion criteria for phase 1(a) were as follows:

- Cancer patients diagnosed for more than a year.
- Attending treatment on out-patient basis.

Inclusion criteria in phase 1 (b)

- Health care professionals in direct contact with cancer patients
- Permanently employed for more than a year in public heath hospitals in Limpopo and in the selected hospitals

The exclusion criteria for phase 1(a) were as follows:

- Cancer patients who were critically ill and were unable to comprehend information.

The exclusion criteria for phase 1(b) were as follows:

- Health care professionals who were not working directly with cancer patients because they might not have the necessary information regarding psychosocial care and support needs of cancer patients at hospitals in Limpopo province.
- Visiting consultants/health professionals.

2.5.3. Sample size

Polit & Beck (2012) defines sample size is the number of people in a study. A sample size should be large enough to sufficiently describe the phenomenon of interest and address the research question at hand. The goal of qualitative research should thus be the attainment of saturation.

Thirteen patient participants were interviewed in phase 1 (a) and 5 focus group discussions with the 4-5 participants per group health care professionals and data saturation was reached when no more new themes and subthemes emerged.

2.6 DATA COLLECTION

Data collection refers to systematic gathering of information relevant to the research purpose or specific objective, question, or hypothesis of the study (Burns & Groove; 2011; Brink, van der Walt & van Rensburg, 2018). The researcher used triangulation in data collection whereby a semi-structured one-on-one interview using an interview guide, along with an audiotape recorder. Field notes to capture information followed by verbatim transcriptions of the recordings. Interviews is a technique or method that the researcher used to gather information by directly asking participants about their experiences of psychosocial care and support needs in phase 1(a) and challenges faced by health care professionals in the provisioning of psychosocial care and support in phase 1(b). The researcher obtained information through direct interchange with the individual groups that were expected to possess knowledge that was needed in the study. The selected participants in focus groups knew the cancer and psychosocial support needs of the patients and their challenges in the provisioning of care and support needs of these patients. Patient’s participants knew how they would want to be cared for and supported psychosocially.

2.6.1. Pilot study

A pilot study is a pre-trial or mini study to determine the validity and reliability or trustworthiness of the data collection process. For this study, a pilot study was conducted before the main study at a hospital and the hospital was not included in the main study. The pilot study was intended to assist the researcher to verify whether the questions in the interview guide were relevant to answer the research objectives Furthermore, it was to evaluate whether the questions were vague, simple, well-constructed and not intrusive or offending.

2.7 DATA COLLECTION PROCESS

All the permissions from ethical bodies, including permissions from the districts and institutions were obtained, the researcher started to access the health care workers and the cancer patients, introducing the study, setting dates and times agreed upon. A letter of recruitment was given to the health professionals in advance and consent forms with information about the study (Annexure C).

Participants in the interviews were provided with a private cubicle and those in focus group discussions an office space was provided. The face-to-face interviews and focus group discussion lasted for 45min to an hour and the proceedings were audio-recoded, and the researcher and research assistant took field notes. The researcher created a conducive, non-threatening, and relaxed environment by introducing themselves and outlining the purpose of the focus group discussion. Participants were given a chance to clarify aspects of the study process or ask questions if they did not understand any of the given information.

2.7.1 Data collection instrument

Different methods are used in qualitative research. The most common are interviews, focus group discussions, observational methods, and document analysis. Combining two or more data collections methods, for instance, interviews as well as focus groups (data triangulation) enhances the credibility of the study (Brink, van der Walt & van Rensburg, 2018; Heale & Forbes, 2013).

- **Individual in-depth interview**

Interviews give the most direct and straightforward approach to gathering detailed and rich data regarding a phenomenon. An open or unstructured interview will often be based on a single question, with the interviewer and interviewee then shaping the conversation in real time, rather than following a prewritten schedule. The researcher conducted the interviews to explore the care and psychosocial support needs of the cancer patients using the following central question:

*“What are your psychosocial care and support needs that you expect from the cancer services in the hospit*als”?

The question was translated into the different languages for the different patients. The researcher is well conversant with the three languages and got clarity and assistance from the language experts so that the questions should be able to get the intended response. The questions were followed up by relevant probes. It also involved the systematic recording and documentation of responses as well as intense probing for deeper meaning and understanding of the responses.

The following communication strategies were used in this study:

- **Scene setting**

Scene setting by the researcher and the participants, the researcher ensured that the participants are comfortable. The times set were adhered to. Protection of the participants from all forms of harm was ensured (Brink et al., 2014).

- **Minimal response**

The researcher encouraged the participants to express their perceived unmet needs without being interrupted in their responses and persuade the health care professionals to explain and share their challenges in the provisioning of psychosocial care and support for the cancer patients.

- **Reflecting**

Reflecting is a process of the researcher summarising a conversation or part thereof to make sure there is mutual understanding of the facts that are shared by the participants. The researcher verified the discussions of each interview with the patient participants by summarising the main ideas that the participant had shared to verify the truthfulness and right capturing of facts. The researcher too had verified and summarised the facts highlighted by the focus group participants to verify truthful capturing of the shared ideas.

- **Probing**

The researcher used probes to encourage the participants to share more on the subject at hand. The cancer patients were encouraged to participate more to assist in providing tangible information about their perceived psychosocial care and support needs rich enough for their contribution to the development of the strategies. The challenges encountered by the health care workers in providing the patients with psychosocial care and support were probed until there was no more to explore.

- **Field Notes**

Field notes were kept for use during the interviews, the notes of the observations during the interviews and the focus groups, this reminded the researcher on the happenings especially those that could not be captured by the audio recorder.

- **Focus group discussions**

The focus group is a method of data collection in which a moderator/facilitator (usually a core searcher) speaks with a group of 6–12 participants about issues related to the research question (Barrett &Twycross, 2018). As an approach, the focus group offered the researcher an efficient method of gathering the views of health care professionals at one time. Since the objective at hand was about challenges providing psychosocial care, discussing the same issue was discussed together and resulted in an enhanced level of debate.

An interview guide was formulated including participant’s biographic data and qualification as the focus groups were expected to be inclusive of a diversity of the health care professionals. An interview guide was provided as an (Annexure A). The questions were based on a full assessment of the patients and the holistic approach to patient care as according to the Sitzman,(2007) Watson’s theory of human caring (1988) and the theoretical appraisal and coping process of Folkman and Greer (2000) as the theories that directed the study as discussed in chapter one.

The research assistant captured facts, made notes, and recorded the proceedings on audio recorder. The researcher too kept the field notes and were compared and merged with the ones kept by the research assistant in analysis and transcribing the data. The use of in-depth face to face interviews in phase 1 (a) were to explore the care and psychosocial support needs of the patient participants required at the hospitals for their quality care.

2.8. PLAN FOR DATA MANAGEMENT AND ANALYSIS

The collected data on interviews was kept away from the persons not involved in the study and kept locked. And the audio recorder was played by the researcher alone during transcription and shared with the promoter of the study. The focus group information was audio recorded and important information scribbled alongside the interview guide. No persons that are not involved in the data analysis shall gain access to the data.

2.8.1 Data analysis

Data analysis is the process of bringing order, structure and meaning of the collected data (Brink et al., 2018). It was important to do the analysis of both data from the interviews and the focus groups to draw a conclusion that was encouraging and informing the development of the strategies that will improve the cancer care and support services in Limpopo hospitals.

The researcher used a Tesch's thematic analytical approach in discussing of the data.

- **Becoming familiar with the data**

The researcher was familiarised with the depth and breadth of the content data, read through the entire data set from the focus group with the health care professional's discussions and the in-depth interviews with the patient participants before the coding as ideas, identification of possible patterns was shaped as the researcher was reading through (Brink et al., 2018).

- **Transcription of verbal data**

Transcription of verbal data informs the early stages of analysis. The researcher developed a far more understanding of the data through transcription. A close attention was paid in transcribing data and interpretative skills were employed to analyse the data.

- **Generating initial codes**

The data was initially coded and collated, a long list of the different codes was identified across the data, and codes were sorted into themes. (Brink et al., 2018). The themes and subthemes derived from the data are presented in the following chapter.

- **Searching for themes**

The data was initially coded and collated, and there was a long list of different codes to be identified across the data set. This phase, re -focuses the analysis on a broader level of themes, rather than codes, which involved sorting the different codes into potential themes (Brink et al., 2018).

- **Reviewing the themes**

The researcher diversified a set of candidate themes, and involved the refinement of those themes, during this phase, it became evident that some candidate themes are not themes while others collapsed into each other. Other themes were broken down into separate themes (Brink et al., 2018).

- **Defining and naming themes**

The researcher had a satisfactory thematic map of the data, the researcher further refined the themes and presented them for further analysis by identifying the essence of what each theme is about and determining what aspects of the data each theme captures. Names were given to each theme.

- **Producing the report**

The analysis provided a concise coherent, non-repetitive and interesting account of the study (Brink et al., 2018). The write-up must provide sufficient evidence of the themes and subthemes within the data which will be discussed in detail in chapter 3.

2.9. MEASURES TO ENSURE TRUSTWORTHINESS

Trustworthiness or rigor of a study refers to the degree of confidence in data, interpretation, and methods used to ensure the quality of a study (Pilot & Beck, 2014). In each study, researchers should establish the protocols and procedures necessary for a study to be considered worthy of consideration by readers (Amankwaa, 2016; Connelly, 2016). Ensuring trustworthiness entails taking measures to make sure that the research findings are worth paying attention to and taken into consideration. It is especially important to note that the researcher was the instrument of data collection and analysis, therefore the truthfulness and accuracy of the data was based on the interpretations of the researcher. The researcher ensured that the data collected was accurate and that she made the right representation and interpretation. To ensure that the findings of this study are a true reflection of patient participant’s needs of care and psychosocial support needs, the criteria that was used for developing trustworthiness of this study include credibility, dependability, conformability, and transferability. The researcher used the following criteria of Lincoln and Guba (2003) to ensure trustworthiness. These criteria include credibility, dependability, confirmability, and transferability; they later added authenticity (Guba & Lincoln, 2003).Data collected will be kept safe for a period of five years.

2.9.1 Credibility to ensure truth value.

Credibility alludes to confidence in the truth of the data and interpretation thereof (Brink, et al, 2018). Credibility of the study, or the confidence in the truth of the study and therefore the findings, is the most important criterion (Polit & Beck, 2014) Truth value is a criterion that explains how one can establish confidence in the truth of the findings of an enquiry. The researcher used the strategy of credibility to ensure that the findings of this study reflect the psychosocial care needs of the cancer patients.

- **Prolonged Engagement**

The researcher engaged with the participants longer during recruitment, consenting and data collection. The participants expressed their need for their psychosocial care needs and the challenges of the health workers in providing care and support freely and without fear, the researcher established a relationship of trust with the participants to relate their needs and challenges without fear of intimidation. The researcher engaged with the participants as she introduces herself as a student researcher that required patients to participate in the study. The researcher involved the participants by giving them an information sheet during the signing of the consent form and then discussed the interview time and focus group. The researcher believes that with the number of engagements the researcher planned to have with the participants was enough for them to ensure a trusting relationship.

- **Triangulation**

Triangulation in this study was done by asking diverse questions, seeking different sources, and using different methods (Brink, van der Walt & van Rensburg, 2018). In-depth interviews of the research participants, direct observation of the patient participants narrating their care and psychosocial support needs. The health care professionals narrated their challenges in providing care and support, use of an audiotape recorder and contacts with the research supervisor and co-supervisor enhanced the trustworthiness during the initial stages of data collection and data analysis to ensure the truth value of the data collection and analysis**.**

- **Member checking**

Member checking was done by providing feedback to the participants after the interviews to ensure that the researcher has captured the true meaning of the patient participants' care and support needs and the challenges experienced by the health care professionals in their provisioning of care and support needs of the cancer patients to allow validation by the participants (Brink, van der Walt & van Rensburg, 2018). This strengthened the trusting relationship the researcher had built with participants and allowed the researcher to rectify mistakes in the data captured.

- **Referential adequacy**

The researcher kept field notes written about everything that was happening during interviews and all non-verbal gestures noted. The notes kept by the research assistant were also used to compare with the researchers to verify the observations. An audio recorder was used to capture all information during interviews. This allowed the researcher to provide the best description as narrated by the participant. Verbatim transcription of the recorded information was done.

- **Peer debriefing**

Discussion of the findings was done with colleagues of similar educational level at the university's peer review forum (Brink, van der Walt & van Rensburg, 2018). Peer review was done to check information gathered and how the researcher had analysed the information. An independent coder was asked to analyse the information. Data and method of analysis was discussed with promoters who have an interest in the subject matter but neutral.

2.9.2. Consistency to ensure dependability.

Dependability refers to the provision of evidence such that, if it were to be repeated in the same setting or similar participants in a similar context, the findings would be similar (Brink, et al, 2018). Methodology used in this study was described in full by the researcher. The proposal was presented for peer review and methodology was clearly described. The researcher provided a dense description of the method and steps employed in this study.

2.9.3. Neutrality to ensure conformability.

Conformability means answering a question, on how the researcher will ensure that the findings will be reflecting the participants' voices in the interview rather than using the researcher's biases (Brink, et al, 2018). This will clearly indicate that findings are the product of concern, and the focus of the interview will not be biased by the researcher.

The researcher followed research methods following previous studies on how others conducted their own. The researcher examined and identified herself to avoid being biased. The researcher was the only investigator, asked the supervisor and the co-supervisor to be involved in the research from the initial planning phase until the final report. An independent coder was invited to validate and confirm the study findings.

8.9.4. Applicability to ensure transferability.

Applicability refers to the ability to apply the findings in other contexts and settings or to other participants (Brink et al., 2018). The strategy for establishing applicability is transferability. This consists of the nominated data, sampling, dense description of the results and direct quotations of the study participants. Transferability was ensured by presenting dense descriptive of data that allows comparison**.**

9. ETHICAL CONSIDERATIONS

Ethics is a set of moral principles that are suggested by individual persons or a group of people (de Vos et al., 2011) Ethical principles relating to human participant protection played an important part in this study. A code of ethics in qualitative research that involves moral decision was considered by the researcher throughout the process of the study.

Permission to conduct the study.

The proposal was presented before the University Research Ethics Committee and the University Higher Degrees Committee. An ethical clearance to conduct the study was granted by the University of Venda Research Ethics Committee (UREC) with project number (SHS//18/PDC/25/0812).

Permission to conduct the research was obtained from the Limpopo Provincial Ethical Research Committee, Chief Executive Officers (CEO) Nursing Service Managers and health care professionals (Nurses, Social workers, psychologist, oncologist of different hospitals and the nursing management of the relevant hospitals. The following ethical measures were considered:

- **Respect for human rights/protection from discomfort**

The right to protection from discomfort and harm is based on the ethical principle of beneficence, which holds that one should do good and, above all, no harm to the study participants. The researcher ensured that participants are comfortable by selecting suitable venues, times, and days to participate in the research. The researcher guarded against embarrassing the participants during the interviews. Questions and probes were considerate. The researcher ensured that participants do not incur any financial loss by participating in the research by travelling to the settings. During the interview, participants were promptly observed for any type of discomfort, there was no form of discomfort observed during the focus groups and the face-to-face in-depth interviews, and participant’s needs were provided for.

- **Permission to conduct study**

Ethical clearance to conduct the study requested and obtained from the University of Venda higher degrees and ethics committee. After the approval of the proposal, permission was obtained from the department of health in Limpopo, the hospitals where data was collected and from the study participants.

- **Right to self-determination and justice**

The right to self-determination is based on the principle of respect for the subjects. The researcher treated the participants as autonomous beings with freedom to conduct their lives as they wish. The researcher informed the participants about the proposed study, allowed them to choose voluntarily to participate in the research and to withdraw from the study at any time they find it necessary. The researcher did not violate the participant's rights of self-determination by coercing them to participate in the research, covert data collection and deception.

- **Informed consent**

Informed consent refers to the provision of full information about the study process to the participants so that they have more information on the right to voluntary participation or not to participate. An information sheet was prepared for the participants to take an informed decision including information about the study, the processes of the participation, the purpose of the study, the benefits of the study and assurance of anonymity and confidentiality. Written informed consent (Annexure B) was obtained from the participants voluntarily without duress, coercion, or bribery.

- **Freedom from Exploitation/Right to Fair Treatment**

The right to fair treatment is based on the ethical principle of justice, which is grounded on the ethical principle of justice, which asserts that each person should be treated fairly (Brink et al., 2018). The researcher ensured that the participants are fairly selected as outlined in the sampling criteria. The roles of the researcher and that of the participants was thoroughly explained in the study and on the information sheet (Annexure C) accompanying the consent form. The researcher avoided inflicting psychological harm to the participants by carefully considering the phrasing of questions.

- **Confidentiality**

Confidentiality is related to the researcher's management of private information shared by the participants, information must not be shared with others without expressed authorisation of the research participants (Brink et al., 2018). The researcher has not allowed other health professionals or unauthorised persons access to raw data of the study. In this study, confidentiality was maintained by using numbers instead of names. The data collected was not related to participants' names. The data collected was kept in a safe place and can only be revealed to the study supervisor if requested. Permission to share the data with the supervisors was obtained from the study participants as the researcher has informed them that she is a student under supervision.

- **Right to Privacy**

Privacy refers to the extent that a participant is prepared to share personal information or withhold it from others (Brink et al, 2018). Private information of the participants was not shared with other participants. The researcher ensured that the participants do not lose their dignity, friendships, or employment. The researcher ensured that the self-respect and dignity of the participants was maintained throughout the study. The researcher conducted the study in a non-judgemental manner. Anonymity was used in the raw data and no names were recorded. Voluntary participation was upheld. Participants were regarded as autonomous, with the right to make choices without intimidation or being forced. Participants were informed of their right to terminate or withdraw their participation any time in the study despite having provided prior consent to participate, without suffering any negative consequences or victimisation whatsoever.

10. PHASE 2: STRATEGY DEVELOPMENT

A strategy was developed after data analysis and interpretation based on the findings to deliver quality cancer care services. From the analysis of data and results the researcher developed strategies that may facilitate implementation of the strategies during the psychosocial care and support of the cancer.

11. PHASE 3: VALIDATION OF METHODOLOGY

Validation is described as a scientific process where collected and analysed data is checked for accuracy. The method emphasises on structuring group communication processes systematically to achieve a reasonable convergence of opinion from a group of experts (Linstone & Turoff, 2011; Gupta & Clarke, 1996) the main purpose of validating the results is to provide evidence of the effectiveness of the strategies which were developed. In this study the objectives of the used method were to validate if the results are a true reflection of the study or not.

Validation through e-Delphi- Technique was used to gain consensus among a group of experts or informed respondents. The e-Delphi panel validation and verification ensured whether the assumptions that have been made are reasonable concerning the real fragments. The draft strategies were sent to experts in medical field to comment on the proposed strategy document to assist in reaching the consensus. A mini-Delphi type of Delphi was chosen as the number of professionals and experts are not many in the province. The participant was recruited based on the participants' knowledge in cancer services and psychosocial care and support for patients and have an interest in the outcome of the study and encourage thoughtful response to limit attrition. Participants are selected through non-probability sampling techniques to save resources and ensure appropriate participants are selected.

The first round of the Delphi technique involved participants providing answers to the research question, which was ranked in future rounds. In subsequent rounds, participants were asked to respond to the analyzed options from round one. Between rounds the group's responses are analyzed, summarized, and communicated back to the participants, a process called controlled feedback. Subsequent rounds were analyzed to identify convergence of participant responses, and to provide controlled feedback. These results were fed back to participants in the next round, although no consistent method for reporting exists was followed.

12. CONCLUSION

In this chapter the research design and methodology used in this study were outlined. Three phases were used, which included phase 1 qualitative, phase 2 strategy development and phase 3 validation of a developed strategy using Delphi technique (consensus method). Qualitative data collection and data analysis were conducted in phase 1 (a) and (b) of which the results were used to guide phase 2 for strategy development. Chapter 3 presents the themes and sub-themes data and the literature control to validate the findings.

CHAPTER 3

PRESENTATION AND DISCUSSION OF THE FINDINGS

3.1 Introduction

The previous chapter outlined the research process and the method used for data collection. This chapter presents the findings that have addressed the objectives of the study. The data was collected qualitatively from two sets of participants. The first participants were the health care professionals that were engaged in focus group discussions. The question that directed the focus group discussions followed by the probes was: “What challenges you experience as health care professionals in rendering care and psychosocial support for the cancer patients in the hospitals”. The discussions lasted for (45) forty-five to (60 minutes) an hour. Five (5) focus group discussions were conducted at the selected hospitals. The data was analysed using the eight steps of Tesch’s method inductively and open coding technique. Five (5) themes were generated and (16) sub-themes from the focus discussions presented in the table in this chapter.

In -depth face to face interviews were conducted on the second set of participants were the cancer patients that have been on cancer care at the hospitals for a year or more. The question that directed the interviews was: “What are the care and psychosocial support needs you expect from the health care professionals at the hospitals”. The interviews lasted for (30) thirty to (45) forty-five minutes each. The data was audio-recorded and transcribed, analysed using Tesch’s open coded method. Four (5) themes and ten (10) sub-themes emerged from the face-to-face interviews. Both interviews and focus group themes and sub- themes are presented separately and supported by literature and the theoretical framework to analyse, critique, and support the study findings. The discussion on the convergence of both the results is presented to indicate the similarities and the contrasts in both the findings.

Table3.1: Demographic profile of participants in the focus groups

Hospital	**No of participants**	**Age**	**Occupation**	**Years of experience**	**Gender**
Hospital A	4	28	1 Doctor	2	M
		32	1 professional nurses	7	F
		54	1 professional nurse	12	F
Hospital B	5	45	1 professional nurses	19	F
		33	1 professional nurses	10	F
		30	1 social worker	7	F
		32	1social worker	5	M
		54	1 oncology trained nurse	17	F
Hospital C	5	57	1 professional nurses	24	F
		59	1 professional nurse	26	F
		48	1 oncology trained nurse	18	M
		30	1 social worker	8	F
		33	1 doctor	3	M
Hospital D	4	47	1 professional nurses	7	F
		39	1 professional nurses	12	F
		55	1 professional nurses	24	F
Hospital E	6	38	1 professional nurses	12	F
		36	1 professional nurses	15	M
		52	1 professional nurses	22	F
		7	1 doctor	6	F

		33	1 social worker	4	F
		31	1 psychologist	3	F

For clarity, the following abbreviations will be used to signify participants: D-doctor; P-psychologist; SW- social worker; PN- Professional nurse, and ON- Oncology nurse.

3.2. PRESENTATION OF THE FOCUS GROUPS DISCUSSIONS

The following section provides an overview of the results based on themes and sub-themes that emerged from the analysis of the focus group interview transcripts and field notes gathered to gain an understanding of the challenges experienced by the health care professionals in the provisioning of psychosocial care and support for the cancer patients in the hospitals in Limpopo.

The themes are supported by verbatim quotations from participants which are written in italic and indicate the gender, age, and occupation of the participant. The following five (5) themes and sub-themes emerged. The findings of the focus group discussions are presented in the table: 3.2.

Table3.2: Thematic Presentation of findings of focus groups discussions Source: author's own work.

HEALTH CARE PROFESSIONALS	**THEME**	**SUB-THEMES**
	3.2.1.Shortfalls of human resource in oncology care.	3.2.1.1 Lack of skilled health professionals 3.2.1.2. Overwork of the available personnel 3.2.1.3. Rotation and allocation of the available personnel
	3.2.2Poor patient administration and support in cancer services	3.2.2.1. Delays in the diagnosis. 3.2.2.2. No reports on follow up of the patients. 3.2.2.3. No available staff to navigate patients to the treatment centres. 3..2.2.4. Losing patients along with the transfers

	3.2.3 Poor co-ordination of cancer care services	3.2.3.1 Loss of patient files and laboratory results 3.2.3.2 Lack of cancer policy guidelines/protocols 3.2.3.3. Inadequate and inefficient collaborative support in cancer care
	3.2.4. Concerns relating to conflicting values and norms	3.2.4.1 Failure to appreciate indigenous knowledge system. 3.2.4.2 Factors contributing to delayed treatment and diagnosis. 3.2.4.1 Use of traditional healers
	3.2.5. Concerns with disclosure of their diagnosis.	3.2.5.1 Concealed emotions and fear of death 3.2.5.2. Failure to disclose diagnosis and concerns to caregivers.
	3.2.6. Observance of maladaptive personality traits affecting mental health-related quality of life	3.2.6.1. Depression and denial of the physical illness

The health care professionals are aware of the challenges that they have in the provisioning of the psychosocial care and support of the cancer patients. Their main concerns were the shortage of skilled health care professionals and the poor patient administration emanating from maladministration and lack of policy and guidelines in cancer care. Their perception on improving cancer care is that improvement is possible with the strategies that are to be developed. They believe is that it will be a guide on how to deal with the challenges and that they will communicate better as a team of health professionals in cancer care. Six themes immerged from the focus group discussions with the health care professionals as discussed below.

3.2.1. THEME1: Participants expressed shortfalls of human resource in oncology care.

3.2.1.1. Lack of skilled health professionals

3.2.1. Shortfalls of human resource in oncology care.	3.2.1.1 lack of skilled health professionals 3.2.1.2. overwork of the available personnel 3.2.1.3. rotation and allocation of the available personnel

Cancer management requires different health professionals, cancer disease makes the whole person to suffer physically, psychologically, emotionally, and spiritually. Such requires multidisciplinary team to be able to support all the spheres and care of the cancer patients. The availability and the sufficient health workers, with the relevant competencies and skill enhances the provisioning of quality health care for the needs of the cancer community.

The subthemes that emerged from the theme above are lack of skilled health professionals, overwork of the available personnel and rotation and allocation of the available personnel. The subthemes will be discussed here below.

3.2.1.2. Lack of skilled health professionals

Skills needed to manage oncology patients need to be learned and developed over time to gain experiences to deal with complex challenges brought about by being diagnosed with cancer. World Health Organisation (WHO, 2014) has indicated that the chronic under-investment in education and training of health workers in some countries and the mismatch between education and employment strategies about health systems and population needs are contributing to continuous shortages. These are compounded by difficulties in deploying health workers to rural, remote, and under-served areas. Moreover, the increasing international migration of health workers may exacerbate health workforce shortfalls, particularly in low- and lower-middle-income countries.

The participants expressed their concerns regarding the need for a skilled multidisciplinary team. Hereunder are the verbal quotes of what they had to say:

A participant in the FGD # B shared her challenges this way*:*

> *"I am supposed to know what to do with the cancer patients when they are in the wards, but I hardly know the protocols and how to address their challenges. I rely mostly on my colleague who is oncology trained, they are only two at the hospital and are not always available, in the wards we treat them like any other ill patient, in terms of psychosocial support we rely on sending the patients to the social services if there is a need." [Female, 33yrs, P/N].*

The participant implied that she does not have enough information on psychosocial care needs of the cancer patients and as such it is a challenge to her when she must support the patients referred.

The same participant indicated that**:**

> *"When patients are referred to the social services they are supposed to be discharged and come back some other time for the service due to long queues as the social services are for all the patients in the hospital and they are only one or two in the hospital at a time. Sometimes patients are referred to their community social worker and never keep the appointments." [Female, 33yrs, P/N].*

The participant implied that there are fewer social workers to deal with patients' needs when the patients are still in hospital and that there is a long waiting list for the patients to see a social worker.

The participant in the same FGD#D shared the need for the skills:

> *"I have realised the need to be able to communicate to the cancer patients about their plight and psychosocial care needs, most important knowledge and education on cancer care to improve my relationship with them." [Female 30yrs, SW].*

Social worker implied that they do not have enough knowledge and skills to satisfy the psychosocial care and support needs of the cancer patients.

A participant in FGD #C indicated her frustration regarding her colleagues:

> *“Some nurses in the wards and in out -patients’ department do not make an effort in assisting the cancer patients, once they establish that the patient is attending cancer clinic they just straight away send the patient to the oncology office and not assist, sometimes patient need to wait for a long time before seeing the oncology nurse, when engaged in the discussion about the patients, they claim to have no knowledge of cancer care*” {Female, 39yrs P/N}.

Participant implied that the nurses that are not working in the oncology section feel inadequate in the management of psychosocial care and support of the cancer patients and do not want to get involved as such they shift patients to the oncology section without an effort of trying to assist.

The world population reached 7.8 billion in 2020, tripling since 1950, and is expected to grow further in the next few decades. Population size, age structure, and geospatial distribution have changed over time and across regions and countries and will change further. These changes pose challenges and opportunities for providing essential health services. Future health programming the process of selecting interventions to improve health in a target population must consider demographic changes, including overall population trends and urbanisation, as they will contribute to health service needs. (You, Beise, Lee, Requejo, and Strong, 2021).

Cancer is the leading cause of death in Asian Americans, who face cancers endemic to their native countries, perhaps because of infectious and cultural factors, as well as those faced by all Americans, perhaps because of westernisation in terms of diet and lifestyle. Despite the mortality rates, Asian Americans have less cancer screening than other Americans. This review highlights the need to educate Asian Americans to improve cancer literacy and health care providers to understand the important cancer risks of the fastest-growing racial/ethnic group in the U.S. Eliminating disparities is critical to achieving an equitable society for all Americans. (Adams, Rauw, Weller, Campbell, Pollock, and Goulart, 2021)

This however is the same in South Africa, the growing population and longevity poses a threat in the availability of available resources for cancer care. The treatment modalities available are sustaining the survivors of cancer patients and as such there is need for more professionals to care for the cancer patients.

3.2.1.3. Overwork of the available personnel

The hospitals are having a dire shortage of professionals let alone the specialised personnel like oncologists, psychologists, social workers, and the facilities important for general patients' care. Cancer care is physically and psychologically challenging both for care recipients and caregivers. Shortage of staff is jeopardising efforts to meet the Sustainable Development Goal of health for all by 2030, a pledge made by the international community in 2015. There is a need to raise number of nurses by at least six million by 2030.Currently, 80 per cent of world's nurses only serve 50 per cent of world's population (Baron, 2020).

A participant in FGD# B indicated the following:

"it is so challenging to deal with all the patients available, at our hospital there is no psychologists, as nurses you have to make sure you do patient and family care and counselling" {Female 33yrs}.

One other participant in the same focus group indicated that*:*

"The nurses are so overworked that they fall sick in the wards and are getting sick and often booked for long sick leave and as such those remaining in force with the load of work cannot cope with" [Female, 57yrs, P/N].

The participant implies that nurses are working excessively long hours. Overwork leads to fatigue and fatigue leads to greater chances of mistakes. Excessive overtime has been shown to impact negatively on patient care and increase the risk of fatigue which includes desensitisation and loss of empathy.

A participant in FGD #C indicated concerns in failing to secure appointments for continuity of care:

> **“***As a social worker, I sometime wish to follow up on some patients that I see, go to their home establish a relationship to be able to know of their social environment to make certain recommendations for financing and social support, there is no time to do so, transport to do the tasks has to be ordered or requested from the pool of vehicles in the hospital at least two days before, when an emergency occurs transport is prioritised for other services, sometimes there are meetings that were not planned and you miss patients appointments that you have scheduled. It is very disappointing to the patients and makes you inefficient and challenged*” [Female, 30years, SW].

The participant implied that the shortage they have in the social services prevents them to do social visits for the patients they see in the hospital so that they can be able to deal with each case on its merit. The participant further implied that the lack of transport is also a challenge to the social services as some patients stay far and transport is to be shared.

A participant in FGD #B indicated the following with sadness:

> *“I wish there could be four of us in the oncology service, there is so much to do, meeting patients ‘needs, doing pap smears, counselling arranging for transfers and transfer staff, briefing the available relatives and counselling patients and clients. I am not coping at all with the workload. The problem is that the hospital managers are also saying they are challenged by the shortage in other hospital units*” [Female, 45 years, P/N].

The participant implied that the workforce shortage in the oncology service at the hospitals prevents her from doing well in terms of psychosocial support for the patients because patients are many and with so many activities that should be done for the patients and does not get assistance from the hospital managers.

A psychologist in FGD #C expressed her dissatisfaction that:

> “Due to lack of satisfaction on the job in the government sector, our colleagues are resigning for better jobs, in the private sector, and there seem not to be an improvement in the work for us psychologists’ and yet we have so much to

> contribute to the quality of life of our patients that need psychosocial support” [Female, 57yrs, P/N]

Participants implied that their colleagues are resigning from the public sector to less stressful and well-paying jobs which then lead to their dire shortages experienced by the hospitals. South Africa has lost staff in health care services to countries like Dubai due to their comparative high remuneration packages in the last decades and that have crippled the health care and affected the quality of health of the consumers.

Tralongo, Gebbia, Mercadante, Bordonaro, Ferraù, Barni, and Firenze, (2021) has indicated that over the last few decades, early detection, effective drugs, and personalized treatments, the natural history of cancer has radically changed due to these advances, it has been observed how survival of cancer patients has increased, becoming an ever more important goal in cancer care. Effective clinical governance of survivorship care is essential to ensure a successful transition between active and post-treatment life, identifying optimization of healthcare outcomes and quality of life for patients as the primary objectives. For these reasons, potential intervention models must consider these differences to rationalize the available resources, including economic aspects. In this perspective, trained health professional, also focused on longevity, could represent the right management solution in all those intermediate clinical conditions that arise between the hospital specialist, frequently overworked, and the general practitioner, often biased by the lack of specific expertise.

3.2.1.4. Rotation and allocation of the available personnel

The rotation process or employee rotation is a managerial tool with the objective of enabling the worker to work in different jobs. This practice consists of a systematized rotation with previously defined objectives and scheduling among those involved in the process.

The participant expressed dissatisfaction with the policy of staff rotation and allocation, that when you are beginning to adjust and learning they rotate you, and oncology clinical exposure is not sufficient. It is this issue that kills staff morale and undermines the services growth.

A nurse participant complained in FGD# B a professional nurse.

> *"Much as I want to stay with the oncology unit to learn and assist patients, I am not able as the other services also require professional nurses, I am not trained in oncology nursing as such, I will only be able to get allocation when my term comes for exposure before training as an oncology nurse and offered an approved study*" (Female 36 years, P/N).

Another Participant further reiterated her dissatisfaction in FGD: #B.

> *"Some staff members have studied oncology privately at universities but not recognised, not allocated to assist in oncology care as there are no posts for them, some are allocated in maternity ward and in the rest of the hospital for other responsibilities, these are nurses that can be assisting in the cancer services, unfortunately their speciality is not recognised and are not paid as specialist nurses in oncology, they end up going for much needed specialities like advanced midwifery and others" [*Female, 33 years, P/N].

The participants implied that even if you find nurses interested in oncology services they are rotated to other units as deemed fit by the allocation and are not retained in oncology because of lack of qualification. Participants further expressed poor recognition of additional qualifications of self-trained nurses by management and placement concerns. Training and staff development in Limpopo is only done when there is a post to be filled and is then that a study leave is granted. Those who empower themselves through private studies are not acknowledged and remain demotivated.

According to Fagan, Noronha, and Graboyes, (2021) Leading health ethicists and other professionals have already penned articles addressing the remerging dilemmas regarding the allocation of scarce life-saving resources accounting for existing legal literature and critical thinking about allocation methods and benefiting from their accumulated wisdom. They lacked a broader interdisciplinary perspective.

Availability of enough health care professionals in cancer care may reduce the possibility of staff shifting and allocation especially in the era of Covid -19 where most available personnel is shifted to manage the pandemic with little or minimum staff to care for the cancer patients and other chronic illnesses.

3.2.2. THEME 2: POOR PATIENT AND ADMINISTRATION SUPPORT IN CANCER SERVICES.

3.2.2.1. Delays in the diagnosis

3.2.2 Poor patient administration and support in cancer services	3.2.2.1. Delays in the diagnosis. 3.2.2.2. No reports on follow up of the patients. 3.2.2.3. No available staff to navigate patients to the treatment centres. 3.2.2.4. Losing patients along with the transfers

Administration and proper management of cancer patients makes life easier for the patients. It allays patient's anxiety, reassures the patients, and reduces uncertainties the patient's experiences due to the cancer diagnosis. When patients submit themselves to the health care professionals, they are having expectations of being alleviated off their issues especially the psychological burden thereof. Maphumulo & Bhengu (2019) indicated that there are many quality improvements programmes that had been initiated, adapted, modified, and then tested but did not produce the required level of quality service delivery as desired. Such as procedures for intra-departmental transfers and hospital transfers. Therefore, the Government of South Africa has a challenge to ensure that implementation of National Core Standards to deliver the desired health outcomes, because achieving a lasting quality improvement system in health care seems to be a difficult challenge.

The participants have a perception that the patients are coming to the hospital late and the processes of finding a diagnosis also take time and delay patient to find treatment, the themes that emerged are delays in the diagnosis, no reports on follow up of the patients, no available staff to navigate patients to the treatment centres and losing patients along with the transfers. The subthemes are discussed here below.

3.2.2.1. Delays in the diagnosis

Patients in the community are not well informed about cancers, even if they anticipate a symptom that may be cancer related, they are either in denial or are negligent and present themselves late to the hospitals with advanced cancers that become very difficult to treat. Patients present more quickly when their symptoms are more serious and perceived to be more serious, including the presence of pain or bleeding. The participants in this study have indicated that when patients are diagnosed late, there is no more time for the patient to be thoroughly engaged and supported in choosing what is to happen, they are hurried through the processes to get treatment as such they are stressed by the diagnosis, treatment and they get less or no social support.

The health workers in FGD #D expressed this as a challenge:

> *"The patients are not coming to the hospital as they identify changes in their bodies, some are too busy to come to the hospital, and some are not able to identify the signs earlier*" [Female, 36years, SW].

Another participant in FGD #D further explained the challenge that:

> *"In my community patients rely mostly on the faith healers and the traditional healers before they can come to the hospital".* [Female 39 years old P/N].

Participants implied that it is easy for communities to look for support within their traditional people and old traditional remedies before submitting to the hospitals were, they find no comfort when thinking of the queues and the people they do not know as such they delay coming for treatment. That contribute a lot to the delay in their submission for diagnosis and treatment as they are not able to identify common cancer symptoms.

There is a need to curb late diagnosis and improve health outcomes in cancer morbidity in the rural communities. When patients are consulting at the clinics, a thorough history taking and examination to exclude cancer and other comorbidities should be done, there should be no misses opportunities in the clinics to educate and screen the patients considered to be at risk.

A participant in the FGD #E suggested the following:

> "*It is important that the campaigns to create awareness should be intensified, not to wait for the cancer awareness dates on the health calendar, it should be in all available opportunities and gatherings*" [Female, 38 years, P/N].

Participants implied that their urgent strategies are needed to increase public awareness on cancer, symptoms, and signs and when, where, and how to get assistance.

Gathani, Clayton, MacInnes, and Horgan, (2021) has indicated that In March 2020, a directive was issued to all NHS providers to reconfigure services to manage the anticipated first wave of COVID-19 patients. Although cancer services were instructed to continue, the imposition of the national lockdown on 23 March 2020, which advised all citizens to stay at home except for exceptional reasons, understandably resulted in a reduction in the numbers of patients accessing healthcare, either through primary care or screening, as patients chose not to present for medical assessment and breast screening units suspended the issuing of routine invitations to reduce footfall in hospitals.

Patients with cancer were not navigated to other hospitals due to the restrictions that hindered patients from getting screened and finding their results early resulting in late resumption of treatment.

3.2.2.2 No reports on follow- up of the cancer patients from treatment centres

Patients are shared between the primary hospitals and the tertiary hospitals, sometimes patients never bring reports to the referring hospital to continue managing the patients as such patients are lost within the system and no follow up is done. It contributes to the patients defaulting treatment and ultimately disappearing from the system. -

A participant in FGD #D indicated the following:

> "*It is important for the reports to be send back to the referring hospital with the advice on how to continue with the treatment of the patient, patients' default, and you meet them after a long time in a devastating condition after months of defaulting"* [Female, 39 years, P/N].

It is evident from the participants' discussion in this focus group that they all believe that new diagnosis of cancer needs to be followed up to appraise their stress and coping behaviour to be able to be assisted, within the understanding of their framework, the assessment of the patients cognitive and behavioural coping strategies that can greatly assist the health care professionals in making clinical assessment regarding their coping strategies and the relieve of stress. If there is adequate communique amongst both the specialists, there system would reduce defaulting treatment on the part of the patients.

3.2.2.3 No available staff to navigate cancer patients to the treatment centres.

Navigating cancer is focused on enabling personalized cancer care for every patient. It provides a single, coordinated platform to deliver comprehensive cancer care for cancer patients.

Health care professional FGD # B spoke about the challenge of navigation this way***:***

> *"We nurses are so short staffed, you find a patient who is supposed to go for the first time transferred along with other patients who are going to other specialists, and all are allocated only one nurse that knows nothing about the patients*" [Female, 33 years, P/N]

The other participant said in the same FGD#B:

"Patients get emotionally and physically affected being tossed between care-providers" [Female, 30 years, SW].

The need to self -navigate the cancer patients is high but due to the shortage and transfer policies in the hospitals as they are unable to leave the services and accompany their first-time patients for transfer. Barsom, Jansen, Tanis, van de Ven, van Oud-Alblas, Buskens, Bemelman, and Schijven (2021) indicated that in the Netherlands, medical care requiring specialist expertise is more and more concentrated in centres of excellence as a consequence, the travelling distance to the hospital for patients and relatives is increased .Travelling to the surgical oncology outpatient clinic in the post-operative care trajectory, particularly if not (yet) fully recovered, is physically demanding, costly and time consuming. To overcome unnecessary travelling while preserving the benefits from face-to-face specialist interaction, video consultation (VC) might be an option for many surgical patient in the post-operative surgical care trajectory .The use of video for interaction allows patients to speak and see their caregiver whilst being in the comfort of their own home or workplace Reported benefits are improved access to healthcare for patients with impaired mobility and enhanced access to care for other informal caregivers, while reducing traveling time and traveling costs preserving patient satisfaction (Barsom, et al 2011).This is unfortunately not possible in Limpopo as most of the patients are not learned and lack the advance technology equipment's to can be consulted online.

3.2.3. THEME 3: Poor coordination of cancer care services

3.2.3 Poor co-ordination of cancer care services	3.2.3.1 Loss of patient files and laboratory results 3.2.3.2 Lack of cancer policy guidelines/protocols 3.2.3.3. Inadequate and inefficient collaborative support in cancer care

There is a need for improved health care about the role of intra sectorial collaboration in the cancer treatment and the need for increased access to treatment centres and cancer services in rural and regional centres.

3.2.3.1 Loss of patient files and laboratory results

Computerized Health Information system affords health services efficiency of its patient's information; however, hospitals in Limpopo are practicing hospital retained patient's record systems and majority have no computerised patient records. Manual capturing and storage of hard copies delays retrieving file, delays flow regarding patients' medical needs and follow up on the result and X-rays. Patients' records are also used daily to further record information about the patients' personal details, prescriptions, and diagnosis for future reference and for follow-up patients. The information recorded is eventually used to confirm the patients' health history during current and future consultations.

A health worker spoke of records getting lost this way FGD: #B.

> *"Patient's records are very important and create confusion if they are lost at the central file rooms, no one can be held responsible for the loss, by the time the patient finds the file it is too late, the doctor or the health professional is gone or the patient cannot wait for interaction, either due to transport or other social commitments beyond their control*" [Female, 54 years, P/N].

The participant further indicated that:

> "*Some patients are given reports from one therapist to the other and unfortunately they lose them before their appointments with the other health care provider*". [Female, 54 years, P/N].

Another participant indicated that: FGD#C.

> "*The notes of the sickness and those of the social workers do not need to mix, as such in her office she keeps a summary of what she discusses with the patients as they come always with a new file"* [Female,30 years old SW].

Participants implies that the missing files contribute to the length of time patients wait to be assisted. Thus, nurses and doctors are unable to assist patients or treat them immediately. The introduction of an electronic records management system that can capture and provide access to a full patient record, as well as tracking paper records movement, irrespective of the location is necessary. Paper-based patient records have a potential to negatively impact the quality of care that a patient receives and impact on the information continuity. Other issues that paper-based health records present, include unclear handwriting, incomplete or inaccurate information and inaccessibility of health records from different locations which then expose patients to medical mistakes because healthcare providers would not be able to draw a connection between current and past medical history.

Ochoa, Toledo, Iyawe-Parsons, Navarro, and Farias, (2021) in a study on black patient experiences with care indicated that communication is needed to bring these into the equation of decision making. Integrating social and financial support systems can improve compliance and therefore indirectly improve outcomes. Navigating patients is what the patient participants and health worker participants felt could be a solution and the computerised records can ease follow-up care. Emerging themes that influenced patient ratings were perceptions about their interaction with medical providers, physician communication, the doctor's expertise, and aspects of the physical facilities. Global ratings of care measures were widely influenced by patient interactions with their providers that were empathetic, non-discriminatory, and where the doctors addressed all concerns.

3.2.3.2. Lack of cancer care policy guidelines/protocols

Guidelines and protocol shave an influence on patient and professional behaviour, and consequently contribute to delays in cancer diagnosis and poorer cancer outcomes in some countries, include centralisation of services, free movement of patients between primary care providers, access to secondary care, and the existence of patient list systems. The guidelines and policies are important for the patient safety in the health care discipline resulting in preventing the rise of patient harm in health care facilities. It aims to prevent and reduce risks to the patient safety.

Participants in this study indicated that, much as they are not well informed in cancer care, they are not well informed of the policies if any exists.

A participant in FGD #C indicated the following:

> *"When I see the cancer patients, I always thought that someone will do the rest, I was only doing my part, which I think is only a part of what the patient is in need of, never crossed my mind about policies in cancer care and management" { Female,30yrs SW}*

Another participant indicated the following on protocols: FGD#B.

> *"Protocols and policies should be distributed to all in cancer care and in-service trainings would be a b better platform to teach each other about these protocols to benefit the patients". {Male 32yrs SW}*

A participant in FGD #C indicated this:

> "*Once you see a patient and order what you should, you believe that the nurses and the matrons know what protocols are to be followed, we never make a follow up, even if the patient is to be transferred it is always up to them to arrange, and we trust that they have been doing this for ages"*. {Male 33yrs Dr}

The participants in all the focus groups agreed that there is a need to curb the challenge they have of not knowing the available protocols and the need to develop the protocols that are useful to their hospitals and the type of services they provide to improve what is already in place.

World Health Organization(2020) indicated that WHO framework for strengthening and scaling-up of services for the management of invasive cervical cancer. Preventative cancer strategies, which are embedded in the targets and indicators of the WHO Global action plan for the prevention and control of noncommunicable diseases 2013–2020, are good values and good investments for health care systems . When implemented to scale with adequate coverage in a person-centred and rights-based approach, comprehensive cancer control is achieved. The availability of cancer care policies in the hospitals would direct the cancer services to a more directed service that the cancer patients need would be satisfactorily fulfilled and improve the quality of life of the cancer patients.

3.2.3.3 Inadequate and inefficient collaborative support in cancer care

Knowledge is essential in-patient care and support; it assists the professionals to be able to reach the patients in the sphere the patient is lacking. It also provides insight into the ability of the professional to identify other deviant issues in the health of the patient to provide total care. Support staff are needed in the care and psychosocial of the cancer patients, there are some who are experienced that have worked in the specialised areas of oncology. Those that work with the entire oncology team where they have been established.

Participants in the FGD #B shared this:

> *"I am very busy at the office, but since the beginning of the year I have only seen only one patient with cancer, and it was of a social reason and need for financial aid only, I did not know what else to discuss with him about his illness, I felt so dumb could not Google up in his presence, I wish we need a little orientation on cancer and other important hints on how to support and counsel them*". (Male, 32yrs SW*)*

He added by saying:

> *'I think we need to be oriented into the general needs of the cancer patients and what to assist them with as they visit our offices, maybe by workshops or constant meetings with the people directly involved in the cancer patients care*". (FGD#B, 32yrs, SW)

The participants agreed that there is a need for inter-professional collaboration in patient care so that the psychosocial care and support needs of the cancer patients can be met. Collaboration focuses on patient-centred and population-based care is consistent with today's health care environment as it provides centralized psychosocial care, increasing convenience for cancer patients. Mertens, Debrulle, Lindskog, Deliens, Deveugele, and Pype, (2021)timely and effective inter-professional information exchange was considered fundamental. A perceived barrier for interprofessional collaboration was the lack of a shared electronic health record. Efficiency regarding multidisciplinary team meetings and inter-professional communication were subject to improvement. Mertens, et al (2021) indicated that insufficient open communication of specialists towards patients and the lack of shared decision making. This not only hampered advance care planning discussions and early integration of palliative home care, but also the functioning of other professionals.

3.2.3.4 Maintenance of professional boundaries

In this study nurses who are working in the out-patient department who are not specialised in cancer care and management are not wholly involved in the quality care, they are said to be awaiting the oncology nurses to do most on the psychosocial care and support. A professional nurse in FGD #C indicated this:

> *"I feel so bad that I am not able to help as I should, the problem is that I feel inadequate, I only provide basic nursing care needs and expect the oncology nurse to do the rest, though some are trying to assist, but cancer care needs specialisation". (Female, 57yrs, P/N)*

Another participant in the same FGD#B indicated the following:

> *"Now that we have been invited to this focus group, I nurse cancer patients in the surgical wards, we nurse them for their surgical ailments, like all other patients, I feel that we have not being anything to them, but to let them die in silence, it never crossed my mind that there is a need to continuously assess their psychosocial status, never got to worry whether they have had a visitor or not". (Female, 33yrs, P/N)*

Participants indicated that even though such advanced specialized roles have been introduced in patient's care, cancer care is still being provided by non-specialized cancer nurses in the hospitals, same way as the non-cancer patients with chronic illnesses.

Goltz, Major, Goffney, Dunn, and Latini, (2021) indicated that the benefits of collaboration, for both the oncology patients and health care professionals, have included improved clinical processes, multimodal treatment, holistic care, continuity of care, collaborative decision making, and reduction in time for referral follow-ups. Goltz et al

(2021) indicated that the terms “multidisciplinary” and “interdisciplinary” are often used interchangeably, teams ascribing to these models differ widely in their degree of collaboration, communication, and control over processes and outcomes. Interdisciplinary team models describe multiple disciplines working interdependently (collaboratively with open communication) and that they have, to the extent possible, shared responsibility for goal setting and decision-making in-service delivery. In contrast, multidisciplinary models leverage the skills of the various disciplines represented on teams, but these members provide direct patient care independent of the other disciplines and communication is more indirect in nature.

3.2.4. THEME 4: CONCERNS RELATING TO CONFLICTING VALUES AND NORMS.

3.2.4. Concerns relating to conflicting values and norms	3.2.4.1 Failure to appreciate indigenous knowledge system. 3.2.4.2 Factors contributing to delayed treatment and diagnosis. 3.2.4.3 Use of traditional healers

Societal values and family roles are important norms in cancer care, societal values and perception of health and illness play a role in cancer management and care. These cultural factors affect communication in cancer, disclosure of the diagnosis and issues related to death and dying affect the psychosocial being of the cancer patients. Age, gender, level of education, socio-economic level, and ethnicity are characteristics that have been found to influence patterns of communication in cancer care. The subthemes that emerged from the above themes are failure to appreciate indigenous knowledge system, factors contributing to delayed treatment and diagnosis and the use of traditional healers which will be discussed below.

3.2.4.1. Failure to appreciate indigenous knowledge system.

Most individuals acknowledge that a diagnosis of cancer is serious and life threatening, requiring urgent treatment. Among the options available to persons diagnosed with cancer, to them indigenous traditional healing is an ancient, deeply rooted, complex holistic health care system practiced by indigenous people worldwide. Religion too is a cultural system of beliefs, practices, rituals, and symbols designed to help the individual with sacred aspects of one's life and spirituality is a personal search for answers in relation to the meaning of life.

A participant in focus group: FGD # C

> *"Patients have their own belief systems, and they are different, understanding their belief systems depends on the relationship the health worker and the patient develop over time, it is necessary that the health professionals know the patients well, unfortunately the rotation and allocation of staff interferes with bonding with patients and understanding their norm and values"* [Female, 48yrs O/N]

Another participant in FGD#D indicated the following:

> *"Some patients are asking for discharge from the hospitals to go for their spiritual and traditional healers before they can agree to treatment, and if they are not given what they want they become more stressed and end up signing refusal of hospital treatment"* [Female, 39yrs P/N]

Participants implied that it is difficult to diversify a patient that strongly believe in indigenous way of doing things and fully convince them to trust in western medicines. Nurses expressed difficulties and challenges meeting the cultural needs of patients.

Savioni, Triberti, Durosini, Sebri, and Pravettoni, (2021) has indicated that cancer patients' participation and commitment to psychological interventions on non-participation is often linked to factors related to intervention' commitment and its interference with daily life. On the contrary, patients' reasons to participate often identify with the value they find in the intervention according to their personal needs and experience of illness.

3.2.4.2 Factors contributing to delayed treatment and diagnosis.

This is difficult due to a lack of early disease-specific symptoms that the patient and nurses at the clinic can suspect cancer. Patients sometimes do not give a history that is not leading to the provisional diagnosis of cancer. Community awareness and knowledge of common signs of cancer can assist in the patient's early diagnosis, induction of the primary health care on the referral pathways for screening and diagnosis to avoid delays.

The challenge that was brought forward by a participant in the focus group #C was:

> *"Clinic nurses delay referring patients to the hospital, hospital delay diagnosis, patients themselves lose confidence in health systems, shop around for whoever can help, starting from the spiritual healers to traditional healers, it is just a lot of factors causing the delay in the diagnosis and treatment" [Male, 33yrs, Dr].*

There was mutual understanding that though most participants focused on cancer awareness and screening, some noted that treatment was often unavailable and advocated for a broader strategy to improving access to care and suggested that collaborations, including oncologists and other medical professionals involved in cancer care, is crucial.

Chan, Paldánius, Mathieu, Stumvoll, Matthews and Del Prato (2021) indicated that early diagnosis programs involve complex public health interventions aiming to address unmet health needs by acting on patient, clinical, and system factors. However, there is uncertainty regarding how to optimize the design and evaluation of such interventions. Decisions about early diagnosis programs should consider four interrelated components: first, the conduct of a needs assessment to identify the cancers that may benefit most from early diagnosis in the target population; second, the consideration of symptom epidemiology to inform prioritization within an intervention; third, the identification of factors influencing prompt help-seeking at individual and system level to support the design and evaluation of interventions; and finally, the evaluation of factors influencing the health systems' capacity to promptly assess patients. Chan et al., (2021) further indicated that this conceptual framework can be used by public health researchers and policy makers to identify the greatest evidence gaps and guide the design and evaluation of local early diagnosis programs as part of broader cancer control strategies.

3.2.4.3 Use of traditional healers

The traditional healers are part of the community, easily accessible and trusted by the community. Seen as the available solution providers when they are afflicted, believing cancer as which craft is rife in the community that is why they are believed to can bring solutions.

Participants in the focus groups shared the idea of which craft and the problems of patients not disclosing what medications they have received from their traditional healers; one participant says she discovered this: focus group #B.

> *'I only knew about the traditional healer when I was discussing with a family member about the patient having not turned up for referral to the treatment centre who told about the patient staying with the traditional healer for some time, after the patient was discharged and waiting for the appointment to treatment for a long time, going to the healer disturbed the whole process". (Female,* 45yrs P/N)

A participant in FGD #E said this:

> *"Patients are defaulting treatment because they believed that they should first use their traditional medicines and see if they can work, when you inquire, they do not want to reveal the staff they are using*". {Female 38yrs P/N}

Some desperate cancer-patients are resorting to the traditional way of treatment due to fear they might not survive the complex medical therapy of chemotherapy and radiotherapy for fear they might not survive the treatment process and because they would not feel comfortable in such unfamiliar conditions. Participants implied that even if participants were attending and getting treatments from their traditional healers, they are secretive about it, sometimes they are convinced that the way to go is to continue with them and default hospital treatment. Participants believe there should be inclusion of the community traditional healers in the education about the basics of how to recognise cancer and referrals to western medicine. Chaitanya, Baye, Ali, Usamo, (2021) indicated that in Africa the use of traditional medicine is one of the important health care systems, the traditional African medicine is now evolved as evidence based healing system and serving as good prime element in reverse pharmacology and drug system.

3.2.5. THEME: 5: CONCERN WITH PATIENT DISCLOSURE OF DISEASE.

3.2.5. Concerns with disclosure of their diagnosis.	3.2.5.1 Concealed emotions and fear of death 3.2.5.2. Failure to disclose diagnosis and concerns to caregivers.

Patients do not like disclosing their conditions to family, friends, and health care workers whom they do not trust. As such patients are observed not to be truthful to the health care workers in their initial state of interaction. This could be the results of the initial encounter at disclosure of the cancer diagnosis and how much the patient was empowered by their diagnosis and how they perceived the whole cancer disclosure. Out of concern of fear of the negative psychological impact of such revelation.

Patients are autonomous and have the right to information, care should be taken not to allow attitudes of medical staff or patients' families, language difficulties and organisational issues become barriers to patient's access to information and their psychological coping of the illness. Be aware of the cultural environment of the patient and the families' emotional needs even as we aim to match the patient's desire for information. The sub themes that emanated from the above theme are concealed emotions and fear of death and failure to disclose diagnosis and concerns to caregivers and will be discussed. Iddrisu, Aziato, and Ohene (2021) indicated that perceptions and beliefs; economic concerns; and secrecy in disclosing their cancers. Patient participants perceived that breast cancer was a test of faith, a spiritual disease that is contagious and disgraceful. Mostly, patients stopped work to cater for themselves, and as a result, they encountered financial challenges. Their challenges were compounded with conscious efforts to keep diagnosis secret to avoid being stigmatized.

3.2.5.1 Concealed emotions and fear of death

Patients in distress are sometimes unable to tell how they feel and what their fears are. Patient with cancer believe that the diagnosis is a death sentence and as such they believe in fate and the end. Participants in this study explained how they are having trouble in knowing how the patients feel and what they are thinking about their diagnosis and treatment.

A participant in FGD #E said this:

> *“Patients do not communicate their innermost feeling about fear of death and dying, they believe they are destined to death even if they have a greater chance of survival” {Female 38yrs P/N}*

Participants implied that when a professional want patient to share their feelings they should have a solid base professional good relationship with their patients to get disclosures of such concerns.

3.2.5.2. Failure to disclose diagnosis and concerns to caregivers.

Disclosure is an ethical and legal aspect, and it is sometimes difficult for doctors to disclose, they may not know how and when to break the news to patients or in the presence of caregivers to reduce anxiety and distress.

A participant in FGD#B indicated:

> “*You know what will surprise you is that sometimes you find a patient accompanied by a relative or spouse, but the patient does not want them to be in the consultation room, they have to wait outside because s/he does not want them*

> *to know, they are always in the dark especially men, maybe is culture"* [Female, 54yrs, P/N]

She further indicated that:

> *"What is also a challenge is that even if the patient was diagnosed elsewhere, they will not tell you until you repeat the investigations and make a new diagnosis, which delays the time to start the treatment"* [Female, 54yrs, P/N]

Participants implied that cancer parents have culture-specific considerations, such as concepts of death, there are barriers between cancer parents and children in communicating about the illness and unmet needs for information and support emotions and fear of death. Most patients who are fearful of western medicines doctors and the nurses, will always show signs of being reserved and would not converse easily about themselves in the early days of submitting to them, it gets better as the relationship with each other progresses. Neckel, and Hasenfratz, (2021) highlighted that the emotional motives behind the scenes should not go unnoticed in sociological research within the ecological crises. Nurses in cancer care should be skilled in assessing the emotional and psychological state of the cancer patients.

3.2.6. THEME 6: OBSERVANCE OF MALADAPTIVE PERSONALITY TRAITS AFFECTING MENTAL HEALTH RELATED QUALITY OF LIFE

3.2.6.Observance of maladaptive personality traits affecting mental health-related quality of life	3.2.6.1. Depression and denial of the physical illness

Chronicity in cancer pain is associated with a series of psychological signs such as sleep disorders, anorexia, decreased concentration, irritability, and signs of depressive disorder. Individuals attempt to protect themselves from damaging effects of hopelessness, sadness, fear, stress of cancer diagnosis by denying emotional conflict.

The theme that emerged from the above theme is depression and denial of the physical illness.

3.2.6.1. Depression and denial of the physical illness

A participant in the focus group # E shared this light:

> **"***The challenge in care of the patients with cancer is that some are too depressed and dislike history taking, even if they know the diagnosis the patients will allow you to re investigate them without them disclosing. I think they do not trust the system thinking that they will get another opinion***".** (28 years Dr)

Participants implied that during assessment, patients should be respected if they show denial; patients should not be forced to face stressful situations if they are not yet ready. Denial may serve as a purpose in protecting patients in this regard and thus should be respected. Personality has been commonly viewed as an independent predictor of patient's psychological quality of life, and it is reasonable to assume that patients with optimistic personality can develop better mental resilience to cope with their difficulties, and therefore experience fewer disease-related mood disturbances. Martino, Caputo, Vicario, Feldt-Rasmussen, Watt, Quattropani, Benvenga, and Vita, (2021). Emotion-processing impairment represents a risk factor for the development of somatic illness, affecting negatively both health-related quality of life (HRQoL) and disease management in several chronic diseases.

The focus group discussions have shared valuable challenges in their practices as health care professionals in cancer care and will assist in the formulation of strategies to improve the psychosocial care and support in the hospitals in Limpopo.

The data was collected from the health care professionals focus group discussions have clearly indicated how challenged they are in the provisioning of the psychosocial care and support to the cancer patients. The researcher further collected data from the individual patients using face to face interviews about their needs for psychosocial care and support. The results of such interview will be discussed below.

3.4. PRESENTATION OF FINDINGS FROM INTERVIEWS WITH CANCER PATIENTS

The following section provides an overview of the results based on themes and sub-themes that emerged from analysis of the face-to-face individual interview transcripts and field notes gathered to gain an understanding of patients care and psychosocial needs at the hospitals in Limpopo.

Table 3.3: Demographic profile of the patient participants

District	Hospital	Number of participants	Age	Gender
Vhembe	A	2	54	F
			47	F
Vhembe	B	2	33	F
			58	M
Mopane	C	3	48	F
			68	M
			45	F
Capricorn	D	2	44	F
			47	F
Capricorn	E	2	67	M
			52	F

The themes are supported by verbatim quotations from participants which are indented and written in italic and indicate the gender, age and district which is represented by #alphabet. The following four (5) themes and sub-themes emerged. The findings of the face-to face individual interviews is presented in the table: 3.4.

TABLE 3.4: REPRESENTING THE THEMES AND SUBTHEMES DRAWN FROM THE FACE-TO-FACE INTERVIEWS.

PSYCHOSOCIAL CARE AND SUPPORT NEEDS OF THE CANCER PATIENTS	**THEME**	**SUB-THEMES**
	3.4.1. Ideal needs of communication strategies	3.4.1.1 Proper information on screening diagnosis and family involvement on disclosure of diagnosis 3.4.1.2. Comprehensive information sharing
	3.4.2. Concerns regarding confidence and reliance with a known practitioner	3.4.2.1. Maintaining rapport with practitioner 3.4.2.2. Interruption of reliance on treatment and care/ Loss of reliance in the provision of treatment and care 3.4.2.3 Accompaniment by known health provide for support during the referral
	3.4.3. Ineffective knowledge of cancer-specific therapeutic regimen	3.6.3.1. Need for information on the disease process, clinical manifestations. and treatments 3.4.3.2. Lifestyle modification for therapeutic care 3.4.3.3. Adherence to treatment
	3.4.4.Need for psychoanalysis and therapy	3.4.4.1. Feelings of anxiety and frustration 3.4.4.2. Lack or absence of social support.
	3.4.5. Need for continuity of care.	3.4.5.1. Proper management and holistic care a discussion of discharge plans

3.4.1. THEME 1: IDEAL NEEDS OF COMMUNICATION STRATEGIES

Proper communication in cancer care and support is essential. It is a concept that is overridden by many casual talks in health care and loses its actual intention in care and support, communication skills can certainly be learned, and being an effective communicator is a core competency of both health care professionals. This competency must be learned by the professionals on how to communicate in different setups and topics. The participants in this study indicated how they would like communication with the cancer patients be that would alleviate the stress they are experiencing due to their cancer disease. The subthemes emerged from the theme are need for proper information on screening diagnosis and family involvement on disclosure of diagnosis and comprehensive information sharing.

3.4.1.1. Proper information on screening, diagnosis, and family involvement on disclosure of diagnosis

3.4.1. Ideal needs of communication strategies	3.4.1.1 Proper information on screening diagnosis and family involvement on disclosure of diagnosis 3.4.1.2. Comprehensive information sharing .

Participants in this study has indicated how they wanted communication about their diagnosis to be better than their experience. The participants expressed the need to be informed about their cancers at a time that they are ready and have their significant other or spouse with them as they needed support at the sessions of screening and at disclosure. They expressed that as in the following discussions:

Patients, 47 years old in cancer care indicated the following on communication at screening and diagnosis:

> *"I was never really informed of the possibility of cancer, what the doctor said to me was that I should be taken bloods and the results will be communicated when I come back for check-up. On the day of my return the results were not followed up, I was feeling better and went home without the blood results. I never went back for the results as I was fearful of the truth in the results as my symptoms were persisting, I had a discharge that was not pleasant and then profuse, I only went back because I could no longer cope with what I was experiencing after two months*". (#D age 47)

Patient participants implied that there is a need to improve in the way they are communicated to about their diagnosis, treatment, and prognosis.

The best tool that the nurses can use is the way they communicate with their patients to establish rapport with the patients, when communicating to the patients the nurse should also observe the non- verbal communication of the patients and should also keep in check how you as a professional communicate to the patients. Positive communication instils hope and faith.

Another patient in the interviews indicated that:

> "*Whatever they told me when the diagnosis was made, I could not recall because I was in great shock. I never thought that bruising more frequently could be a cancer, I was in total disbelief and denial at the same time*". (#E age 52)

The participant further indicated that:

> *"The nurse and doctor tried to explain to me thoroughly, but I was just not ready for the diagnosis*". (#E age 52)

In assessing cancer patients, one should observe the occurrence of positive and negative psychological states amid enduring stressful circumstances, that has an important implication for understanding psychological well-being in the face of serious illness, focusing on psychological well-being and the coping processes in the support of the ill patient, it is a complement to the traditional focus in both the medical and behavioural sciences on psychiatric symptoms.

However, one other patient confessed that he was clearly informed about the diagnosis and how he was going to be screened but was not ready to talk to this young doctor about how he felt, and this is how he explained his fears:

> ” *I was in great distress as he told me about the results. She had previously informed me about the rectal examination that my prostate was enlarged and needed to do bloods. I felt like crying on the spot, but I felt I needed to keep my cool. The doctor is so young and the nurse too’’*. (#B.67, M)

The participant further explained that:

> *“I needed to be with my older relative or my wife when I received the news, it took me time to inform them and that delayed my time to agree to start treatment*”. (#E age 67 M)

The participant said it with a sad emotion and with an exceptionally low tone. In the intervention with staff and patients, the researcher chose the stress-adaptation model by as particularly relevant to assist patients to cope in their crisis. All efforts to overcome interpersonal isolation, have important roles in times of severe strain and stress the need to have a relative or significant other when receiving the sad news would at times relieve the patient of the anxiety and would receive support, though it is not all patients that want to share and be seen by their loved ones when they are at their lowest in this study. Though some patients have eluded that theirs and some other therapists speak in the patient’s language which is always not possible for all individual patients, Limpopo has diverse languages spoken, some patients understand the English language, and some are assisted by the interpreters in the form of nurses and other personnel. When probed about what they think the solution to alleviate the distress they experienced would be, to improve the services for the other patients and themselves, these are the responses the researcher could find.

Another participant responded to the probe in this way:

> “*I wish that cancer awareness could intensified to make more people aware so that they can at least be aware of the signs of cancer and their risks so as to seek screening*” [# C age 48].

Addressing and intervening needs of the cancer patients are the multicomponent approach to address the practices of supporting patients. It includes guideline development, practitioner education, and anti-stigma public health campaigns about cancer, offering post-diagnosis treatments and support for cancer patients as well.

He further explained the following with sadness:

> “*It never crossed my mind how important it was for men to go and check for the state of their prostate until I had urinary retention and was told its enlarged and the blood revealed very high results for cancer screening*”. (# C age 48)

Patients need support from family and the health team, as such it is important for the health professionals to probe for such concerns and intervene, and however, many factors are involved in proper communication and the sequel to the diagnosis including care and treatment.

One other participant expressed the need to discuss his condition and its advanced stages and expressed the emotional need of the children before the eminent death and make them equipped considering the possibility of their own death from advanced cancer.

> *“I am involved very closely with my sons and need to make them aware of my diagnosis and need to teach them a lot of survival skills especially in the family business and how I would like them to continue with the business, I wish that all cancer patients can embrace their circumstances and help one another to deal with our fate and uncertainties that is brought about by the illness*”. (#C age 68, M)

‘When asked of his need for the psychosocial support this is how he responded:

> “*I wish there were many health care professionals enough to access the cancer community to educate the families and the patients, especially to form and lead the support groups and counselling in the community at large”.* (#C age 68)

It is encouraging to find the cancer patients identifying that there is a need for support groups, planning for such groups in the community would be an initiative from the cancer patients themselves, meaning that they may be the ones leading them and sustaining them with the support of the health professionals. Patients need for family support is not always possible and patients in this study had a different view on family involvement in their diagnosis and care. However, it is not always possible to find patients accompanied to the hospital by their significant others, as such it could be especially useful to enhance the psychosocial care and support for our cancer patients if that is to be arranged.

3.4.1.2 Comprehensive information sharing

History taking in patients with cancer, is especially important as a way of building rapport between the patients and the health workers particularly when the patient is seen for the first time by a therapist, however some patients are not comfortable with the re-interviews as they might have had interviews with many other therapists involved.

A patient participant responded to the probe on what he meant when he said he is interviewed by so many professionals this way:

> '*I wish I had only one therapist that was to see me and treat me in totality and that will lesson all these other members of the team where I am to explain same things always". (#C age 68)* Explaining to him how important it is to see different specialist the patient said: *"I felt like there is something wrong that I have done; if I was to go along with my whole file when transferred*". (#C age 68)

Patients implied that they get distressed by changing therapists and their metal state shifts and they become inactive in answering and asking questions about their treatment and care due to the distress. Discussion about treatment and side effects becomes easy when the patient has a platform to discuss the issues based on the findings on interviews. Promotion and acceptance of expression of positive and negative feelings is important so that you as the health professional can understand the participant better and appraise the concerns. Allowing the patients to tell how they feel without judging them and realizing that it is not about the health care professional and that it is about the patients.

Participants expressed the need to be pre-informed about the side effects as follows:

> '*I wish I were told that my hair was going to fall off. I was incredibly sad and disappointed; it was mentioned to me that it may happen that my hair could fall off*

> *and I did take it as it is bound to happen. I was not ready at all, I had to shave my head the thing that I had not done for many years, it created a lot of stress to me, I was socially stranded that I was asking anyone I trust to give approval of my new look*" (#B age 33).

The participant softened up and said:

> *"I know that there was nothing that the doctors and nurses could have done its only that I needed a lot of support on this issue because it was not the hair only even my nails got very dark and was shy to show my hands*". (#B age 33)

Physicians should not rely on presenting written information but should mainly engage in direct communication about the expected side effects.

3.4.2. THEME 2: REGARDING CONFIDENCE AND RELIANCE WITH A KNOWN PRACTITIONER.

3.4.2. Concerns regarding confidence and reliance with a known practitioner	3.4.2.1. Maintaining rapport with practitioner 3.4.2.2. Interruption of reliance in treatment and care/ Loss of reliance in provision of treatment and care 3.4.2.3 Accompaniment by a known health provide for support during referral

It is distressing for everyone to talk about your innermost concerns to a person you are meeting for the first time. This is same for the cancer patients about their diagnosis and especially to part of the health care professional they see for the first time. The cancer patients have in this study explained of their lack of trust and confidence in the new therapists and did not see the reason to explain themselves to them as there are letters communicating and files about them from the referring practitioners. They indicated how that damages their self-confidence and causing damage to their relationship. The subthemes emerged from the above theme Maintaining rapport with practitioner, interruption of reliance in treatment and care/ Loss of reliance in provision of treatment and care and an accompaniment by a known health provide for support during referral.

3.4.2.1 Maintaining rapport with practitioners.

Cancer care in the hospitals of Limpopo is given at the community, district, and provincial hospital where the specialists are mostly based, it is the treatment centre were the patients of Limpopo see their oncologist and receive chemo or radiation and oral treatments. Patients are referred to the treatment centre as per appointment and are expected to have some communication in the form of letters and X-rays to inform the other therapist on the other side. Patients in cancer care are informed of the transfers and some understand the logistics thereof, but some has reservations about seeing new therapists.

This is how the study participants responded about the transfers and new therapists:

> *"I knew that I should go for treatment, but how could I trust the people I was going to see, were they going to give me the same type of care you were giving me here*". (#B 58,F)

When asked about the experience of first-time attendance at the centre this is how the participant responded:

> *"it was scary and had a lot of uncertainties in my head, especially that it was the first time to go to that hospital, but the experience allayed my anxiety, thy explained everything well to me and in the language I understand well and were open to my questions, though I wish there should be treatment centre in our hospitals, I now am comfortable going there the issue of trust is the thing of the past for me, though trusting is not easy but I now understand'*.(#B age 58,F)

About patient retained records the other participant responded as such:

> “*I am not happy about the lost files and loss of histories. I truly wish we could be given our records because when asked I find that I do not have enough information to satisfy the other person asking, I may give incomplete information and stay asking myself if I am to trust the new therapist to give me treatment based on what I have relate to him.”* (#B age 58, F)

Every hospital and province have a way to control their patients file, in Limpopo patients are not allowed to take their files home except the booking card of the pregnant woman. However, the availability of patient retained records can be an improvement in some of the care facilities which could be a strength in sharing of information and the use of computer accessible records can be great though some of the hospitals do not have such infrastructure. The patient participants in this study felt it a great need to avoid interrogation each time they are to consult a different therapist. The therapeutic relationship is a concept often ignored. As such, the importance of good patient rapport may be overlooked. To address these concerns, highlighting the effects that strong therapeutic relationships may have on patient satisfaction, treatment compliance and client outcomes, strategies that practitioners can employ to facilitate the development of good patient rapport should be formulated to improve the psychosocial care and support for the cancer patients in the hospitals in Limpopo Province. Abbe, and Brandon (2014) indicated that rapport has several positive effects on interviewing, positive interpersonal interaction, rapport can increase the amount of information provided by witnesses and sources, increase trust, and produce more cooperation, and faster agreement in negotiations.

3.4.2.2 Interruption of reliance in treatment and care/loss of reliance

Travelling to and from treatment centre at the provincial hospital the cancer patients are escorted by the health workers assigned to do the transfers. These health workers are not trained in cancer care and sometimes they see the patients on the day of commuting. The cancer patients in this study explained that they feel lost with these transfer staff. Uncertain of how much they should relate to them or discuss about the expectations of where they are heading to. It is important for the cancer patients to get to know all the members of their health care team. The doctor, nurse practitioner, social diagnosis, through worker, navigator, dietician, counsellors, oncology nurse, physical therapist and pharmacist are all key players in helping cancer patients to find their way from diagnosis to survivorship. Unfortunately, they are short staffed to provide for the navigation of all patients.

A participant shared own view of the situation as follows:

> "*If it's the first time going to another hospital, you need someone you can trust to go with you or someone that you have a conversation about your illness with, I understand that the nursing staff in our hospitals are not enough, but I still wish that something should be done about it".* (#B age 58)

Provisioning of support, protection, physical and sociocultural and spiritual environment is important for the patients in our care. The importance of recognising the internal and external factors influence the individual's health and healing, the health care professionals in cancer care provides a healing environment for the cancer patients. Participant explained that the other patients that they find at the treatment centres are very kind, but the different cultures make them not to mingle well, thus causing them not to interact well and further said the following about the health personnel at the other settings of care:

> *"I am a person that I would normally like my stories not to be told casually to people, I don't know, my vaginal bleeds are private, examination by a male doctor with a male nurse in the room was something that made me to feel like I am walking naked in public, those two are very young maybe younger than my first grandchild*". (# An age 54, F)

She further suggested that:

> *"If only the nurses travelling with us are from our hospitals, they would know our culture and would eliminate if not reducing the way things are said or done, even in our own hospitals nurses would talk to us about issues as if they are talking to their own kids, they should be culture sensitive and have concern of age."* (#An age 54, F)

Another participant explained that cancer is sensitive to the person diagnosed this way:

> "*I felt that cancer was heavy to absorb, could not talk about it even to my children, needed to keep it close till I am ready, nurses spoke about this openly about my diagnosis about my cancer amongst themselves even in front of non-concerned"* (#D age 47, F).

Measures are needed, including tailored education and achievement-based selection. To have a culture sensitive environment for the cancer patients we need a more sensitive professional who has cultural competency and cultural awareness. Professional culture provides and promote accountable non-discriminatory person always centred and sensitive care. Reflecting on people's values and beliefs, diverse background, culture characteristics and language requirements needs and preferences. Taking account of any need adjustment for the cancer patients.

3.4.3. THEME 3: INEFFECTIVE KNOWLEDGE OF CANCER SPECIFIC THERAPEUTIC REGIMEN

3.4.3. Ineffective knowledge of cancer-specific therapeutic regimen	3.4.3.1. Need for information on the disease process, clinical manifestations. and treatments 3.4.3.2. Lifestyle modification for therapeutic care 3.4.3.3. Adherence to treatment

Patient's participants in this study expressed their need to be allowed to keep their files and reports. As part of self-care the patients should be taught the basics of how to care for themselves in the absence of the health care professionals and how to keep appointments of different professionals and what to bring at each appointment. Study participants indicated that they need to know about the effects of treatment and side effects and other measures that they can employ to be healthy. The expectations of the therapist from the patient as they journey to their interaction in fighting the cancer.

External radiation therapy is usually provided on an outpatient basis, individuals receiving this mode of treatment are responsible for their own self-care the subthemes that emerged from the above theme are the need for information on the disease process, clinical manifestations and treatments, lifestyle modification for therapeutic care and adherence to treatment and will be discussed below.

3.4.3.1. Need for information on the disease process, clinical manifestation, and treatment.

Knowledge of cancer is lacking amongst the community evidenced by the fact that the community can see the signs different from their normal functioning and ignore and or treat themselves. The factors that are affecting early or immediate medical assistance in the communities are associated with age, literacy or level of education and occupation and the environment of the individuals. These factors also affect cancer prevention consciousness. Using local language and lay leaders with locally accessible terminology is more important in community education, Simple language with a clear message is essential, however the patients access the hospitals when the cancers are diagnosed later when it is more difficult to treat perhaps due to economic or cultural barriers that affect cancer care negatively. Disparities in cancer care also affect cancer care negatively creating more stress to the affected.

A participant in this study indicated the need for education as:

> *"If only I had known about cancer, I would have gone for screening even before. I wish there were ways that the community can be informed about cancer the same way it is informed of HIV/AIDS. Maybe campaigns to screen communities are essential as the others in other diseases*". (# A age 54)

Another participant indicated the following:

> "*There is so much I did not know about the disease, even after diagnosis, I just trusted that the doctors and the nurses knew what they were doing, devastated and did not want to give it much of the thinking. I only realised that I need to know about the disease when I heard my sister saying she was experiencing the same*

> *symptoms I had. Issues like cancer may run in families and how to take care of self."* (# A age 54)

She continues to confess that:

> "*I am also fearful that what if my cancer may return? What if I am unable to make it not to return, am I able to control its return. One need such education.*" (# A age 54)

Self-care relies on the patient making correct decisions, in response to the symptoms they are experiencing, about the appropriate use of medical care. The risk is that the patient may miss something difficult for them to understand but important about their symptoms, thereby leading them to misdiagnose themselves. Participants have self-blame about not being able to access care in time.

The other respondent responded to the probe on the need of education about cancer community education as follows:

> *"I am not educated, I listen to the local radio, it does talk about cancer, but I wish that it can be intensified. The knowledge that I have now since I was diagnosed is valuable for the community to undergo screening especially if they have had a family member who have had cancer. I needed this information before I was diagnosed*". (# E age 52)

Community education is a need on diseases that affect them using different opportunities that are available like" imbizos" and other community structures. There are key community opportunities available to incorporate culturally tailored community programs designed to ensure that the community and patients gain access to quality, culturally responsive health care for the patients with cancer despite the disparities and economic deprivation.

Another participant said the following about cancer education and education material:

> *'Most of the people in my community are not educated, the education materials we see displayed about cancer and other diseases are in foreign languages and as such the information does not reach the community well*." (#D, Age 45)

Most cancer education pamphlets that are accessed at the hospitals are indeed in the foreign language and some are only limited to the signs and symptoms of cancer and silent about treatments. This is what the need of the cancer patients in this study is about improving the health literacy in the communities of Limpopo.

3.4.3.2 Lifestyle modification for therapeutic care

A patient who is educated about his diagnosis is easy to treat and the patient can also be involved in the self- care and compliance. The patients need to hear about their specifics of their diagnosis and their treatment modalities. Accepting practical and emotional support from family and significant others. Having a network of supportive people is very beneficial for health, especially emotional support.

A participant in this study indicated concern on the need to be enlightened on his condition this way:

> *"I was diagnosed with cancer, took time to come back to the hospital to discuss treatment, though I was told about the availability of treatments I could not comprehend that at the time, I felt the need to understand my condition and treatment before I could take decision to accept*." (#D age 47)

It is important for the patients to be educated and supported psychosocially to improve their lives and allay their anxieties regarding their diagnosis. The psychosocial needs that should be considered including those for information, emotional support, collaborative decision-making, education, and socialisation. The importance of focusing on patients' and families' concerns when arranging psychosocial support is highlighted, together with the requirement to reassess their needs continually throughout the trajectory of the illness.

Montagnese, Porciello, Vitale, Palumbo, Crispo, Grimaldi, Calabrese, Pica, Prete, Falzone, and Libra (2021) indicated that the quality of life in women diagnosed with breast cancer after a 12-Month treatment of lifestyle modifications had improved. Healthy lifestyles are associated with better health-related quality of life (HRQoL). Montagnes et al., (2021) further indicated that favourable prognosis and lower mortality in breast cancer

(BC) survivor. A healthy lifestyle treatment of traditional Mediterranean diet and exercise may impact positively on HRQoL in BC survivors possibly through reductions in body weight.

3.4.3.3 Adherence to treatment

Counselling as a form of allaying anxiety in the cancer patients throughout the cancer trajectory is important. Spring, Stump, Penedo (2019) indicated that to improve care systems for disease management and health promotion for the growing population of cancer survivors will indicate that no entity in the health care system self-identifies as claiming primary responsibility to address longstanding unhealthy lifestyle, behaviours that heighten survivors' susceptibility to cancer and complications, and other co-morbidities that can both increase stress and whose improvement could enhance quality of life.

A participant in the interview indicated how she has lived with uncertainty this way:

> *'I did not know if I will get healed or would die from the cancer, most of the people I know with cancer have died, I received counselling from the nurses but in real fact I was not satisfied I needed to hear it from other people who has had the same condition, had undergone the same treatment"*. (#B age 58)

Further indicated that:

> "*With the stress of having cancer I resorted to alcohol, not eating, I did not care what happens next, I thought it was the end of me".* (#B age 58)

Reducing their stress level can help cancer patients to maintain physical and mental health. A healthy diet can help patients to manage cancer side effects, recover quicker, and improve health. It may also lower your future risk of cancer. In addition, the cancer patients should avoid and control smoking and alcohol intake as environmental toxins. Esther, Julius, and Deogratius (2021) Delayed health-seeking and poor adherence to treatment were related to emotional and psychosocial factors including stress of cancer diagnosis, stigma related to oesophageal cancer symptoms, and fear of loss of jobs and livelihood, limited knowledge and recognition of oesophageal cancer symptoms by both patients and primary healthcare professionals, and limited access to specialized cancer care, mainly because of long distance to the facility and associated high transport cost. Esther (2021) indicated that while inadequate communication and some degree of incivility were reported, majority of patients thought the healthcare professionals were empathetic and supportive.

3.4.4. THEME 4: NEED FOR PSYCHOANALYSIS AND THERAPY.

3.4.4. Need for psychoanalysis and therapy	3.4.4.1. Feelings of anxiety and frustration 3.4.4.2. Lack or absence of social support.

Patients with cancer can develop a feeling of dependence on the health care, though the patients are taught to be self-reliant, there is a need to continuously monitor the patients for assessment of re-curing of the cancer or other diseases that the patient may develop. Needs for survivorship care may vary according to life stage and urban or rural place of residence. The psychological, social, and physical effects observed at different life stages may help.

Loneliness and social isolation are a problem for patients with cancer. Participants in this study indicated that it is more distressing as they continue to have fears, need care and support for their psychological well- being to be able to deal with their own life circumstances. The subthemes that emerged from the above theme are feelings of anxiety and frustration and lack or absence of social support are discussed below.

Graham (2021) indicated that difficulties have been found when making decisions with people who either do not accept their diagnosis and do not accept the current evidence-based treatments for personality disorder. Other challenges have been identified regarding the patient/clinician relationship, the level of distress the patient presents with, and the clinician view concerning the individual, the diagnosis, and the available treatments.

3.4.4.1 Feeling of anxiety and frustration.

A participant who has been on chemotherapy expressed the need for continuity of care with the oncology health care team as follows:

> *"I have a trusting relation with the nurses and doctors that were responsible for my treatments, the social worker too that was involved, it is now difficult to come to the hospital and see other health care teams that do not know what I have been through, especially when I am not sick, consulting to raise concerns about my previous cancer state and treatment"*. (# A age 54)

She further indicated that:

> "*You feel they would not understand and would not be able to answer my questions or allay my anxieties*". (# A age 54)

Another participant indicated the following:

> *"I want to continue coming to the oncology clinic for them to assess me for any problem that I have before I can see other therapists, I feel that they are the only ones that can refer me to the others as they have a full history of my condition, and they would know which appropriate therapist I should consult*". (#D age 44)

A participant shared the following about the feeling of social isolation:

> *"I feel so alone even if there are people with me. I wish I can share my fears and insecurities with my family." The participant further explained that "even if I were to tell, they would not understand as they have not had the experience, I believe it would be better to have more of support from the people who share the experience and fears*. (#D age 44)"

The need for more support groups was identified by most participants in this study and need to be taught more of the coping strategies. Family and other community structure are needed to reduce the stress of social isolation and disintegration to cope with the stress. Interventions and activities aimed at reducing social isolation and loneliness are needed, beginning with the identification of and to reduce social isolation. Practitioners can thus help clients improve their social networks, increase the use of preventive services, and improve their well-being. The importance of focusing on psychological well-being and the coping processes that support it, as a complement to the traditional focus in both the medical and behavioural sciences on psychiatric symptoms that needs psychosocial support. Stocklassa, Zhang, Mason and Elsner (2021) eluded that terminally ill cancer patients often have a substantial need for information about their condition while their preferences are widely consistent with those in Western societies. Training for health professionals needs to focus on communication skills to overcome barriers in patient interaction.

3.4.4.2 Lack or absence of social support.

Psychological screening programs play an important role in improving, detection and management of distress. It is common in the terminally ill. It is often not detected and not treated and has significant impact on the individual and family. Psychological and social screening programs play an important role in improving detection and management of distress.

> "*I am a survivor of the most difficult times in my journey as a cancer patient, during my chemotherapy period I was so sick that I could not explain what my problem was, from pain, loss of appetite and loss of weight. I so wished someone could assess and identify that which I was unable to explain* (#C age 68)

Another participant expressed the need for pain management as follows:

> "*I suffered pain, had the pain medication, was not getting relieved, I realised that the care givers did not understand the intensity of the pain I suffered, I cried to myself until I cried loud to ask for more medication".* (#E age 62)

Patients explained that they need to be supported when they are experiencing pain and other problems emanating from the disease treatment or side effects. This is how a participant expressed the need for full assessment. Preparing patients to cope with their life circumstances assist patients to accept and assist in their own recovery and self – care.

Haugan and Eriksson (2021) indicated that providing high-quality and effective health care requires a holistic physical-psychological-social-spiritual model of health care is required. A great number of patients, both in hospitals and in primary health care, suffer from the lack of a holistic oriented health approach: Their condition is treated, but they feel scared, helpless and lonely. Health promotion focuses on improving people's health despite illnesses. Accordingly, health care that supports/promotes patients' health by identifying their health resources will result in better patient outcomes: shorter hospital stays, less re-hospitalization, being better able to cope at home and improved well-being, which in turn lead to lower health-care costs.

3.4.5. THEME 5: NEED FOR CONTINUITY CANCER CARE.

3.4.5. Need for continuity of care.	3.4.5.1. Proper management and holistic care a discussion of discharge plans

Increased trust, confidence, and rapport between the patient and the healthcare professional is important to allay anxiety and psychosocial problems. Healthcare professionals should have a better understanding of patients' social and family context, they may be able to better identify patients' psychosocial problems and unspecific symptoms. a subtheme that from the theme of the need for continuation of care is proper management and holistic care a discussion of discharge plans and is discussed below.

3.4.5.1 Proper management and holistic care a discussion of discharge plan

Once a cancer diagnosis is made, a patient requires all sorts of care including treatment. Care required stems from the immediate needs of the physical wellbeing and psychological and social support. Receiving a new diagnosis of cancer or of its recurrence is distressing and there are increasing numbers of people living with the disease, some taking continuous treatment, as well as others who have been cured.

A survivor informed the researcher of how important it is to have a comprehensive care this way:

> "*I was admitted several times before a diagnosis was made, faced a lot of challenges, fortunately when in hospital you find support from the nursing staff, the most challenging times when I got discharged, was having no one to assist with the activities of daily living, my family members were unprepared and devastated by the diagnosis. I was so distressed and does not wish anyone to suffer the distress I had. I so wish there are enough cancer care facilities where patients are cared for*". (#C age 45)

Lack of professional and social support for the patient is the cause of distress, affording patients can pay for services to assist in this case, and some patients depend on the services of the home-based carers and relatives who are willing to assist.

A patient participant indicated the following about continuity of care:

> "*When discharged I wanted to have knowledge of how to access care from home, I felt the need to have something written to keep it as a reminder of what to do and how, I was so fragile and needed a lot of support* "(#C age 68).

Patients are willing to take part in their care if they are informed and taught how to care for themselves and given instructions. Proper instruction on discharge may improve compliance and better coping mechanisms for the cancer patients.

A participant explained:

> "*The frustration that I had was that following the transfer to another hospital it was not easy for me to find appointments to see my local therapists, especially after completing treatment and I was in greater distress of fear of the return of the cancer, needed to stay connected to the hospital cancer care providers. Getting to the hospital I was seen by different doctors without prior knowledge of my journey.*

> *To make matters worse my hospital file was lost, and I had nothing from the other hospital except a small paper without full information*". (# age 33)

Participants has a need for continuity of care and support, losing patients files in the filing room that contains the patient's history and treatment journey is distressing for the patients. However, patient retained records are a problem to other patients.

A patient who has completed the cancer treatment highlighted the following:

> *"When treated for cancer, there are other diseases that interfere in the elderly patients and other patients with cancer, the need to constant check-ups at the clinics and hospital is necessary*". (#C age 48)

Participants implied that when discharged from active cancer care, they would need support and continuous care by the cancer care team. Providers may feel pressured to recommend that an older adult with complex care needs be discharged to a skilled nursing facility rather than home, potentially contradicting the patient's wishes**.** Alizadeh, Rohani, Rassouli, Ilkhani, and Hazrati (2021). Transitional care program refers to the health care continuity during transferring from one health care setting to another or to home. This is an essential program for cancer patients Alizadeh et al., (2021) further indicated that it is necessary to revise hospitals' discharge program, and home health care centre's plan for admission and delivering health care services for cancer patients. Also, a pilot program is necessary to find the system advantages and disadvantages and it reduces the risk of unnecessary hospital admissions as well as the complications of the disease.

3.5.6. THEME 6: OBSERVANCE OF MALADAPTIVE PERSONALITY TRAITS AFFECTING MENTAL HEALTH-RELATED QUALITY OF LIFE.

Cancer patients are observed to have some signs of mental illness emanating from the deep sited stress that they are unable to cope with and shifting the stress from their conscious mind, evidenced by:

3.5.6.1. Depression and denial of the physical illness

It is not unusual for patients to have denial of their symptoms and diagnosis, and they end up denying treatment and does not act in their daily care.in focus group #B it emerged as a concern and the participants agreed that it is more frequent to see that happen in the services.

> “a patient denies their diagnosis and symptoms to an extent that they end up going around all possible health care services and not revealing that they have been diagnosed, some stay at home and believe in fate and that there is nothing that can be done to help them” (#B age 48).

Cohee, Johns, Alwine, Talib, Monahan, Stump, Cella, and Champion (2021) indicated that avoidant coping may indicate risk for, or presence of, distress among cancer patients. Interventions to reduce distress may benefit from addressing avoidant coping styles. Appraisal of symptoms of distress is important to assist patients to better cope with the disease.

3.6 CONVERGENCE/MERGING THE FINDING OF BOTH THE FOCUS GROUP AND THE IN-DEPTH INTERVIEW OF THE CANCER PATIENTS

The term ‘triangulation’ originates in the field of navigation where a location is determined by using the angles from two known points. The objective is to increase confidence in the findings through the confirmation of a proposition using two or more independent measures. The combination of findings from two or more rigorous approaches provides a more comprehensive picture of the results than either approach could do alone (Heale & Forbes, 2013). Qualitative findings from both face-to-face individual interviews and focus group discussions from health care professionals were compared, merged, and checked for contradictions.

Table 3.5. Convergence of findings

Challenges of health care professionals	**related subthemes**	**Psychosocial care needs of the patients**
3.2.1 Shortfalls of human resources 3.2.1.1 Lack of skilled health professionals 3.2.1.2. Overwork of the available personnel 3.2.1.3. Rotation and allocation of the available personnel		**3.4.1 ideal needs of communication strategies** 3.4.1.1 Proper information on screening diagnosis and family involvement on disclosure of diagnosis 3.4.1.2. Comprehensive information sharing .
3.2.2 Poor patient administration and support 3.2.2.1. Delays in the diagnosis. 3.2.2.2. No reports on follow up of the patients. 3.2.2.3. No available staff to navigate patients to the treatment centres. 3..2.2.4. Loosing patients along the transfers		**3.4.2 Concerns regarding concerns** and reliance with a known practitioner 3.4.2.1. Maintaining rapport with practitioner 3.4.2.2. Interruption of reliance in treatment and care/ Loss of reliance in provision of treatment and care 3.4.2.3 Accompaniment by a known health provide for support during referral
3.2.3 Poor co-ordination of cancer care services		**3.4.3 ineffective knowledge of cancer**

3.2.3.1 Loss of patient files and laboratory results 3.2.3.2 Lack of cancer policy guidelines/protocols 3.2.3.3. Inadequate and inefficient collaborative support in cancer care		specific therapeutic regimen 3.4.3.1.Need for information on the disease process, clinical manifestations and treatments 3.4.3.2. Lifestyle modification for therapeutic care 3.4.3.3. Adherence to treatment
3.2.4 Concerns relating to conflicting values and norms. 3.2.4.1 Failure to appreciate indigenous knowledge system. 3.2.4.2 Factors contributing to delayed treatment and diagnosis. 3.2.4.1 Use of traditional healers		3.4.4 **Need for psychoanalysis and therapy** 3.4.4.1. Feelings of anxiety and frustration 3.4.4.2. Lack or absence of social support.
3.2.5 Concerns with disclosure of the diagnosis 3.2.5.1 Concealed emotions and fear of death		**3.4.5 Need for continuity of care** 3.4.5.1. Proper management and holistic care a discussion of discharge plan

3.2.5.2. Failure to disclose diagnosis and concerns to caregivers		
3.2.6. Participants expressed observance of maladaptive personality traits affecting mental health-related quality of life. **3.2.6.1. Depression and denial of the physical illness**		

The above table has indicated how the two set of data from the merging of the two sets of data relate to each other. Data from the focus group discussions and the with the focus group with the health care professional on the challenges they experience in the provisioning of psychosocial care and support for the cancer patients at the hospitals and the face-to-face interviews with the cancer patients about their needs for psychosocial care and support at the hospitals. The themes of both data collection were fitting well allowing the convergence to reduce both themes to 5 (five) and only one (1) theme that was a stand-alone about depression and denial of the physical illness that should be recommended for further research to explore the concept further. The discussion of the above table will be discussed here below. The merging shall reflect the similarities or related concepts, confirm and contrasting ideas or expand on the findings.

3.6.1. Shortfalls of human resources

3.2.1.1 Lack of skilled health professionals has been discussed by the health care professionals as an element that gives more challenge in the proper provisioning of psychosocial care and support for the patients living and battling cancer. This too was identified by the patient participants in 3.4.2.1 maintaining rapport with practitioner, patients do not find enough time to maintain relations with the health care practitioners they have started with, as personnel are rotated from one service area to another, patient participants are affected by the shortage when they are transferred as indicated in 3.4.2.3 of the patients need to be transferred by a known practitioner to the treatment centres.3.2.1.2 in the focus group they indicated the overwork of the professionals bringing about burnout and inability to do proper care and support for the patients and this also brings about feeling of anxiety and frustration to the patients as their need for psychoanalysis is not met as indicated in 3.4.4.1. Lack of social support is an issue brought about by the lack of skilled professionals. Due to the shortage of skilled professionals in the province, cancer patients should travel for treatment. Family involvement is important in the communication about the diagnosis as indicated in 3.4.1.1. some patients do not like the involvement of family as they do not want to worry their children and spouses. The need to have a relative or significant other when receiving the sad news would at times relieve the patient of the anxiety and would receive support, though it is not all patients that want to share and be seen by their loved ones when they are at their lowest in this study.

Merckaert, Libert and Delvaux et al., (2005) indicated that patients sometimes are reluctant to disclose their psychological concerns spontaneously, and they leave the initiative of discussing these topics to their physician. It has been reported that distress in older patients is more difficult to detect, because elderly patients tend to show less overt symptoms of distress and often are more reluctant to talk explicitly about problems with emotional functioning. Low, McGrath, Swaffer and Brodaty (2019) highlighted that patient circumstances including level of awareness, level of severity and family support are the ones that influence effective communication in the diagnosis of patients and the health and social care system including access to specialist, diagnostic services, and reimbursement for diagnosis/management and availability of services. One other participant expressed the need to discuss his condition and its advanced stages and expressed the emotional need of the children before the eminent death and make them equipped considering the possibility of their own death from advanced cancer.

The hospitals are having a dire shortage of professionals let alone the specialised personnel like oncologists, psychologists, social workers, and the facilities important for general patients' care. Cancer care is physically and psychologically challenging both for care recipients and caregivers. Shortage of staff is jeopardising efforts to meet the Sustainable Development Goal of health for all by 2030, a pledge made by the international community in 2015. There is a need to raise number of nurses by at least six million by 2030.Currently, 80 per cent of world's nurses only serve 50 per cent of world's population (Baron, 2020). South African nurses are working excessively long hours ending up and not providing quality care. Overwork leads to fatigue and fatigue leads to greater chances of mistakes. Excessive overtime has been shown to impact negatively on patient care and increase the risk of 'compassion fatigue' which includes desensitisation and loss of empathy (Piennar, 2016). Patlak & Levit, (2009) also indicated that the expected shortages in other health care workers who are involved in cancer care, including nurses, physician assistants, laboratory and radiology technicians, social workers, radiologists, surgeons, pharmacists, public health workers, and cancer registrars, will affect both the quantity and the quality of cancer care in the 21st century. The nurse should provide a safe, emotional, spiritual, and physical environment for healing while incorporating all disciplines in care. Multidisciplinary team members play a part in providing a healing environment for the cancer patients.

The general practice in the hospitals is that nurses should rotate to have experience of other wards and services, but cancer care requires intensive nursing and skills for cancer care. This interferes with the promotion of interpersonal learning and teaching in cancer care, as indicated in carative factor 7 of Watson's theory of human caring. Nursed engages a teaching and learning environment where continuous education of staff and patients is always happening. Nurses learn from each other and transfer skills from each other (Rexroth & Davidhizar 2003). Levit, Smith, Benz & Ferrel, (2010) indicated that retaining professionals in the services requires evaluating the entire pipeline of workforce development, starting with efforts to attract individuals into health careers, making education available and affordable, and investing in efforts to retain professionals in oncology careers (Levit, Smith, Benz & Ferrel, 2010).

De Beer, Pienaar and Rothmann (2016) indicated that both public and private sectors face major challenges to produce, recruit, and retain skilled nurses. He indicated that in a bid to keep bright medical professionals, young nurses are often fast tracked into senior positions by management. However, this practice often deprives these capable nurses of clinical expertise and the opportunity to specialise. Furthermore, the author contends that the number, competencies, and effectiveness of nurses is critical in determining the quality of care, patient outcomes, as well as improving the performance of our current weak health system (De Beer et al., 2016). Health care facilities in Limpopo province lack the necessary personnel with skills since they are rural based with poor infrastructure. Rosenzweig et al., (2012) indicates that it is an institutional obligation to provide practitioners with the necessary knowledge and skills to safely manage patients with cancer and their families. Furthermore, nursing leadership should reach out to physicians and hiring institutions to provide guidelines and templates for optimal knowledge and skill acquisition for new oncology practitioners. This could be accomplished through formal academic programs such as post-master’s programs, or a more flexible and informal electronic format offered while ONPs are in their first months of work (Rosenzweig et al. 2012).

Mbeki (2014) eluded that employee make comparisons of their jobs based on job inputs and outcome. Job inputs are effort, experience, education, and competence. On the other hand, the following constitute outcomes, namely salary levels, raises and recognition relative to those of others; if the perceived ratio is equal to that of the relevant others with whom comparison is made, a state of equity is said to exist. It can be concluded that our situation is fair, that justice prevails. When the ratio is unequal, equity tension is experienced by the staff.

South Africa has lost staff in health care services to countries like Dubai due to their comparative high remuneration packages in the last decades and that have crippled the health care and affected the quality of health of the consumers.

3.6.2 Poor patient administration and support

Administration and support of the patients in cancer care differ slightly with the other disease processes as oncology services are a specialised service that deal with patients that are scared and devastated about their diagnosis and in themselves would believe that it is the end of the road for them.3.2.2.1 On the delaying of patient's diagnosis is one of the factors that elevates uncertainty and anxiety states on the patients. Patients need information about their diseases process and clinical manifestations as indicated in 3.4.3.1 of the subthemes of the patient interviews. Patients are affected psychologically by the transfers and about changing therapists, exacerbated by the loss of files, and having to relate their plight every time a new therapist is to see them.

Patients felt that they needed to be navigated along to the treatment centres as indicated by the patients in 3.4.2.2 and in 3.4.2.3 .The health care professionals are also concerned of losing the patients along the transfers , once their patient is transferred from a local hospital to treatment centres it is not always possible to get report and to see the patient again as indicated in subtheme 3.2.2.4 resulting in questionable adherence to treatment regimen in subtheme 3.4.3.3 and lifestyle modification in 3.4.3.3 for therapeutic care. Patients get lost and sometimes never come back as they lose hope and courage to continue without support. Patients need to be encouraged to be hopeful in their cancer journey, instilling faith and hope as in Watsons carative factor 2 to the patients by incorporating of individual faith tradition in assisting patients with the acceptance of their current health status is part of providing holistic care and individualizing patient care, facilitates the promotion of positive health between the nurse and the patient (Rexroth & Davidhizar, 2003).

Lack of communication is a factor in cancer care as patient will not know how to identify the signs and symptoms without being taught and communication between the health care professionals and the patients as indicated in 3.4.1.1 on the need of proper communication from the health care professionals. Some of the patients do not find communication valuable as they are angry about their disease and does not take kindly to discussion about their plight. Pene and Kissane (2019) discussed issues around communicating with angry patients and patients in maladaptive denial in the clinical oncologic encounter can have several adverse effects on patients, families, clinicians, and collaborative decision-making. Pene and Kissane (2019) further indicated that that interventions on further communication toward clinicians and patients can benefit clinician-perceived self-efficacy and work quality of life and patients' emotional responses and engagement in decision-making, respectively.

Al-Azri (2016) indicated that patients are unable to identify common cancer symptoms such as unexplained bleeding, difficulty swallowing, change in bowel or bladder habits, sores that did not heal, unexplained pain, cough or hoarseness, unexplained lump or swelling, change in the appearance of a mole, and unexplained weight loss. Furthermore, the most reported barriers to seeking timely medical help include being too busy to make an appointment, concern about what the doctor might find, and difficulty talking to the doctor (Al-Azri,2016).

The best tool that the nurses can use is the way they communicate with their patients to establish rapport with the patients, when communicating to the patients the patients the nurse should also observe the non- verbal communication of the patients and should also keep in check how you as a professional communicate to the patients. Positive communication instils hope and faith which is necessary for the curative and the carative process as indicated by Watson's theory in the fourth and eighth carative factor of helping and trusting relationship.

Isenberg-Grzeda and Ellis (2019) indicated that patient recall of information, understanding of prognosis, establishment of goals of care, and shared decision-making are only some of the examples common to medical practice that are critically dependent on effective communication Isenberg-Grzeda and Ellis (2019) further indicated that effective communication in cancer care increases treatment compliance and improves outcomes, including satisfaction with care.

There is a need to curb late diagnosis and improve health outcomes in cancer morbidity in the rural communities. When patients are consulting at the clinics, a thorough history taking and examination to exclude cancer and other comorbidities should be done, there should be no misses opportunities in the clinics to educate and screen the patients considered to be at risk.

Urgent strategies are needed to increase public awareness on cancer, symptoms, and signs and when, where, and how to get assistance. Pearson, Poirier, Fitzgerald, Rubin, et al., (2020) reported that poor public awareness for early symptoms of cancer is the predominant reason for delayed presentation, particularly if symptoms are atypical in nature. Patients presenting to primary care with site-specific alarm symptoms can be referred onto urgent suspected cancer pathways, whereas those with non-specific symptoms currently have no dedicated referral routes leading to delays in cancer diagnosis and poorer outcomes.

Folkman and Greer (2000) theory of stress and coping encourages that individuals who are subjected to stressful events of a new diagnosis of cancer need to be followed up to appraise their stress and coping behaviour so as to be able to be assisted, within the understanding of their framework, the assessment of the patients cognitive and behavioural coping strategies can greatly assist the health care professionals in making clinical assessment regarding their coping strategies and the relieve of stress. If there is adequate communique amongst both the specialists, there system would reduce defaulting treatment on the part of the patients. If such has been assessed patients can be put on a programme that will relive the distress, this is in line with what Lewis-Thames, Carnahan, James, Watson & Molina (2020) suggested that written patient-provider communication improved timely follow-up care for self-identified rural cancer survivors. This study supports policy and practice that recommend the receipt of written survivorship care plans. Implementation of written survivorship care recommendations has the potential to improve survivorship care for rural cancer survivors.

Patient participants also require a navigator who is knowledgeable in the transfers and able to assist the patient fully until the patient can manage their circumstances and acquainted with the environment at the other hospital. Ugalde, Blaschke & Boltong et al.,

(2019) indicated that caregivers assumed several responsibilities once they arrived at the receiving hospital for cancer services, they provide various forms of personal assistance to the patient and assist in navigating the health services for multiple appointments during a single visit and the physical hospital environment, they described their tasks in navigating and locating different services in the hospital as cumbersome, when unable to attend and assist the patient themselves, efforts were made to organise another person to assist the patient during appointments. Support to navigate patients can be sought from the retired staff who are familiar with patient accompaniment to the oncology care services and can allay the patient anxiety states whenever that surfaces. This may present discomfort when having to recruit support from their hospital networks or request a member of their local community to travel to treatment centres (Ugalde et al., 2019). The status quo is different in rural settings of Limpopo province as only nurses of lower categories are the ones allocated to accompany patients to urban treatment centres and are not directly involved in the care of patients to continue with support.

3.6.3 Poor co-ordination of cancer care services

Cancer care services in Limpopo are said to have a poor co-ordination as such it is affecting psychosocial care and support services for the cancer patients. However, patients are given medical care and radiation under these poorly co-ordinated services.

3.2.3.1 Loss of patient’s files and laboratory results affect the whole process of information and screening as indicated by the cancer patients in 3.4.1.1. If the file of the patient is lost the whole issue about communicating cancer information and continuation of care is affected. Delaying patients to be diagnosed also is affecting the proper communication to the patients as to what is wrong with the patient to achieve maximum co-operation from the patient regarding treatment and care. Lack of policy and guidelines is impacting negatively on the patient’s psychosocial care and support as each therapist seem to deal with the patients anyhow or either way, they deem fit. Providing feedback or not to the referring hospitals. Availability of records is seen by patients as helpful not to repeat their story to other therapist and provide better understand of the patient by the health care provider.

According to Marutha & Ngoepe (2017) missing files contribute to the length of time patients wait to be assisted. Thus, nurses and doctors are unable to assist patients or treat them immediately. The introduction of an electronic records management system that can capture and provide access to a full patient record, as well as tracking paper records movement, irrespective of the location is necessary (Marutha & Ngoepe, 2017). Missing records too lead to interference in proper co-ordination of health of care services.

Most healthcare providers still use paper-based systems to capture and store patient records. According to Mostert-Phipps, Pottas & Korpela, (2012) and Wong & Bradley (2009) comprehensive medical records are a cornerstone in the quality and efficiency of patient care during the hospitalization and in subsequent follow-up visits, as they can provide a complete and accurate chronology of treatments, patient results, and future for care.

Paper-based patient records have a potential to negatively impact the quality of care that a patient receives and impact on the information continuity. Other issues that paper based health records present, include unclear handwriting, incomplete or inaccurate information and inaccessibility of health records from different locations which then expose patients to medical mistakes because healthcare providers would not be able to draw a connection between current and past medical history (Bantom, 2016).Subtheme 3.2.3.3 of the health worker challenge on inadequate and inefficient collaborative support in cancer care is supported by Moser, & Narayan (2020) that suggested that cancer care involves primary care, radiology, nuclear medicine, pathology, surgery, medical and radiation as such good communication and coordination is needed.

Moser & Narayan (2020), believe that allocation of treatment and consultations are not only medically driven, but also depend on patient’s capacity to understand, consent, travel and pay. Patients with cancer are affected socially and financially as they have interrupted times attending treatment and they are also paying for their local travels; Limpopo province provide them with transport to the treatment centres. All these should be well co-ordinated to enhance the proper management and psychosocial care and support for the cancer patients and to reduce feelings of anxiety and frustration for the cancer patients as in theme 3.4.4.1 and in 3.4.4.2 on lack of social and professional support.

3.6.4 Concerns relating to conflicting values and norms.

The norms and values of the indigenous and non-indigenous patients are different 3.2.4.1, In 3.4.3.2 patients' participants are concerned about their lifestyle modification for therapeutic care and elude that they do visit their traditional healers as their first contacts in the community that understand these illnesses and they trust in them more than they can trust the western medicines. Though patients do not talk much about their traditional medicines, the health workers uncover that as they continually converse with the patients. This has been seen by patients not fully adhering to treatment in 3.4.3.3 as they use more time in using alternative medicines and that lead to the factors that contribute to the diagnosis and treatment as indicated in 3.2.4.2. there is a gap in cancer knowledge about the disease process, clinical manifestation and treatment emanating from these conflicting values and norms.

It is important for the patients to be educated and supported psychosocially to improve their lives and allay their anxieties regarding their diagnosis. The psychosocial needs that should be considered including those for information, emotional support, collaborative decision-making, education, and socialisation.

Beentjes and Cocket (2020) indicated that while survival rates are high, diagnostic tests, symptoms and treatment regimens can have negative psychological and sociological implications for patients and their families, considering physical health needs and financial concerns. The importance of focusing on patients' and families' concerns when arranging psychosocial support is highlighted, together with the requirement to reassess their needs continually throughout the trajectory of the illness.

According to Watsons carative factors, factor one it eludes that patients and family, should be treated as they are and respect their values even if they are different from your own.in doing so this gives satisfaction through giving and creates the extension of the sense of self (Rexroth & Davidhizar, 2003). Most patients who are fearful of western medicines doctors and the nurses, will always show signs of being reserved and would not converse easily about themselves in the early days of submitting to them, it gets better as the relationship with each other progresses. Health care professionals should encourage patients positively so that they can accept the fact that they may not be cares by the same professionals always. The more meaningful conversations with the patients can serve as a way of psychosocial care and support for the patients, patients will have a point of reference when they need support.

Li, Luo, Cao, Lin, Xu & Li (2019) indicates that open and constructive communication can reduce cancer caregiver burden, promote intimacy between cancer patients and their spousal caregivers, and improve the physical and mental health of patients and caregivers alike. Wang, Arber, Shen and Qiang (2020) indicated that psychosocial assessments and consultations, education, and interventions need to include a focus on the dependent children of adult cancer parents.

3.6.5 Concerns with disclosure of the diagnosis

Patient participants in 3.2.5.1 were having problems in disclosing their fears due to lack of trust in the different health works they were engaged with. Some patients would talk about their fears in a circumstantial manner and would ask the researcher not to divulge their fears to family due to their lack of social support and the fear of death. Concealed emotions and fear of death Wang et al., (2020) indicated that the perspectives of Chinese cancer parents toward truthfully disclosing their diagnosis vary, but all are for protecting their children, indicated that Chinese cancer parents have culture-specific considerations, such as concepts of death, there are barriers between cancer parents and children in communicating about the illness and unmet needs for information and support emotions and fear of death.

The following themes, theme six (6) was not well fitting into the convergence, this was observed by the health professionals as a behaviour of the cancer patients and none of the patient's participants has eluded on their observation of their change in behaviour and the denial of their condition. The focus groups have all agreed that patients deny their conditions and do not partake in the activities that show that they acknowledge the seriousness of their conditions. The researcher suggests this to be a future area of concern to be studied.

3.6.6. Depression and denial of the physical illness

Chronicity in cancer pain is associated with a series of psychological signs such as sleep disorders, anorexia, decreased concentration, irritability, and signs of depressive disorder. Individuals attempt to protect themselves from damaging effects of hopelessness, sadness, fear, stress of cancer diagnosis by denying emotional conflict or intrinsic or extrinsic stressors (Topuzoğlu, Cimilli, Ağdanlı & Binbay, 2019).

Depression and denial of the physical illness is interrelated with the feelings of anxiety and frustration in 3.4.4.1 and concealing of emotions and fears. Patient participant has expressed the need for psychoanalysis and proper management and holistic care. The concealed emotions and fears that was identified by the health care professionals can be uncovered by continuity in care and continuous communications. During assessment, patients should be respected if they show denial; patients should not be forced to face stressful situations if they are not yet ready. Personality has been commonly viewed as an independent predictor of patient’s psychological quality of life, and it is reasonable to assume that patients with optimistic personalities are able to develop better mental resilience to cope with their difficulties, and therefore experience fewer disease-related mood disturbances. However, patients with more physical comorbidity reported elevated fear, anxiety, and depression (Sun, Yang, Zhang, Liu, Wang, Garg & Zhang, 2019). Denial may serve as a purpose in protecting patients in this regard and thus should be respected. Therefore, properly informing patients is one of the most important factors in supplementary treatment of cancer because it can help in facilitating informed decision making and in developing a sense of control in patients (Topuzoglu et al., 2019). Isenberg-Grzeda and Ellis (2019) indicated that patient recall of information, understanding of prognosis, establishment of goals of care, and shared decision-making are only some of the examples common to medical practice that are critically dependent on effective communication. Isenberg-Grzeda and Ellis (2019) further indicated that effective communication in cancer care increases treatment compliance and improves outcomes, including satisfaction with care. The level of literacy too has an effect in compliance and the support that the patient is receiving influences cancer patient's compliance, personality too is a dependent factor. Patient's personality has been commonly viewed as an independent predictor of patient's psychological quality of life, and it is reasonable to assume that patients with optimistic personality can develop better mental resilience to cope with their difficulties, and therefore experience fewer disease-related mood disturbances. However, patients with more physical comorbidity reported elevated fear, anxiety, and depression (Sun, Yang, Zhang, Liu, Wang, Garg & Zhang, 2019).

Pene & Kissane (2019) discussed issues around communicating with angry patients and patients in maladaptive denial in the clinical oncologic encounter can have several adverse effects on patients, families, clinicians, and collaborative decision-making. Pene and Kissane (2019) further indicated that interventions on further communication toward clinicians and patients can benefit clinician-perceived self-efficacy and work quality of life and patients' emotional responses and engagement in decision-making, respectively.

Folkman and Greer, (2000) indicated that when individuals are facing such a crisis, they should feel that they are not alone. All efforts to overcome interpersonal isolation, have important roles in times of severe strain and stress (Folkman and Greer, 2000). The need to have a relative or significant other when receiving the sad news would at times relieve the patient of the anxiety and would receive support, though it is not all patients that want to share and be seen by their loved ones when they are at their lowest in this study. Merckaert, Libert & Delvaux, et al., (2005) indicated that patients sometimes are reluctant to disclose their psychological concerns spontaneously, and they leave the initiative of discussing these topics to their physician. It has been reported that distress in older patients is more difficult to detect, because elderly patients tend to show less overt symptoms of distress and often are more reluctant to talk explicitly about problems with emotional functioning.

The focus group discussions and the interviews with the patients has shared valuable challenges in their practices as health care professionals in cancer care and will assist in the formulation of strategies to improve the psychosocial care and support in the hospitals in Limpopo.

3.7. CONCLUSION

The discussion of the patient interviews and focus group with the health professionals was discussed in these chapter, both the findings were similar and related as the patients' needs were fitting to the challenges the health worker brought to light, that assisted in the merging of the finding. Literature control was done on the findings and presented following the merging. The focus group discussions and interviews has shared valuable needs and challenges in their practices as health care professionals in cancer care and consumers of cancer care services and will assist in the formulation of strategies to improve the psychosocial care and support in the hospitals in Limpopo.

CHAPTER 4

CONCEPTUALISATION OF A THEORETICAL FRAMEWORK

4.1. INTRODUCTION

The previous chapter described the findings from both interviews and focus group discussions. A discussion of the related aspects of Watson's theory of human caring and Folkman and Greer (2000) theory of stress and coping were incorporated in the elaboration of the study findings. In the following chapter the theories will be equally incorporated and applied.

4.2 CONCEPTUAL FRAMEWORK

The study was guided by Watson's theory of human caring and Folkman and Greer theory of stress and coping. The conceptual model by Folkman and Greer (2000) is based on three prominent psychological theories, health, stress, and coping, uncertainty and illness, and psychosocial adjustment to illness. Watsons theory evolves around the ten curative factors that directs the two theories are concerned with the proper assessment and appraisal of patient's health status and the thorough planning interventions that will provide greater achievements of the best health outcomes that should be implemented.

4.2.1 Core concepts of the framework

The following are the main concepts in Folkman and Greer are coping, positive emotion, chronic stress. this framework is used to define variables that research indicates contribute specifically to psychological well-being during serious illness.

The first core concept that relate the two theories is the occurrence of a stressful event of which in this study is a cancer diagnosis that brings along a need for proper and full or holistic assessment of the physical and the psychological adjustment to the diagnosis social aspect of the individual and the spiritual aspect.

When an event occurs, it triggers a reaction in an individual that may need to be appraised. the role of appraisal in the coping process at the diagnosis of cancer would be to identify if the challenge of cancer is a major threat to the patients psychological being or not. The assessment whether there is a positive or negative attitude towards issues such as denial that will be evidenced by the cancer patient carrying on with life as if there is no cancer diagnosis and the acceptance of defeat.

Greer and Watson have identified five common adjustment styles as fighting spirit where the patient engage in all ways possible to seek help and taking active role in own recovery. avoidance of denial when the patient denies the impact of disease were the patient displays positive avoidance. Not thinking about the disease nor acting to get help. Person with passive acceptance and believing that as fate and not attending to own health needs.

The second core is appraisal of an attitude of hopelessness and helplessness is important as patient’s show evidence being overwhelmed by the diagnosis and focusses attention to the impending los and the perception of negative outcome and no effort of trying to get involved in own recovery. Watson’s theory stresses the need to plan for the perceived problem as appraised in the Folkman and Greer (2000) theory, so as acknowledge, and resolve the physical and emotional challenge experienced by the patient and becoming problem focused in dealing with all the challenges the patient is experiencing to assist in the total health of the patient and family.

The third core is the implementation phase of these theory, there is a need to strive to positive outcome to optimise the health of the patients. Appraising and reassessment of negative outcome of cancer diagnosis is necessary as there will be symptoms that are evident and that may be related to treatment, changes in mental and physical challenges, challenges in the patients social and financial roles and the changes in the appearance of the individual patients. The individual adjustment to the disease or the stressor is the results of the interpretation of the stresses involved and the coping strategies that are available. It is also influenced by personality and influenced by the quality of emotional support available (Folkman & Moskowitz 2000).

The fourth core is maintenance of psychological well-being in the face of serious illness. The upliftment of the patient’s morale towards improvement and instilling hope is essential for people who are coping with serious and prolonged psychological stress so as they can be able to survive their ordeal. Hope has an incredibly special quality that is especially important in managing uncertainty Hope and coping are related terms. This relationship is illustrated with two adaptive tasks common across situations that threaten physical or psychological well-being—managing uncertainty and coping with a changing reality (Folkman 2010). The essay describes ways in which coping fosters hope when it is at low ebb as well as ways in which hope fosters and sustains. According to Folkman (2010) hope is discussed from the vantage of psychology and stress and coping theory, hope and psychological stress share several formal properties which are both contextual, meaning-based, and dynamic, and both affect well-being in difficult circumstances.

4.2.2 Contextualisation of the framework

In Watson theory, there are essential elements necessary to uphold when dealing with patients diagnosed with cancer to assist them in their journey during care and treatment, they are those that are necessary for my study as they contribute to psychosocial care and support in a big way. These elements are as follows.

Embrace

Altruistic Values and Practice Loving Kindness with Self and Others. Altruistic values have been conceptualised as part of personal value structure or overall guiding principles that motivates individuals to contribute to the wellbeing of others or society as a whole (Swart, 1972).The concept care has been central in the theory of Watson of human caring, essentially based on humanistic values of respect, collaboration, and uniqueness rather than on objectification, control, and categorization of the person cared-for, a professional's practice rooted in caring is aimed at helping individuals and their families, which can only be carried out through respect for human dignity (Cara & O'Reilly,2008). In this study the researcher has based the whole concept of psychosocial care and support of the cancer patients on the importance of understanding the uniqueness of patients with cancer and their different backgrounds to fulfil their cancer care and support needs. Presenting and availing yourself as a heath care professional to listen and support the cancer patients would be a therapeutic relation starting to form and which should be nurtured throughout the patient’s journey with the diagnosis and treatment.

Inspire

To inspire other people is an extraordinary quality as if arising from an external force to instil faith, hope and to honour others. Nurse’s behaviour that is perceived as caring is giving of self, meeting patients' needs in a timely fashion, and providing comfort measures for patients and their families (Chipman, 1991). The phenomenon of caring is perceived by patients and nurses differently. Hope is an important factor to consider when caring for cancer patients as a key component of coping with adversity (Sanatani, Schreier & Stitt, 2008). In this study Watsons theory of human caring has been constantly referred to as a source of hope and encouragement in identifying what is lacking in the provisioning of psychosocial care and support for the cancer patients considering identifying strategies that can be used to fulfil the gaps identified. Over time, overall hope should be maintained or increased even if cancer patients are at their worst situations, these will remind the health care professionals to explore the experience of hope with all patients to ensure that the subjective needs and goals of the patients are met by the proposed therapies (Sanatani, Schreier & Stitt, 2008)

Trust

Self and Others by Nurturing Individual Beliefs, Personal Growth and Practices, the Core Principles evolving from carative factors (Watson, 2008) involve the practice of loving-kindness and equanimity, authentic presence that enable deep belief of other, cultivation of one’s own spiritual practice toward wholeness of mind/body/spirit—beyond ego and the therapeutic use of self in the psychosocial care and support of the patients with cancer. The eighth carative factors according to Watson’s theory encourages that creating healing environment at all levels, whereby wholeness, beauty, comfort, dignity, and peace are potentiated.

Nurture

Helping, Trusting, Caring Relationships

The following professionals are instrumental in helping to maintain a trusting and creating a relationship with the patients with cancer, welfare workers career counsellors, teacher's nurses, health visitors and midwives, occupational therapists and speech therapists' social workers, physiotherapists, ministers of religion, voluntary and youth workers (Hough, 2006). In the practice of nursing, nurses bring our clinical knowledge and humanity to the intersection of professional and patient, find opportunity to learn and grow from each of these encounters to improve the nurse's practice and insight into the care provided. However, such learning and growth requires intentionally reflecting on those interactions with the goal of identifying successful and unsuccessful strategies in care delivery (Pilkington, 2003). In this study the continuous assessment of the patient's psychosocial needs and strategizing on how to improve on their care and support and improve on the services rendered, with experience the health care professionals will row to understand how effective and important it is to develop a caring and trusting relationship with patients.

Accepting positive and negative Feelings of oneself and others. Sustaining a caring healing environment is imperative for both patients and staff. Cancer patients may have negative feelings about themselves and their diagnosis, they may also express negative thoughts brought about by the distress they feel or the perception of care they are receiving as patients perceive care differently. The health care professionals should strive to instil positive thoughts to assist the patient as much as possible to have hope and trust.

Folkman and Greer (2000) theory of stress and coping is also used in the development of the strategies to upraise concerns that are negatively impacting on the cancer patients weighing them down and unable to cope with their circumstances. It uses human subjects to develop the model, focuses on how individuals interpret stress differently, and promotes managing stressors through psychological coping mechanisms (Lim, 2020). Stress and coping theory are a framework for studying psychological stress. Events or situations that are perceived as unexpected and negative as in cancer illness that can disrupt life plans and lead to emotional distress. The theory holds that stress is contextual, meaning that it involves a transaction between the person and the environment, and it is a process, meaning that it changes over time. Stress is defined as a situation that is appraised by the individual as personally significant and as having demands that exceed the person's resources for coping. (Wolff, 2020). In this study the stress and coping theory will assist in developing strategies that will assist in appraising the psychosocial concerns of the patients and the strategies to meet the identified needs and the re- evaluation of the cancer patient's distress until an equilibrium is sought in the patient's life. The concepts that are engaged more with in this theory are:

Stress

Psychological stress results from an imbalance between the external environmental demands and an individual's perception of meeting them. Mental stress is often associated with depression, anxiety, and physical conditions including cancer and cardiovascular disease. People often experience stress if they realize that their assets are inadequate to handle a situation. The relationship between psychosocial stressors and disease is affected by the nature, number, and persistence of the stressors as well as by the individual's biological vulnerability (Prasetio, Tamura & Tanno, 2020). Both the disease and treatment lead to impairments in physical appearance and general bodily functioning (Oers, & Schlebusch, 2020).

Most cancer patients are devastated by the sad news of their illness and associated factors such as long-term treatments and their social interruptions caused by the cancer, as such they get stressed and anxious and wonder if they are going to cope and make it through. The theory will assist in the appraisal of the stressors and identify suitable strategies in coping with the distress.

Appraisal

The cognitive appraisal of stress is composed of two stages, namely the "primary appraisal", and the "secondary appraisal" (Folkman & Lazarus, 1984). Primary appraisal is the term applied to the appraisal of the personal significance of a situation, what is happening and whether it matters and why. Primary appraisal is shaped by the person's beliefs, values, and goals. Primary appraisal includes the initial perception of a stimulus, and the individual decides whether the event is threatening or stressful for himself (Bookless, layer, & McFarlane, 2000; Folkman, Lazarus, Gruen & DeLongis, 1986; Folkman & Lazarus, 1986).

Secondary appraisal refers to the person's evaluation of options for coping during the secondary appraisal stage, the individual evaluates his resources for coping, and determines how to cope with the stressor (Folkman & Lazarus, 1986). These options are determined both by the situation, such as whether there are opportunities for controlling the outcome, and by the person's physical, psychological, material, and spiritual resources for coping. The appraisal process generates emotions such as anger or sadness, associated with loss of appraisals. Anxiety and fear are associated with threat appraisals. The personal quality of the appraisal process explains why a given event can have different meanings for individuals.

Coping

Coping refers to the thoughts and behaviours people use to manage the internal and external demands of stressful events, to address the problem causing distress using strategies such as information gathering, decision making and emotion-focused coping to regulate negative emotion using strategies such as distancing, seeking emotional support, and escape-avoidance. Positive emotions serve important functions in the stress process by restoring resources for coping, which helps transform threat appraisals into challenge appraisals, and motivating and sustaining coping efforts over the long term.

The various types of coping often work in tandem, such that the regulation of anxiety (emotion-focused coping) will allow the person to concentrate on deciding as problem-focused coping (Gruszczyńska & Knoll, 2015), which in turn is informed by a review of underlying values and goals as meaning-focused coping. Ideally, there would be independence among these processes to permit prediction (Gruszczyńska & Knoll, 2015).

Hope

Hope is a way of thinking about goals. A person’s level of hope reflects the amount of agency and pathways he or she has. Higher levels of hope have also been correlated with more positive health outcomes (Snyder, 2004; Snyder & Sigmon, 2002). Snyder, Shorey, Cheavens, Pulvers, Adams & Wiklund (2002). Hope is defined as yearning for making better of a dreaded outcome. Hope has also been characterized in the nursing as something that is deep inside oneself that remains positive whatever happens, goal-setting entity in response to situations, anticipating future possibilities and positive results. Hope and psychological stress share many formal characteristics. Hope, like stress, is appraisal-based, it waxes and wanes, is contextual, and is complex (Folkman, 2010). Hope has a cognitive base that contains information and goals. The revival of hope in intensely stressful situations depends at least in part on cognitive coping processes. In turn, the person's capacity to sustain coping with intensely stressful situations over time depends at least in part on having hope with respect to the desired outcome. The interdependence of coping and hope is played out in many ways over the course of prolonged stress, as can be illustrated in the case of serious disease. Learning that one has a serious disease changes how things are for the patient and the patient's family members and close friends, especially those who are involved directly with the patient's caregiving. The challenges to well-being may differ according to diagnosis and patient characteristics such as age, health, access to care, social support system, and psychosocial and psycho-spiritual resources. But certain adaptive tasks are common seriously ill patients and their family members.

4.2.3 Contextualisation of the framework in the study themes

This study started by finding out about the challenges that are experienced by the health workers in the provisioning of psychosocial care and support for the cancer patients using focus group discussions and the face-to-face interviews of the patients undergoing cancer treatment on their psychosocial care and support needs at the selected hospitals in Limpopo.

Key areas of challenges and needs were identified and merged in chapter three which are:

Shortfall of human resources

Shortfall of human resources affect patients significantly and the health care professionals as the processes of creating and experiencing transpersonal caring -healing moments with the patients. The understanding of Watsons human caring moments one would understand how much a patient who is diagnosed with cancer would need adequate time and skilled workers to provide the immediate and long-term psychosocial care needs.

Watson's theory has evolved to bring about the ten carative factors to that are applied in this study and that indicate an ideal way of engaging with the patients with cancer to optimise their challenges. The practicing of loving kindness within the context of caring consciousness. The patient participants in this study indicated how much they needed their known practitioners to treat, navigate them and accompany them through their cancer journey which is impeded by the challenge of shortage of health skilled health worker challenge and attrition.

Holistic care of the cancer patient is seen in this study as inspired by Watson's theory in the full assessment of the cancer patients and the appraisal of effects of the cancer diagnosis by Folkman and Greer theory.

Poor patient administration and support in cancer services

Participants in this study has indicated how the services for the patients are lacking support for the patients because of the disintegration of services. Patients are seen by the different category of health care professionals at different level of care who are not reporting or communicating about the patients' progress and needs. This brings about uncertainty and increases the level of stress in the cancer patients. Patients' needs for communication and information about their diagnosis is compromised as the health professionals are also not communicating amongst themselves. For the cancer patients to be able to be fully functional depends on the hope instilled by the health care professionals that the persons psychological wellbeing will flexible, adaptive, and creative in finding ways to survive the cancer. This according to Watson's theory requires that the care givers should be authentically present and enabling and sustaining the deep belief system of self and other being cared for. Being available for the patients to provide for their needs is instilling of hope and trust.

Poor coordination of cancer services

Participants in this study has indicated that patients' files are lost in the filing rooms and the patients results, that makes the patients to stay long before seeing the doctor. Some patients end up not finding doctors when the files are found. Patient participants are saying when such occurs the feel, they need to take their files home and the hospital rules does not permit. Limpopo hospitals are still not practicing electronic files for easy access.

In this kind of experiences instilling faith and hope to the patients is mandatory to assist patients to stay positive. Patients need you as a source of strength. Therefore, the patients identified the need to be navigated by a known practitioner in their journey to the treatment centres and elsewhere within the health care systems as required. The long wait has seen patients going through a lot of stress and anxiety states and feeling that they have lack of social support. The unavailability of policy and guidelines affect the patients negatively as patient find themselves in the middle of problems due to lack of policy leading to poor co-ordination of the services.

Concerns relating to conflicting norms and values.

Patients have their own belief systems, and which are difficult to change, lifestyle modification and trusting in western medicines are still issues that the patients with cancer are struggling with and when required to adjust it becomes a stressor to them. The health care professionals are expected to practice loving kindness and indicate support that you will be with the patients throughout. The practice of kindness will help the incorporation of individual cultural faith traditions in assisting patients with the acceptance of current health status as part of provisioning of holistic care and individualizing patients care will promote a positive health between the health care professional and the patient. Furthermore, it will be a way of instilling faith and hope. Providing a safe emotional and physical environment is important to providing healing. Respecting the patient values even if they are different from yours is important to uplift the patient's psychological being.

Concerns relating to disclosure of cancer disease.

Patients with cancer has a lot of emotional problems that need to be appraised as there is an element of fear of disclosure of their emotions, some are afraid of death some believe in fate some fear death. Promoting shared problem solving, teaching and self-care, coaching and guiding informing and explaining and giving feedback to the patients as part of nursing care will alleviate negative thoughts that the patient may have. This type of relation uses the nursing process to bring a scientific problem-solving approach nursing care. Helping and Trusting relationship is necessary. if you promise to come back and check on something, keep that promise. Establish a caring presence with your patients.

Observance of maladaptive personality traits affecting mental health related qualities.

Participants in this study are said to be denying their physical illness as they go about their activity living without a care of what the outcomes may be. No efforts done to improve their conditions and sometimes default the treatment and do not turn up for appointments. Some patients require continuity of care and important follow-up plans for them post treatment.

Promote expression of negative and positive feelings is important to appraise concerns and instil hope and create atmosphere to assist patients in coping with their problems.

4.3. CONCLUSION

This chapter has conceptualised the study findings within the conceptual framework. The conceptualization has guided the researcher in the development of strategies to improve the psychosocial care and support services for the cancer patients at the hospitals in Limpopo province. The following chapter will lay out and discuss the strategies guided by the themes that emanated from the study.

CHAPTER 5

DEVELOPMENT OF THE TRATEGIES TO IMPROVE PSYCHOSOCIAL CARE AND SUPPORT OF THE CANCER PATIENTS IN THE HOSPITALS IN LIMPOPO PROVINCE SOUTH AFRICA

5.1 INTRODUCTION

This chapter presents the development of strategies to improve the psychosocial care and support of the cancer patients at the hospitals in Limpopo Province. The chapter presents the processes that were followed in the development of the strategies. The development of the strategies was guided by the findings of the current study, the relevant aspects of literature, the theoretical framework used to form the basis of this study as well as the researcher's insight and experiences in the cancer care services at the hospitals.

5.2 BACKGROUND TO THE STRATEGIES DEVELOPMENT

Cancer patients are experiencing challenges regarding psychosocial care needs and the health care professionals are experiencing challenged in the provisioning of the psychosocial care in the hospitals due to the factors outlined in the chapter 3 of this study. The researcher, Ramutumbu (2016) conducted a study on the experiences of cancer patients regarding care at the hospitals in Vhembe district of Limpopo Province, the study revealed that there are lack of psychosocial care and support for the cancer patients, the researcher then embarked in the present study to develop strategies to improve the psychosocial care and support of the cancer patients in the hospitals. The current study uncovered the challenges encountered by the health care professionals in the provisioning of the psychosocial care and support in the hospitals as discussed in the themes and subthemes in the previous chapter. In the current study the cancer patients have also indicated their psychosocial care and support needs also tabled thematically in the previous chapter 3. There are rules that govern the professional heath care teams to abide with as they practice their professions. The HPCSA (Health Professionals Council of South Africa) and the SANC (South African Nursing Council) lays standards to be upheld when providing whatever health service to the consumers of healthcare across spectrum (Bezuidenhout, 2014). It is also the case with cancer patients who are under care in the hospitals.

5.3 PROCESS OF DEVELOPING THE STRATEGIES

The psychosocial approach looks at individuals in the context of the combined influence that psychological factors and the surrounding social environment have on their physical and mental wellness and their ability to function. This approach is used in a broad range of helping professions in health and social care settings as well as by medical and social science researchers. The proposed strategies were formulated based on the key areas challenges of the health care professionals and the needs for psychosocial care and support for the cancer patients and needs gathered from the current study analysis. The development of the strategies was guided by the theoretical framework outlined in chapter 1. The framework comprises of Watsons theory of human caring and Folkman and Greer theory of stress and coping.

In table 3.5. Key areas of the challenges of the health care professionals and the psychosocial care and support needs of the cancer patient are merged. In the provisioning of psychosocial care and support needs of the cancer patients, the Watsons curative factors in the human caring theory will be made evident in the activities proposed as indicated in chapter and the key elements of Folkman and Greer's key elements of stress and coping theory.

5.4 FORMULATION OF THE STRATEGIES TO IMPROVE THE PSYCHOSOCIAL CARE AND SUPPORT FOR THE CANCER PATIENTS IN THE HOSPITALS IN LIMPOPO PROVINCE.

This section presents the strategies for improving the psychosocial care and support in the cancer services at the hospitals in Limpopo. The strategies are informed by the study that investigated the needs of the cancer patients regarding psychosocial support and the challenges that are experienced by the health care professionals in the provisioning of psychosocial care and support in the cancer services, a wide range of literature review and support for the themes and the professional experience of the researcher. The formulation of these guidelines is also informed by the theoretical framework of Watson on human caring theory and Folkman and Greer (2000) theory of stress and coping as discussed in chapter four.

The strategies are therefore formulated from the key areas of needs and challenges resulting in the study findings. Each strategy is preceded by an objective and the relevant narrative from the study participants and the activities that may improve services in the provisioning of psychosocial care and support at the hospitals in Limpopo province.

5.5 STRATEGIES TO IMPROVE PSYCHOSOCIAL CARE AND SUPPORT STRATEGIES FOR THE CANCER SERVICES AT THE HOSPITALS IN LIMPOPO PROVINCE.

5.5.1. Theme 1 LACK OF SKILLED HEALTH PROFESSIONALS

Objective	Desirable outcome	Responsible person	Time frame	activities
To provide reasonable provisioning of adequate staff for cancer care and support	• Enough staff to cope with workload. Increase staff by at least 30% • Prevent staff from burn out. Reduce absenteeism by 50%	• Nurse managers • Human resource • Multidisciplinary team in cancer care	6 months evaluation to 2 years of 70% achievement	(Indicated below)

	- Provide psychosocial care as always needed by the patients.100% cancer care and support. - Rotate staff less in cancer care .50% of staff to remain in cancer care permanently	- Nurse managers		

Activities

- Create opportunities for training and study leave for the nurses interested in oncology services to increase patient care and alleviate stress and overwork on the available staff.

Recognition of qualified oncology nurses

- Recognise certificates and training of those nurses that are trained in oncology services from universities and colleges with valid and recognised certificates, create posts for them in the services for the cancer patients.
- Recruitment of (appropriately)multi-disciplinary skilled personnel in oncology care, with scarce skills in the oncology services like psychologists and hospital doctors.

Manage the oncology human resource (filling of vacant posts)

- Additional training posts should be filled, in service training of a staff; advertise the posts to attract the staff and liaise with head office HRM to fast track the process of appointment of staff.
- Produce statistics that will inform management in staff recruiting and allocation.

- Limpopo colleges and universities to consider training oncology nursing as a post basic to increase staff trained in oncology care.

- Provide statistics of patients seen and attended by the health workers to inform managers of the allocation of staff.

Design a 24hours oncology care coverage.

- Provide enough personnel to always cover the services to ensure that no patients should be without care and support as needed.

  - Less rotation to ease emotional and psychological stress/strain.
  - Design flexi-time schedules to relieve/overcome physical strain/fatigue.

- Provide for allocation of other personnel in the services to support the oncology services as a means of transferring skills to ensure adequate coverage and the relieve of overwork on the trained staff.

Provide psychological support and debriefing to staff.

- Provide relieve oncology nurses off the stress of overwork by monitoring their sick and leave cycles to ensure that they are also cared for/debriefed to improve the service delivery.

- Resources should be made available, such as clinical supervision, peer support and counselling of the oncology nurses and sessions for debriefing to relive some traumatization that may occur in the services related to cancer care and loss.

- Involve occupational health departments in carrying out regular check-ups and report on the health of the health personnel to ensure that overwork is not overpowering their wellbeing.

- Provide ongoing psychosocial and professional support for the health care professionals involved in cancer care to improve their morale.

- The use of their church support structures should be used in navigating the patients to their treatments.

- Use of retired oncology nurses and other health care professionals can be considered for social support in the community and assist in navigating the patients to treatment.

- Form community support structures with the key leaders in the community.

- Ensure that the cancer patients are not left unsupported.

- Adopt the DOT support system of the TB patients to identify the community support structure that will give social support.

- To develop a policy regarding staff rotation to ensure that personnel should not be rotated unnecessarily to avoid disruption of services and disturb health personnel's interests in disciplines to avoid killing staff morale.

- Health-care systems and institutions need to tailor integration based on their resources; hospitals may include outpatient staff to assist in the oncology services by scheduling the oncology clinics in the less busy OPD days to draw in most staff to the clinic to relive in the shortage of staff. That will ensure the transfer of skill and prevent patient waiting for the services for a long time.

- Establish mechanisms to ensure accountability, transparency pertaining to policy of rotation of staff in the hospitals.

- Ensure that policies are not selectively applied in certain services.it must apply to all services for chronic illnesses in the hospitals.

- Acknowledge and respect every personnel's needs regarding allocation, acknowledge staff strength and weaknesses in the allocation to make the most out of the staff allocated.

- Cancer patients should also be treated as all other patients with chronic illnesses to avoid isolation of the cancer services and the patients.

5.5.2. Theme 2: POOR PATIENT ADMINISTRATION AND SUPPORT IN CANCER SERVICES AND COMMUNICATION WITH THE PATIENTS.

Objectives	Desirable outcome	Responsible person	Time frame	Activities
Provide continuity of care, adequate information about cancer. Avoid delays in diagnosis by integrating with community health personnel, traditional and communicate well with all levels of care in cancer. Navigate patients to all levels of care.	Reduce interruptions of patient care by 60%. 80% of at-risk population educated on cancer screening	Multidisciplinary team in cancer care	1 year Year	Indicated below

Activities

- Intensify patient teachings at all levels about the recognisable signs and symptoms of cancer so that they can report at the health facilities in time.

- Promote campaigns against stigmatisation, discrimination and stereotyping regarding cancer.

- Allow sharing of information or teaching community structures to keep on spreading cancer information.

- Make use of local radio stations to always have slots for cancer awareness not specific health calendar days in different languages spoken locally.

- Deal with the misconceptions in cancer care such as:

1. Cancer is diagnosed in hospitals and replace it by information that all health care professionals can assist in early detection and screening

2. General practitioners are not particularly good at diagnosing cancer replace that by informing the public about the similarities of the services and knowledge of cancer screening and diagnosis, inform the community that the specialist is scarce and costly and can do the same job as the specialist to some extend

3. Screening makes symptomatic diagnosis less relevant and is replaced by informing with information that screening is basic and informs the practitioners of what to screen for and how to make diagnosis

4. The cancer detection rate in clinics should be high, not always will it be as high as expected providers of health care and the practitioners have eyes and ears to the detections of cancer signs and symptoms.

5. There is no proof that early diagnosis of symptomatic cancer matters, inform them that early detection of cancer reduces treatment delays

- Establish a structure to deal with psychosocial support for patients with cancer and make them known by the communities.

- Network with counsellors and therapists to attend to issues such as anxiety, stress, depression, and trauma public's fears is based in their experience with family and friends dying of the disease. Provide assistant care in the home and involve community health workers like home-based carers and men and woman in the village.

- Establish cancer control to improve patients' experiences and change experiential knowledge about cancer and psychosocial support and encouragement of wellness programmes.

- Public awareness and information about how, where, and when to seek medical attention should be made more available improving communication between the health care system and the community through publicity and awareness campaigns. Detecting cancers at early stages would lead to better prognoses and less-costly treatment.

- Communication with cancer patients should be improved to compliance with treatment.
- Allow patients freedom to ask questions about concerns their concerns.
- Give individualised information about each individual diagnosis.
- Health care professionals should know the history of the patient to disclose diagnosis.
- Know how independent the patient is to be able to deal with the diagnosis.
- Availability of support system from trusted family or community member
- Know the academic level of the patient to be a to understandable to use comprehensible language with the patients and the information on disclosure.
- Know the cultural background and belief of client about illness.
- Provide information using different formats on available services.
- Provide full information on patient screening and anticipated treatment well to the understanding of the patients.
- Provide different sessions of reviews with the patients.
- Ensure that patients are accompanied by parents, family during disclosure or breaking of the news the people counselling before treatment to ensure acceptability of treatment they trust
- Use language patients can comprehend
- Be specific about individual patient diagnosis
- Allow patients time to synthesise the information provided and the diagnosis
- Clarify understanding and comprehension of information provided
- Give brief information about their anticipated treatment plan, involve them in the treatment planning
- Make them value seeking for more information about treatment and diagnosis

- Understand the uniqueness of patients. With unique types of needs

- Training of traditional healers can be enhanced to facilitate their professionalization and their collaboration with other health care workers in the prevention of cancer.

- Acknowledge the traditional healers' perceptions of the causes, signs and symptoms, diagnosis, prevention and treatment of cancer and work with them through the department of health, their perceptions of westernized treatment of cancer their perceptions of traditional healers' role in health education.

- Teach patients about cancer so that they can understand the role of cancer western medicines and its effectiveness in treating cancer.

- Some patients are fearful of hospitals and more over cancer treatment centres are to be travelled to ensure that the patients are reassured and supported.

- If possible, allow family to support the patients in attending sessions at the hospitals.

- Create rapport with fellow practitioner at tertiary institutions to be able to make a follow up.

- Improve the factors that could have an influence on patient and professional behaviour, and consequently contribute to delays in cancer diagnosis and poorer cancer outcomes include centralisation of services, free movement of patients between primary care providers, access to secondary care, and the existence of patient list systems to have control of what is going on with the patients to be able to provide support.

- Use community health structures like trusted persons to the patient to support them will reduce stigma and make patients to respond to treatment and care.

- Encourage the hospitals to have electronic files and communication that can be accessed by both health care professionals at any given time to curb the non-communication amongst health professionals.

- In the meantime, patient retained records can be useful to assist in communication about the patient's communication about continuity of care.

- Ensure that there is available staff to navigate patients to the treatment centres.
- Establish department policies that must guide and regulate transfer and navigation of patients to treatments.
- Engage management on the increasing of staff even if they are not yet trained in the oncology services to assist in the transfer and bringing back report about the patients.
- Use of other community members to navigate patients like home-based care and religious support structures and the retired staff in oncology.
- Train local groups in cancer care and navigation to be able to assist in the navigation of cancer patients to cancer treatment centres.
- Engage the family members in navigating patients so that they can also report back on the progress of the patients and in proving psychosocial support.
- Get groups of nurses to volunteer in attending small courses offered for navigating cancer patients including retired oncology nurses and retired professional nurses.
- Church structures can be involved in navigating and psychosocial support and care of their church members in cancer care.
- Patient's that are transferred should be given written reports to return to the transferring hospital.
- Encourage patients to return to primary hospital to assist patients to keep scheduling and appointments.
- Arrange follow-up care, coordinating and streamlining files/results and reports for reporting and care.
- Identifying appropriate local resources and support, helping to identify and obtain elderly care or transportation if needed.

5.5.3. Theme 3: LACK OF CANCER POLICY AT THE HOSPITALS

Objectives	Desirable outcome	Responsible person	Time frame	Activities
Improve cancer care coordination as a priority to improve the delivery of health services for people with cancer	Availability of cancer care co-ordination policy at the hospitals.	Hospital managers.	6 months	See below

Activities

- Identification of the current barriers to effective cancer care coordination is needed to drive service improvement.
- Re-align institutional policy and mission statement with the requirements of the National health policy statement in oncology care.
- Ensure that policy development suit patients' needs and the institutional levels.
- Develop inclusive procedures to accommodate patients' needs and staff challenges.
- Ensure that policies and procedures have inputs from all role players including family and community structures.
- Benchmark policy with the institution's that are running well.
- Disseminate policy and procedures to the entire health care team involved in cancer care will enhance smooth cancer care coordination.

- Policies should be developed that maximize the integration of cancer patients and their families into society.

- Care should be taken to discourage prejudice based on diagnosis, and to ensure that judgments regarding career, employment and insurability be made based on the current health status of everyone.

5.5.4. Theme 4: INADEQUATE AND INEFFICIENT COLLABORATIVE SUPPORT IN CANCER CARE

Objectives	Desirable outcome	Responsible person	Time frame	Activities
Manage cancer care equally alongside with other services in the hospitals.	Recognition of the importance of cancer care and support services at the hospitals Integration of cancer care and support with other health care services by 50%	Nurse managers	Bi-monthly	See below

Activities

- Guidelines/protocols should be known by all in cancer care and support services.
- The set of interactions necessary to go from one type of care to another, such as the transition from detection to diagnosis, including safety, effectiveness, patient-centeredness, timeliness, and efficiency that can be measured for the process.
- Intermediate and long-term outcomes of health-care quality on patient should be set and laid down to assist the health care professionals in their interaction with the patients.

- Intermediate outcomes include changes in risk status, stage at diagnosis, quality of life, quality of death, and financial burden. Long-term outcomes are changes in morbidity and mortality for the population.
- Policies should be developed that maximize the integration of cancer patients and their families into society.
- Care should be taken to discourage prejudice based on diagnosis, and to ensure that judgments regarding career, employment and insurability be made based on the current health status of everyone.

- Establish a solid and caring relationship with clients and patients

- Reassure the patients that cancer is not always leading to death

- Patients who do not disclose should not be judged

- Provide continuous counselling to allay anxieties and focus on improved thought process about the cancer

Involve spiritual counselling if needed.

- Reassure patients that it is fine to hold to their information until they are ready to disclose, encourage them that they should make their minds to disclose so as not to delay treatment

- Understand the belief system of the patients and clients

- Understand the nature of the relationship you have with the client as health professionals

- Rope in cultural community structures trusted by the patient and family members to improve support

- Avoid dependency on one practitioner or hoarding patients

- Encourage patients to understand shared responsibility and confidentiality amongst professionals involved in cancer care

- Encourage open minded attitudes amongst clients about support services and their integration in cancer care

5.5.5. Theme 5: INTERRUPTION OF RELIANCE IN TREATMENT AND CARE/ LOSS OF RELIANCE IN PROVISION OF TREATMENT AND CARE.

Objectives	Desirable outcome	Responsible person	Time frame	Activities
Provide patients with enough information to clear misconceptions. Teach patients about shared confidentiality amongst the health professionals involved in their care.	60%of informed community 90% trust between patients and professionals	Multidisciplinary health care team	On - going	See below

Activities

- Give patients enough information about transfers and how it works, present state of resources

- Psychosocial support is an integral part of the total management of all patients.

- The responsibility for overall management must remain clearly with a single treating physician.

- It is important that the treating physician remains the same, for if possible, to ensure continuity of care, given the close relationship that develops between doctor and patient.

- Encourage hospital management to provide enough support in transferring the patients.

- Use support from local spiritual support structures for transferring patients
- Work with management to develop indemnity in the transfer of patients by volunteers and to provide transport for the support structures

5.5.6. Theme 6: OBSERVANCE OF MALADAPTIVE PERSONALITY TRAITS AFFECTING MENTAL HEALTH-RELATED QUALITY OF LIFE

Objectives	Desirable outcome	Responsible person	Time frame	Activities
Give patients information in a manner that will generate understanding and behaviour change fuelled by support. Proper management and holistic care a discussion of discharge plans	Informed cancer patients 70% behaviour changes and confident cancer patients Availability of a discharge plan Support services for cancer survivors	Nurses ,Managers and multidisciplinary health care team	Continuously Monthly	See below

Activities

- Reassure patients that denial is good if it does not drag the caring and treatment process.
- Allow and assist patients to go through the normal grieving processes if it does not drag and disadvantage patient’s chances of treatment

- Help patients to accept the necessary and often intense treatment and they should be reassured that acute treatment consequences such as pain, or any long-term effects which may occur, can usually be effectively dealt with.
- Talk to patients about their cancer trajectory
- Try to allay anxieties as they surface
- Empower them to be able to identify treatment side effects
- Get treatment side effect support, treat, and employ treatment support structures
- Give education to support structures to ensure that the supporting persons has enough strength and emotionally strong to sustain supporting the ill patent
- Encourage patients to try and identify with their previous self before diagnosis
- Encourage services to plan excises with participants by involving physiotherapy and occupational therapists as part of care.
- Encourage patients to socially interaction with friends and family as before.
- Encourage to participant to participate in normal activities with people who are positive and encourage positive thinking about the cancers.
- Involve dieticians and community members in the nutrition of patients to improve diet and tolerance of the patients.
- Encourage patients to try and identify with their previous self before diagnosis.
- Encourage services to plan excises with participants by involving physiotherapy and occupational therapists as part of care.
- Encourage to participant to participate in normal activities with people who are positive and encourage positive thinking about the cancers.
- Involve dieticians and community members in the nutrition of patients to improve diet and tolerance of the patients.
- Treatment supporters is encouraging to the patients

- Encourage trusted persons by the patients to be involved
- Teach patients importance of taking treatment as directed
- Each time patients come for treatment, treatment, interviews must be held to identify patient’s problems emanating from treatment
- Give support where possible and refer if necessary
- Encourage in-depth talk therapy that aims to bring unconscious or deeply buried thoughts and feelings to the conscious mind so that repressed experiences and emotions, often from childhood, can be brought to the surface and examined.
- Working together, the therapist and client look at how these repressed early memories have affected the client’s thinking, behaviour, and relationships in adulthood.
- Patients with depression, emotional struggles, emotional trauma, neurotic behaviour patterns, self-destructive behaviour patterns, personality disorders, or ongoing relationship issues, may benefit from psychoanalytic therapy.
- Evaluate improvement in symptoms, interpersonal problems, quality of life, and well-being upon completing psychoanalytic therapy.
- Identify that loneliness is a significant psychosocial concern for patients with cancer, and depression may be an antecedent to loneliness.
- Know and understand that the emotional responses that result from a cancer diagnosis vary and may include anxiety, anger, frustration, or depression and is unique to patients.
- Encourage social interaction with community at large. The use of telephonic and social tracing through relatives and patients themselves can curb the loss of patients and getting report about the patient’s condition.
- Form support groups and activity groups with the patients to encourage positive thoughts.
- Make use of able survivors to encourage the patients positively.

- Involve the multidisciplinary team to create activities that supports the patients to encourage positive psychosocial support the need for continuity of care.

- Health care professionals should know the history of the patient to disclose diagnosis.

- Know how independent the patient is to be able to deal with the diagnosis.

- Availability of support system from trusted family or community member

- Know the academic level of the patient to be able to understand to use comprehensible language with the patients at disclosure. Verify patient understanding of the discussion.

- Know the cultural background and belief of client about illness.

- Provide information using different formats on available services.

- Provide full information on patient screening and anticipated treatment well to the understanding of the patients • Provide different sessions of

- Ensure that patients are accompanied by parents, family during disclosure or breaking of the news the people counselling before treatment to ensure acceptability of treatment they trust

- Address concerns about continuity proactively, including assurances that the physician and nurse will continue to be available.

- Maintain contact with patient and family caregiver for a long as needed

- Do not encourage total dependency, encourage them to deal with their own life circumstances with minimal support.

- Formulate and develop community support structures in cancer care and support

- Physician or interdisciplinary team communication involving nurses and other health care providers that facilitates continuity and closure may improve patient and family caregiver experiences

5.6. CONCLUSION

The chapter focused on development of strategies to improve psycho-social support of cancer patients. Cancer patients experience a decreased quality of life and uncertainty. The developed guideline intends to improve cancer services and provide hope to cancer patients. The following chapter presents the validation of the developed strategies.

CHAPTER 6

VALIDATION OF DEVELOPED STRATEGIES TO IMPROVE PSYCHOSOCIAL CARE AND SUPPORT SERVICES AT THE HOSPITALS IN LIMPOPO PROVINCE.

6.1 INTRODUCTION

This chapter presents the validation of the strategies formulated to improve the psychosocial care and support services at the hospitals in Limpopo province. The development of the strategies was based on the data collected in phase 1 and phase 2. A thematic analysis of the data was done. The findings were discussed 3 of this study. The strategies were developed using the themes and subthemes that emanated from the study findings. The e-Delphi technique was chosen to be the one that was used in the validation of the strategies. The e-Delphi method is a practical and structured method of obtaining opinions on a given on a given question from a range of experts and is usually used to gain consensus or informal respondents that constitutes the e-Delphi panel (Skinner, Nelson, Chin, and Land ,2015).

The methodology for the e-Delphi technique and findings are outlined in this chapter. The methodology is discussed under the following headings: reaching consensus from the Delphi technique in health and nursing, Delphi method as a means of reaching consensus with the experts, recruitment, and selection of the experts for the Delphi.

Using fitting participants for a Delphi the panel requires the individual to be at the top of their field of technical knowledge, interested in a wide range of knowledge not only in their own field but everything around it, able to see connections between national and international and present and future development, able to see connections between different fields of science, able to disregard traditional viewpoints, able to regard problems from not only known and safe angles but also unconventional ones, and interested in creating something new: Lilja, Laakso, and Palomaki (2011) Delbecq Ven, and Gustafson (1975) suggest a panel as little as four experts under ideal circumstances. Due to a shortage of the health care professionals in cancer care and support, this study has undertaken to use 12 panel experts. However, under typical circumstances, the panel is usually between 10 and 30 experts.

6.2 REACHING CONSENSUS FROM DELPHI TECHNIQUE IN HEALTH AND NURSING

The Delphi method is a systematic way of determining expert consensus that is useful for answering questions that are not amenable to experimental and epidemiological methods (Jorm, 2015). The validity of the approach is supported by 'wisdom of crowds' research showing that groups can make good judgments under certain conditions. A consensus is a general agreement that is arrived at by most of those concerned. The process of group deliberation has many elements that are common, there should be inclusiveness, participatory, collaborative, agreement seeking, and cooperative.

In this study electronic distribution and collection was preferred as a more engaging process to eliminate biasness of the face-to-face group process and was found to be more rapid in the feedback process and responses from the panel members.

6.2.1 Recruitment of the e-Delphi experts

The participants were known from the health systems and known to be experts in the cancer management, some unknown experts were known to the researcher by means of snowballing by the other experts. A letter of invitation outlining the processes of the Delphi requesting them to partake and consent forms was sent to them individually. Willing participants returned the consent forms acknowledging their interest in the Delphi.

6.2.2 Population of the e-Delphi panellists for this study

The population of phase 3 were experts, competent and knowledgeable in the psychosocial care and support of the cancer patients. To enhance the rigor of the strategies the researcher included all involved in cancer care with different professions and age of experience in the field of psychological care and support for the cancer patients. Rowe and Wright (2001) suggest using heterogeneous experts, in this study the panel considered the health care professionals involved in cancer care, doctor's oncology trained nurses, professional nurses, social workers and psychologists. The following documents were attached and send to a potential participant: (1) letter of invitation outlining the instruction and study objectives and (2) information leaflet including consent form.

6.2.3 Sampling of the Delphi panellists

Purposive sampling was used in this study; purposive sampling is made of elements that possess a characteristic or attributes that the researcher is interested in studying (ref) in this study experts were purposefully sampled based on the area of expertise and years of experience. The experts were those experienced in the psychosocial care and support for the cancer patients. Some experts have published articles in oncology and some who have extended practical experience in cancer services. For the researcher to find participants the researcher used snowballing to identify expert interested in the study of psychosocial care and support of the cancer patients.

Assessment of a feasibility of inclusion in the panel of experts the researcher considered the following aspects:

- Are there sufficient or minimal experts available to make up a panel?
- Is anonymous feedback from the panel of experts feasible?
- Are the experts able to dedicate sufficient time to assess the phenomenon over multiple iterations o feedback and evaluation?
- Is personal contact not possible due to time and constrains or it is not desirable due to concerns about ensuring democratic participation?

The research team can use several experts can use several approaches to identify expert's panellists for the study according to Schmidt, Lyytinen, Keil & Chule (2001) as follows:

- Prepare a knowledge resource nomination worksheet which will give the researcher a template to categorize panellist's background and skill.
- Review and select desired experts, individual contacts will provide an initial wish list of the most desirable experts.
- Contact experts and request the experts to nominate further experts in the field.
- Ranking experts because of the nomination process the list may exceed the desired maximum of the panel experts. Priority ranking should be considered if the number exceed the desires number.
- Inviting the expects to become part of the e-Delphi part of the panel. Each member should be contacted and requested to join the panel.

The following about the experts will be assessed:

PHASE ONE OF VALIDATION QUESTIONNAIRE

Table 6.1: DEMOGRAPHIC INFORMATION OF THE E-DELPHI PARTICIPANTS

1.	What is your gender	Male		female	
2.	How old are you	Years			
3.	What is your home language				
4.	Indicate your current position		Oncology nurse		
			Doctor		
			Professional nurse		
			oncologist		
			Social worker		
			Nurse educator		
			psychologist		
	If other, please indicate		other		
5.	Indicate your highest academic qualification		Diploma		
			Degree		

			Honours
			Master's degree
			Doctoral degree
	If other, please indicate		Other
6.	Indicate your area of specialization		
7.	Indicate the number of years of experience. Related to cancer care and support	---------------------------- years	

6.3. Data collection

In the e-Delphi data collection the researcher facilitated the sending of the questioners to the participants as participants could not convene in a group for data collection in refining the strategies due to the level 3 of Corvid- 19 restrictions. The participants evaluated the strategies unknown to each other in each round participant.

The evaluation of the strategy used a Likert scale where they indicated how strongly they agreed with each component of the strategy and make recommendation and send them back by e-mail. The researcher refined the strategy and send it back to the individual including those feedbacks from other experts. The feedback allows the participants to continue with their initial ideas or reconsider their initial idea. Subsequent round was done, and the experts were given the results of the analysis of the responses from all the rounds undertaken and asked to rate it by using a Likert scale and asked to provide additional recommendations. According to Linston and Turnoff (1975) & Msibi, Mogale, De Waal, Ngcobo (2018) Phases in e-Delphi rounds are:

Phase 1: Characterized by exploring the subject under discussion. Each expert contributes addition information felt to be pertinent.

Phase 2: Reaching an understanding of how the groups views the issues where the members agree or disagree, what it meant by relative terms such as importance, desirable and feasibility.

Phase 3: If there is significant disagreement, then it is explored to understanding or identifying the underlying reason for the difference and evaluate the underlying differences and evaluate them.

Phase 4: Final evaluation occurs after all previous gathered information has been analysed and evaluations fed back to panellists.

The above stages may be staged as in the figure below:

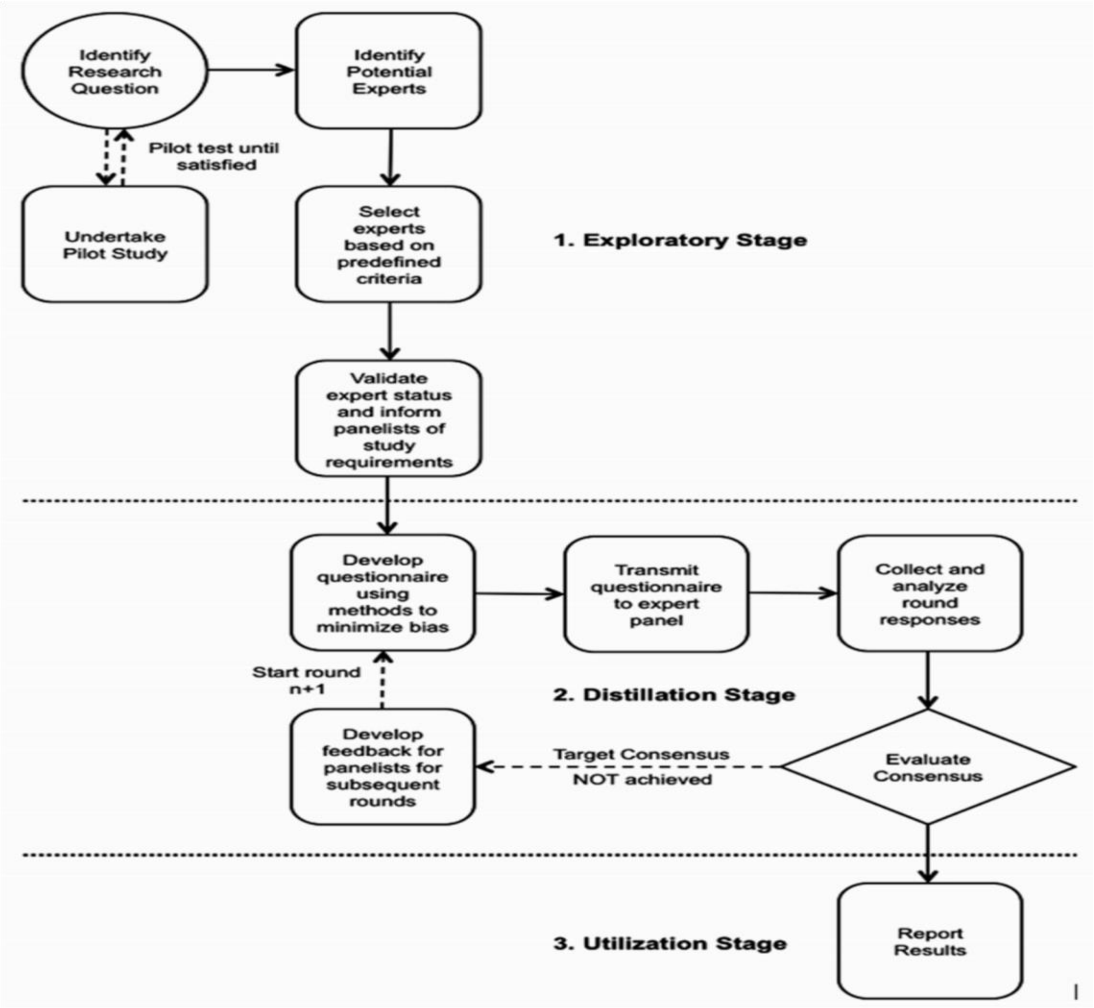

Figure 1. Delphi Process (Adapted from Hallowell & Gambatese, 2010; Day & Bobeva, 2005).

6.4 Data analysis of the Delphi rounds

In the Delphi process data analysis involves both qualitative and quantitative data the repetition of Delphi rounds of the previous rounds as a means of successfully refining the strategies. Identifying and achieving levels of consensus as well as changes in the of the panellist's comments. The principles of validation and refinement of the psychosocial care and support strategies draft were indicated in table 6.2 the principles used. The principles identified were, validity, reliability, applicability, clarity, relevance, comprehensiveness, effectiveness, flexibility, and acceptability. The researcher collated the consensus rate and analysed the open-ended question recommendations and analysed them.

6.5. Trustworthiness in Delphi method

The methodological issues of reliability, validity and trustworthiness ensures that there is rigour in the conduction of e Delphi as a strategy evaluation. In addition, it presents a discussion of the principal forms of establishing rigour, such as the application of rigour using both qualitative and quantitative measurements and corroborating results with relevant evidence in the field for each individual Delphi. Addressing such issues will help enhance the development and utilisation of rigour in the future in using the strategy.

6.6. Ethical considerations in Delphi method

Supporting and protecting the experts in Delphi is mandatory. Their identity and their opinion are to be respected regarding the subject under scrutiny. They can change their opinion at any given time if they see it fit. The experts are recruited and given information letters together with a consent form to sign as an indication of self-willingness to participate.

6.7 Refinement of the draft strategy using the e-Delphi technique.

In this study the process of data collection from the Delphi experts is conducted in subsequent rounds of two weeks each until consensus is reached. During each round, the e- Delphi panel experts are expected to read through the draft strategies and rate the strategies and then write a comment outlining their opinion. The rating is compared to fellow e-Delphi panellists for their comments. Participants remain anonymous from each other, and feedback is given by the researcher. Summary of each Delphi ratings and comments is mailed to the participants; participants were given chance to change their responses and concur with the views of the group or choose to stay with their opinions.

The e-Delphi rounds are discussed in the following sections and the results of all the rounds undertaken of the Delphi.

Table 6.2: DEMOGRAPHIC VARIABLES MEAN AND STANDARD DEVIATION OF THE PANEL MEMBERS IS PRESENTED.

Demographics		Frequency	Percentage	Mean	SD
Gender	Male female	2 8	20% 80%	5	4,24
Age	38-45 46-52	4 6	40% 60%	5	1,41
Experience in cancer care	4-8 10-15	5 5	50% 50%	5	0
Level of education	Doctoral Masters Degree Diploma	2 2 4 2	20% 20% 40% 20%	2.5	1
Job title	Doctor Psychologist Social workers	2 1 2	20% 10% 20%	2	1,22

	Nurses Nurse administrator	4 1	40% 10%		
Total		10	100%		

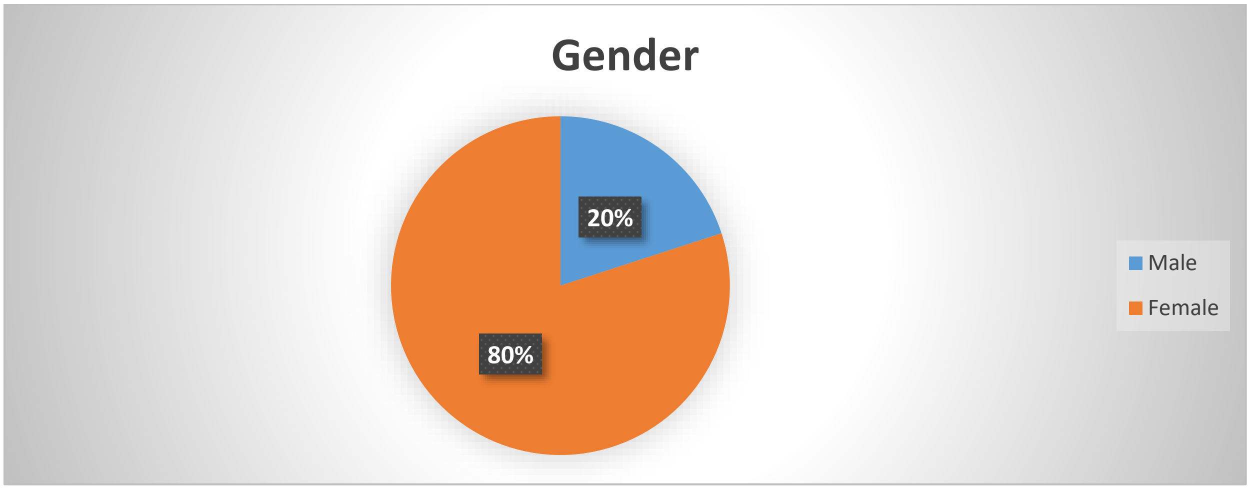

Figure 6.2 respondents according to gender (N=8 females) and (N=2 males)

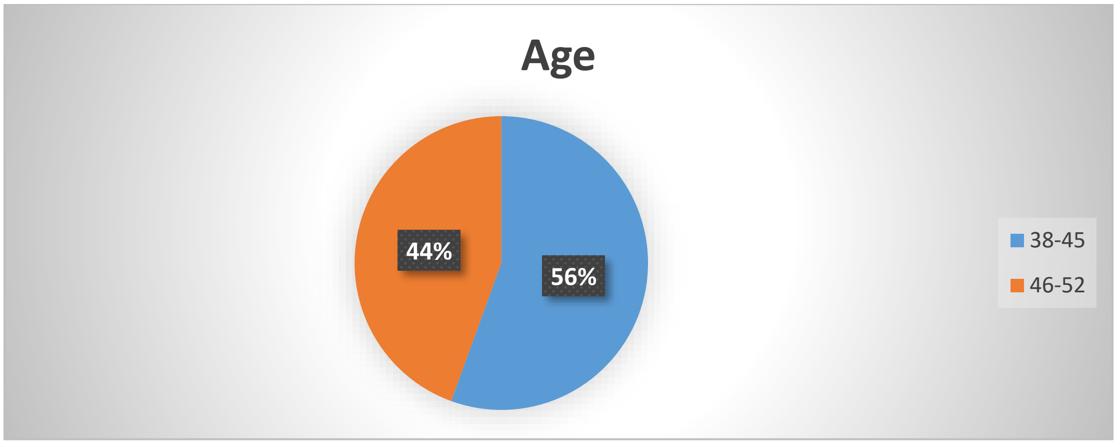

Figure 6.3 respondents according to age

Respondents according to age were between the ages of was N= 4; 38-45 which comprised of the initial 10 panellists and the percentage was 40% and the sixty percent comprised of the age group between 46-52 which was N=6 and that was 60%

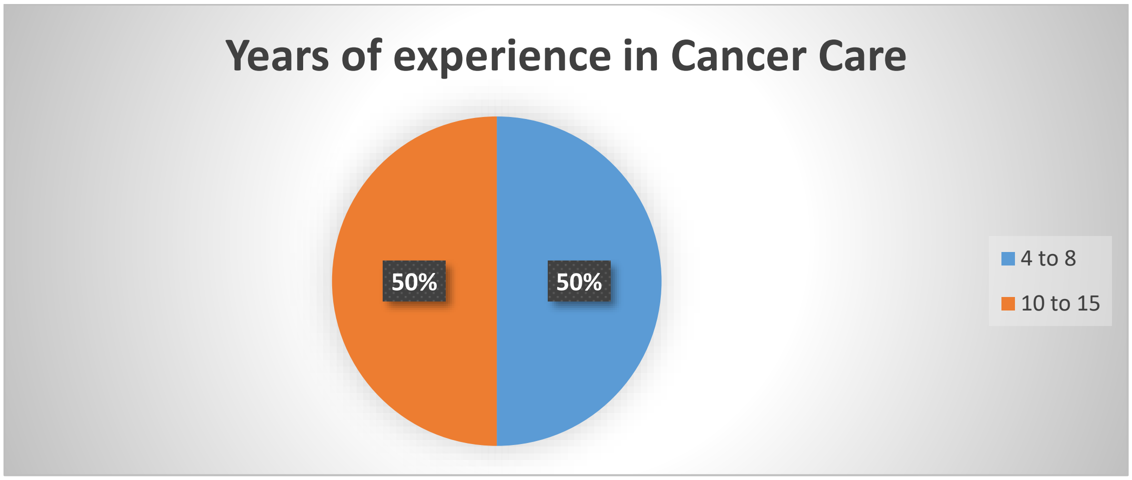

Figure 6.4 Respondents according to age in cancer care

The years of experience in cancer care was between 4-8 and 10 -15

(N= 5; 4-8 years) and (N=5;10-15)

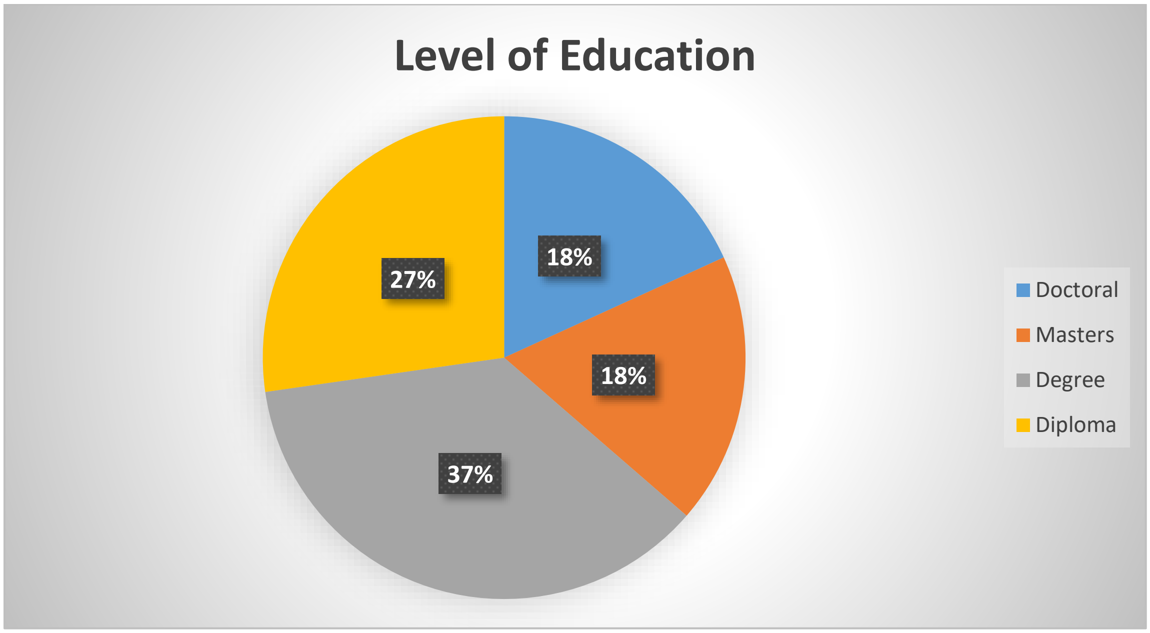

Figure 6.5 Respondents according to level of education

Level of education was doctoral degrees:2 (N=2) 18%;Master's degree :2(N=2) 18% ;Degrees :4 (N=4) 37% and Diplomates :2 (N=2) 27%.

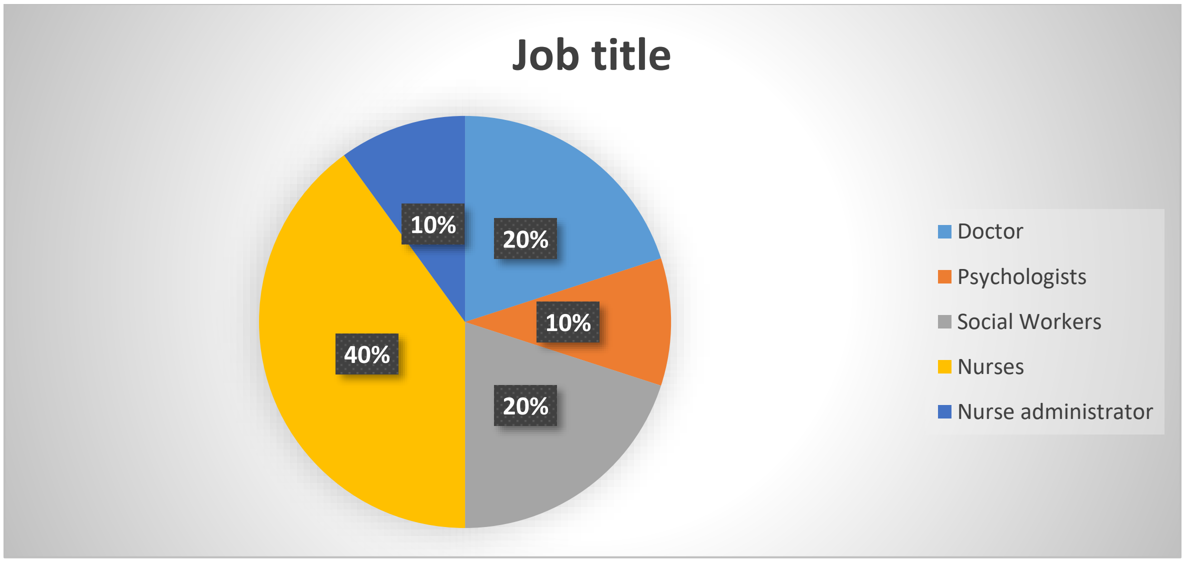

Figure 6.6 Respondents according to job title

The respondents according to job titles were nurses (N=6) 60% all inclusive (specialised and non-specialised professional nurses) and 1 doctor (N=1)10%;(N=2) 20% social worker and (N=1) 10% psychologist and (N=1)10% nurse administrator.

The instrument

To determine consensus among the panellists, a self-administered structured questionnaire was developed for rating. A five-point Likert scale, the questionnaire was used for all rounds. The space provided for comments was meant for refining according to their expert judgements.

Table 6.2 Instrument used for refinement of the draft strategies.

The purpose of the Delphi technique is to rank the statements according to their relevancy, feasibility, appropriateness and importance. You been chosen as a part of an expert panel to rank the following eleven statements as the following instructions. In your own opinion please rank statements in each statement in the questionnaire provided according to their importance, feasibility, and appropriateness using 5-point scale where one is the **Least appropriate feasible relevant, appropriate and important** and five is the **Most appropriate feasible, relevant, appropriate and important** and add any comments or possible items that are not in this questionnaire.

Data Distribution							
	6	**5**	**4**	**3**	**2**	**1**	**Comments**
Applicability: Applicable to hospital settings for psychosocial care support for cancer care							
Clarity: Are the strategies for cancer care and support clear, easily understandable, unambiguous and logical							
Relevance: The psychosocial care and support strategies are relevant for the cancer services at the hospitals?							
Comprehensiveness: Does the strategy indicate the extensive understanding of the cancer patient psychosocial care and support needs?							
Effectiveness: Will the strategies enable the							

health care professionals to be able to render effective and appropriate psychosocial support to the cancer patients						
Flexibility: Will the strategies empower the health care professional to provide psychosocial care and support to the cancer patients						
Acceptable: Are the psychosocial care and support strategies realistic and in line with the National cancer care strategies South Africa's National Health Strategic Plan (2015-2020)						
Key: 5=strongly agree; 4=agree; 3= neutral; 2= disagree; 1=strongly disagree						

6.8 THE MODIFIED E-DELPHI RESULTS.

Final evaluation has occurred after all previous gathered information has been analysed and evaluations fed back to panellists as indicated as part four of the Delphi. A questionnaire was structured based on the study results and the literature control that supported the findings.

The questionnaires were sent to the panellists, the draft strategies, and a consent form to partake in the strategy evaluation and assisting in reaching the consensus. Of 12 only 10 experts of the recruited took part in all the rounds of this Delphi process of evaluating the strategies developed to improve the psychosocial care and support for the cancer patients at the hospitals in Limpopo.

6.8.1 Frequency and descriptive analysis of the demographics

The researcher had recruited 12 panellists of which 2 of them never responded from round one and did not give reason for their non-response after they have initially agreed to take part as part of the panellists. Of the 10 panellists all of them responded well in the first round .it consisted of 2 (two) males (20%) and 8 (eight) females (80%).this indicated that most experts were females and mostly nurses, social workers and specialised nurses in oncology and the psychologists. Of the two males was a nurse administrator and a doctor. In the second rounds they responded 100% too. The demographic data comprised of, gender, age experience in cancer care, level of education and job tittle. Most of the respondents were mostly females and that was a reflexion that most health care professionals in cancer are and support are females.

In the table below is the demographic variables, mean and standard deviation of the panel members is presented.

6.8.2. Round one of the modified e- Delphi

The analysis of the first round of Delphi was examined, the structured questionnaires that were returned from the panellist to the researcher. And the comments made by the panellists. In this study the process of data collection from the Delphi experts is conducted in subsequent rounds of two weeks each until consensus is reached. During each round, the e- Delphi panel experts were expected to read through the draft strategies and rate the strategies and then write a comment outlining their opinion. The rating is compared to fellow e-Delphi panellists for their comments. Participants remain anonymous from each other and feedback is given by the researcher. Summary of each Delphi ratings and comments is mailed to the participants; participants were given chance to change their responses and concur with the views of the group or choose to stay with their opinions. The e-Delphi rounds are discussed in the following sections and the results of all the rounds undertaken of the Delphi.

6.8.3. Analysis of Round one of the modified e- Delphi

The analysis of the first round of Delphi was examined, the structured questionnaires that were returned from the panellist to the researcher. The comments made by the panellists were based on the structured questionnaire that was sent to them with instructions to rate the draft strategy of six strategies using the instrument in Table 6.2 below and indicate and were requested to add any comment or possible addition to the strategies. The panellists were requested to rate the strategies according to their order of importance as in the table below using the following: applicability, clarity, relevance, comprehensiveness, effectiveness, and acceptability (table 6.2) The researcher sent the second questionnaire to the panellists by email. In this round, the researcher asked the participants whether they agree on the proposed ranking, based on importance and appropriateness" using a six-points agreement checklist where one is strongly disagreeing, and six is strongly agree, and to add any comments or possible strategies that are not included in the statements. Accordingly, the researcher used the frequency and percentage of each strategy as per the six points ranking; to identify the agreement, and by using the descriptive statistics which are mean, median, standard deviation, and interquartile range to identify the importance ranking. Acceptable rating was measured by 70% for round one and two of the Delphi. The results are in table 6.3.1 for round one of the e-Delphi.

Table 6.3.1 Ranking agreement and importance of round one

		Theme 1		Theme 2		Theme 3		Theme 4		Theme 5		Theme 6	
		Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percentage	Frequency	Percent	Frequency
Agreement	1= *strongly disagree*	0	0	0	0	0	0	0	0	0	0	0	0
	2 .	0	0	0	0	0	0	0	0	0	0	0	0
	3.	0	0	0	0	0	0	0	0	0	0	0	0
	4.	20%	2	10%	1	20%	2	10%	1	10%	1	10%	1
	5	30%	3	20%	2	20%	2	30%	3	20%	2	10%	1
	6= *strongly agree*	50%	5	70%	7	60%	6	60%	6	70%	7	80%	8
Importance	Mean	1.67		1.67		1.67		1.67		1.67		1.67	
	Median	1		0.5		1		0.5		0.5		0.5	
	Standard deviation	2.07		2.73		2.34		2.42		2.73		3.14	

6.8.4. Discussions of e-Delphi round one results.

Theme 1

This strategy had 50% of the rating as strongly agreed. The other 50% was divided between neutral and agree. The percentage was within the acceptable percentage. One participant expert indicated that the lack of skilled workers and lack of information should be discussed together with delay in diagnosis can be due to lack of information in cancer disease.

Theme 2

The participants felt that it would work well if patients who fall within the theme of losing patients amongst the transfers can be curbed by keeping registers about all patients that are transferred out should be followed up telephonically and the use of social media to trace relatives.

Theme 3

There are differences in the panellists indicating that strategy 3 and four are more same, the large percentage indicated that the totally agree with both strategies as they are.

Theme four

Most of the panellist indicated a greater agreement with the activities in the strategy.

Theme five

There was no significant disagreement between the activities of the e- Delphi panellists .it has most of the rating at 70%.

Theme six

Had most of the rating above 70 % and most panellist had agreed with the activities. No comments were there to implement on the strategies.

6.8.5. Demographic analysis of Round two of the modified e- Delphi

In the 2nd and last Delphi rounds only 7 responded of the 10 panellists which was 70%. The respondents according to job titles were nurses 60% all inclusive (specialised and non-specialised professional nurses) and 10% doctor, 20% social worker and 10% psychologist and 10% nurse administrator. Specialised nurses in oncology were experienced between 6-8 years, were 2(20%) and the professional nurses were 10-15 years' experiences, and they were 3(30%). the doctor was 4 years experienced N=1 (10%). Nurse administrator was 5 years experienced and was 1(10%).

Two social workers of the same work experience of 7 years, 2(20%) and a psychologist of 4 years' experience in hospital patient care, 1(10%). Responses according to highest education levels was that the nurses had diplomas in nursing, of the 50% of the nurses that were in the panel they had degree in nursing 4(40 %)and two 2 (20%) were holders of a masters. degree. Psychologist and social workers had a university degree, the nurses, and the doctor 4(40%).

The comments from the ratings above were as follows:

Strategy one: Panellists commented on the effectiveness that the strategy should be tested first before commenting on its effectiveness. In all other strategies, there was agreement from other strategies except in strategy 6: one participant the flexibility and the other on effectiveness on the strategy 6 giving comments that the strategy cannot be flexible if the behaviours of the participants and display of mental illness is not explored and treated, and the effectiveness of the activities in strategy six will depend on thorough assessment of the patients.

6.3.2 Ranking agreement and importance of round two

		Theme 1		Theme 2		Theme 3		Theme 4		Theme 5		Theme 6	
		Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	percent f	frequency
Agreement	1= *Strongly Disagree*	0	0	0	0	0	0	0	0	O	0	0	0
	2 .	0	0	0	0	0	0	0	0	0	0	0	0
	3 .	10%	1	10%	1	0	0	10%	1	0	0	0	0
	4 .	10%	1	10%	1	10%	1	10%	1	10%	1	10 %	1
	5 Strongly Agree	70%	7	70%	7	80%	8	70%	7	80%	8	80 %	8
	Mean	1.8		1.8		1.8		1.8		1.8		1.8	
	Median	1		1		0		1		0		0	
	Standard deviation	2.95		2.95		3.50		2.95		3.50		3.50	

6.8.6. Analysis of round two of the modified e-Delphi

The researcher received 9 responses from the participants out of 10, response rate was 90%. In this round, the researcher analysed the findings using the same approach used in the previous round. The researcher attempted to summarize the results based on consensus and stability according to agreement percentage and importance ranking. Accordingly, the researcher used the frequency and percentage of each strategy objectives on a six-point rating as per the five points scale, to identify the agreement, and by using the descriptive statistics to identify the importance ranking.

In the table below (table 6.3.2), the strategy objectives and their mean, median, standard deviation, interquartile range, and percentage are presented.

Of the 9 responses in round 2, 90(100%) achieved consensus from the participants on all the ranked strategies. Moreover, no comments were raised from the participants. Additionally, the mean and median were close, which indicates that the responses were stable, and the consensus is achieved between the participants.

The researcher will share these findings and strategies with the nursing cancer services, in peer reviewed journals and in workshops for the multi-disciplinary heath care workers involved in cancer care and evaluation of strategy with future research.

The feasibility of the strategies was rated to be at 80% as indicated in the strategies questionnaire assessing its applicability, acceptability, clarity, relevance, comprehensiveness, effectiveness, and flexibility. Only one e- Delphi participant had indicated that the clarity of the strategies most activities are similar on almost all the strategies.

6.9 CONCLUSION

The recommended adjustment to the strategies were made by the researcher, and finally a comprehensive, promotive, curative care and support strategies is developed to provide psychosocial care and support for the cancer patients. The principles used to refine and validate the strategies were acceptability, applicability, clarity, relevance, comprehensiveness, effectiveness, flexibility assisted the researcher in believing that the strategies may improve the psychosocial care and support at the hospitals in Limpopo province.

CHAPTER 7: EVALUATION, STRENGTH, LIMITATIONS, RECOMMENDATIONS AND CONCLUSSION TO THE STUDY

7.1 INTRODUCTION

The previous chapter described the refinement of the strategies developed to improve the psychosocial care and support services for the cancer patients at the hospitals in Limpopo using a e-Delphi technique. In this chapter the researcher is discussing the evaluation, strength, limitation, recommendations, and the chapter ends with the conclusion to this study.

7.2. EVALUATION OF THE STUDY

The study was evaluated based on the purpose of the study and how the purpose of the study objectives was achieved as set out in the overview of this study.

7.2.1. Purpose of the study

The main purpose of this study was to develop strategies to improve the psychosocial care and support strategies at the hospitals in Limpopo province. There are several studies that were conducted about care in cancer, but little has been done about the psychosocial support for the cancer patients. The findings of this study may contribute to the body of knowledge in cancer care and support in the cancer care facilities of Limpopo province.

The study was conducted to improve the psychosocial care and support to encourage the health care professionals to identify their challenges to provide for the psychosocial care needs of the cancer patients. This was also done to assist in improving on the challenges and set up the strategies to improve the services. The strategies may be used with other support initiatives in place for cancer care.

7.3 THE AIM AND OBJECTIVES OF THE STUDY

The overall aim and objectives of this study was to develop the psychosocial care and support strategies to improve the services in the hospitals in Limpopo.

7.3.1 Phase 1 Objectives of phase 1(a)

The objective here was to explore the psychosocial care and support needs of the cancer patients at the hospitals in Limpopo and to describe them as narrated by the patients themselves.

7.3.2 Objective of phase 1 (b)

To identify the challenges faced by the health care professionals in the rendering of psychosocial care and support to the patients in the hospitals in Limpopo and to appraise those challenges to find a better improvement plan base on both the findings of objective 1 and 2.

7.3.3 Summary the results of phase 1(a) and 1(b).

1(a) As reported in chapter 3 the themes that emerged from the face-to-face interviews with the cancer patients about their needs for psychosocial support and care at the hospital in Limpopo are as follows; ideal needs of communication strategies with the cancer patients, concerns regarding confidence and reliance with a known practitioner, need for psychoanalysis and the need for continuity of care. The subthemes were discussed and supported by literature.

1 (b) from the focus group discussions with the health care professionals of their challenges in rendering psychosocial care and support to the cancer were shortfall of human resource in cancer care, poor patient administration, poor co-ordination of cancer services, concerns relating to conflicting values and norms, concerns with disclosure of their diagnosis the concerns with disclosure of their diagnosis. The subthemes were also discussed and supported by the relevant literature to support the findings.

Both the results from 1 (a) and 1 (b)were merged to identify the relationship and or if there are contrasts in the themes. All the themes from 1(a) and 1 (b)were related to one another in many ways except one theme that was brought up by the health care professionals about the observance of maladaptive personality traits affecting mental health -related quality of life. This theme will need to be explored further to uncover the underlying circumstances surrounding this theme.

7.4. Phase 2: Development of the psychosocial care and support strategies to improve the cancer care services in the hospitals in Limpopo province.

7.4.1. The objective of phase 2

To develop psychosocial care and support strategies for improving cancer services at the hospitals in Limpopo.

7.4.2. Summary of phase 2

The psychosocial care and support strategies were developed and discussed in chapter five of this study based on the themes after merging. The strategies were developed based on the following 6 themes. Shortfall of human resource in cancer care, poor patient administration, poor co-ordination of cancer services, concerns relating to conflicting values and norms, concerns with disclosure of their diagnosis the concerns with disclosure of their diagnosis and the observance of maladaptive personality traits affecting mental health -related quality of life. The use of the theories that supported the study was well discussed in chapter 4 indicating the elements in Watson's theory of human caring and Folkman and Greer strategy of stress and coping are important to consider when the strategies are developed.

7.5. Summary of the findings of phase 2 using e -Delphi technique.

Phase 2 of the study was focused on the refinement and validation of the psychosocial care and support strategies to improve the cancer care services in the hospitals in Limpopo province.in refining the strategies, the data was collected and analysed in phase one, the strategies were drafted in phase 2 and the strategies were refined and validated in phase 2. The experts in the field of cancer care were recruited to refine the strategies.

The strategies were refined in two rounds of e- Delphi based on the comments and recommendations outlined by the panellists in each round of e-Delphi. The rating of the 4- point Likert scale were as follows; strongly agree (4), agree to some extent (3), disagree to some extent (2) and strongly disagree (1). The results of the refinement were quantitatively and qualitatively analysed and presented in chapter 6. the strategies to improve cancer services on the psychosocial care and support at the hospitals in Limpopo were developed as a fulfilment of objective 3 of the study were finally developed.

Triangulation was accomplished by using different health care professionals with different professional backgrounds like nurses' doctors, social workers, and the psychologists in phase one and in phase 3 of the study including the patients themselves in phase 1 when their needs for psychosocial care and support needs were explores in the face-to face interviews. That ensured reliable and credible strategies to be implemented in cancer services for improvement.

The support programme was refined and validated in accordance with the criteria of validity, reliability, applicability, clarity, relevance, comprehensiveness, flexibility, and acceptability.

7.6. STRENGTH OF THE STUDY

The data was collected from both the health care professionals and the patients to identify the correlation between the psychosocial care and support needs and the challenges that hinder the provisioning of care and support needs of the patients.

Triangulation was accomplished through numerous data collection methods including e-Delphi technique to gain consensus.

Familiarisation with the strategies was improved through thematic analysis of the data and to ensure a reliable and credible strategies ready to be implemented.

The strategies were refined according to the criteria of validity, reliability, applicability, clarity, relevance, comprehensiveness, flexibility, and acceptability.

The strategies were designed using a rigorous scientific process and inputs.

7.7. LIMITATION OF THE STUDY

Identifying the limitation, the study, it shall assist in the further studies about the method used to gain the data and the sample size of the study population. The use of convenient and purposive sampling was a limitation in phase I, phase 2 and phase 3 respectively, to select specific persons with experience and knowledge on cancer care and psychosocial care and support. The study was limited to the selected hospitals, other facilities such as clinics and communities and the inclusion of the home support systems were not included in this study. The results therefore cannot be generalised to all areas of care and support structures for the cancer patients.

The other limitation was that the e-Delphi process took long due to the experts taking long in response to verify the strategies. Due to the COVID-19 19 status in the country the researcher was not able to assemble the panellists in one setting at a time, the process of electronic feedback had to be used. Trustworthiness and ethical principles of the study were also applied to the e-Delphi participants. Consent forms were mailed back and kept by the researcher. An example of the Delphi consent and information is attached.

7.8. UNIQUE CONTRIBUTION OF THE STUDY

Participants in phase 1(a) one was given the opportunity to state their needs of psychosocial care and support.it promoted the self-worth and confidence of the patients and was part of psychosocial support and reassurance that they are not alone in their plight.

In phase 1 (b) the ability to have different health care professionals under one roof to discuss psychosocial care and support assisted them in the understanding each one’s role in cancer care and support. They all could identify their roles and how powerful they and efficient they can coordinate cancer care. They realised their roles dependence upon each other.

The strategies guide the cancer care services on how they can improve what was a gap in providing the psychosocial care and support. The strategies are centered around the needs of the cancer patients; that will be greatly appreciated by the patients. In utilizing the strategies patients can beat cancer and be survivors and return to their pre-cancer state.

7.9. RECOMMENDATIONS

The recommendations are based on the study finding and the recommendations for further research.

- The initial training of the strategies will be amongst other things problem solving and creating a system of disseminating the strategies to the primary health care to enhance further co-ordination of health care and psychosocial services for the cancer patients further.
- It should be a way of further focus on empowering recipients of care with information and skills to deal with their psychosocial wellbeing.
- Hospital managers should be in the initial dissemination of the strategies especially in matters of pertaining to procurement, staff recruitment and allocation.

- There should be a custodian that will see that the strategies are fully disseminated with understand and should facilitate support of the health care professionals.
- Home visits and interaction with community is mandatory to extend a hand in psychosocial care and support.
- There should be collaboration between traditional healers, pastors, prophets, and health care professionals to improve the lives of the cancer patients and the survivors.
- Newly diagnosed patients with cancer should be intensively counselled to cope with the mental and emotional traumas associated with the diagnosis.
- Communication with the patients should be improved and amongst the health care professionals.
- Further research is recommended to assess the patients with maladaptive personalities that is affecting their mental health to the denial of their diagnosis resulting in lack of co-operation in taking treatment and acting in steering their behaviors towards self-help.
- Further research should be embarked on how well the strategies have assisted in improving the psychosocial care and support at the hospitals in Limpopo province.

7.10. DISSEMINATION OF THE STRATEGIES

The strategies will be disseminated in workshops with the entire health care professional’s instrumental in cancer care, they may be published in accredited journals and will be presented at the conferences as oral presentations and in a form of posters. The contribution of the audiences will be validated and if possible incorporated in the strategies.

7.11. CONCLUSION

The study has yielded flexible acceptable and compressive strategies to improve psychosocial care and support strategies to improve the cancer services in Limpopo

Province. The researcher has recommendations stated to improve the cancer care and support strategies to further enhance effectiveness of the cancer services. In all the phases of the study the researcher has kept to the rules and ethical standards of the research. The study was challenging as psychosocial aspects of an individuals are self-perceived and may be challenging for the next person to understand the depth of the affection.

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ANNEXURE A: INFORMATION LEAFLET

RESEARCH ETHICS COMMITTEE

UNIVEN Informed Consent

LETTER OF INFORMATION

Title of the Research Study :Strategies to improve psychosocial care and support services at the hospitals in Limpopo Province.

Principal Investigator/s/ researcher : (*Ramutumbu Neo Jacqueline, M Cur*)

Co-Investigator/s/supervisor/s : (Prof *Ramathuba DU, Prof Maputle MS, Ndou ND, PhD*)

Brief Introduction and Purpose of the Study: To develop strategies to improve the psychosocial care and support strategies at the hospitals in Limpopo Province.

Outline of the Procedures : the patient participants will be interviewed face -to face to explore their psychosocial care needs at the hospitals.
The health care professionals will be engaged in focus group discussions to explore their challenges in providing psychosocial care and support at the hospitals in Limpopo.

Risks or Discomforts to the Participant: there is no risk anticipated, if any emotional unsettling topics may disturb participants, the participant will be given attention as needed and referred appropriately.

Benefits: the study will benefit both the patients and the health care professionals in improving the cancer services in the provisioning of the psychosocial care and support. The study will be published in accredited journals and may contribute to the body of knowledge in the provisioning of psychosocial care and support.

Reason/s because the Participant May Be Withdrawn from the Study: the participant may choose to withdraw from the study at any given time if he so pleases or if the participant is somehow uncomfortable in the discussions and interview or if it necessitates that he may withdraw due to ill-health or unforeseen circumstances. There will be no consequences should the participant withdraw from taking part in the study.

Remuneration: There will be no remuneration for taking part in the study.
Costs of the Study : Participants will not be expected to pay a fee for participating in the study.
Confidentiality: Participants names will not be public nor attached to their transcripts. The signed consent forms will be kept locked in by the principal researcher. Data will be labelled in numbers e.g., Participant number five and focus group A or D.

Research-related Injury : There are no injuries anticipated, however if any may occur in the process of the data collection, the individual will be appropriately assisted to get assistance but there shall not be any compensation.

Persons to Contact in the Event of Any Problems or Queries:

(Supervisor and details) Please contact the researcher: Neo Ramutumbu (tel no.0827178190), my supervisor: Prof DU Ramathuba (tel no.015 962 8684) or the University Research Ethics Committee Secretariat on 015 962 9058. Complaints can be reported to the Director: Research and Innovation, Prof GE Ekosse on 015 962 8313 or Georges Ivo.Ekosse@univen.ac.za

General:

Potential participants must be assured that participation is voluntary and the approximate number of participants to be included should be disclosed. A copy of the information letter should be issued to participants. The information letter and consent form must be translated and provided in the primary spoken language of the research population.

ANNEXURE B: CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Neo Jacqueline Ramutumbu, about the nature, conduct, benefits, and risks of this study - Research Ethics Clearance Number: SHS/18/PDG/25.
- I have also received, read, and understood the above written information (*Participant Letter of Information*) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during this research which may relate to my participation will be made available to me.

Full Name of Participant	Date	Time	Signature
I, ………………………………	**………………..**	**…………**	**……………………**

(*Name of researcher*) herewith confirm that the above participant has been fully.

Informed about the nature, conduct and risks of the above study.

Full Name of Researcher

……………………… Date………………. Signature…………………

Full Name of Witness (If applicable)

……………………… Date ………………. Signature………………….

Full Name of Legal Guardian (If applicable)

………………… Date……………… Signature……………………

ANNEXURE C

REQUEST TO HOSPITALS IN LIMPOPO PROVINCE

P.O. Box 7355

Thohoyandou

0950

The Chief Executive Officer

Hospitals in the Limpopo

Limpopo

Application to conduct a study at your institution: ………………………………………

I, Neo Jacqueline Ramutumbu, a Doctor of Nursing student at University of Venda am requesting to conduct research in your hospital as a requirement in my studies.

My research topic is: Psychosocial strategies for care and support to improve the cancer services in Limpopo Province:

The aim of the study: Development of strategies for care and support in the cancer services of the hospitals in Limpopo Province.

The findings of the study may improve the cancer services the hospitals in the provisioning of care and support cancer of patients by the services.

Thanking you in anticipation

N.J. Ramutumbu.

Student number: 11565382

P.O.BOX 7355

THOHOYANDOU

0950

Members of the Health Team

Limpopo Province

Colleagues

Request for your participation in a study focus group.

I am a doctoral student at the University of Venda: student no1156582. I am here requesting you to participate in the study as indicated below.

TOPIC: PSYCHOSOCIAL CARE AND SUPPORT STRATEGIES TO IMPROVE CANCER SERVICES IN THE HOSPITALS LIMPOPO PROVINCE

AIM: To develop psychosocial care and support strategies to improve cancer services in Limpopo Province

OBJECTIVES:

- Explore the care and psychosocial needs of the cancer patients in the hospitals in Limpopo Province.
- Describe care and psychosocial needs of the cancer patients in the hospitals in Limpopo Province.
- Identify the challenges inherent by the health care professionals in rendering care and psychosocial support at the hospitals in Limpopo Province.

Your participation should be voluntary. You will not be paid for your participation. Your participation will add value to this study and a study report will be written.

Times will be conveniently set not to disturb your work schedule.

Hope you find this in order. Mrs NJ Ramutumbu

Request to Department of Health to Conduct the Study

P.O. Box 7355

Thohoyandou

0950

Provincial Department of Health

Research Ethical Committee

Polokwane

0700

Dear Sir/ Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCH.

I am a doctoral student at the University of Venda. I am presently conducting a research study entitled “Psychosocial care and support strategies for improving cancer services in the hospitals in Limpopo Province. My Promoter and Co-Promoters are Prof DU Ramathuba, Dr ND Ndou and Prof S Maputle in the Department of Advanced Nursing Sciences.

The objectives of this study are to:

- Explore the care and psychosocial support needs of the cancer patients at the hospitals in Limpopo Province.
- Describe the care and psychosocial support needs of the cancer patients at the hospitals in Limpopo Province.
- Identify the challenges faced by the health care professionals in rendering psychosocial care and support to the cancer patients in the hospitals.

1. The participants will be interviewed at their hospitals and the data will be captured in an audio recorder for verification of information.

2. The interview will last for 35-45 minutes. Ethical standards will be observed throughout the process of research: Participants will be asked to sign consent forms.
3. Focus groups will be conducted with the health professionals responsible for care and support of the patients at the hospitals for a maximum of an hour or two,
4. Participation is voluntary; withdrawal is allowed anytime; Information gathered will be kept under lock and key and will be kept for as long as required by the university.
5. An audio recorder will be used to capture information and field notes will be written during the interview and all the recordings will kept with all of the information pertaining to the research.
6. Codes or numbers will be used to avoid names to ensure confidentiality and anonymity. The study will benefit health for the oncology patients, influence policy, students and the Department of Health in the Vhembe District

Thank you.

N.J. Ramutumbu

Signature of the researcher: N.J. Ramutumbu ……………………………

Signature of Promoter: Dr D.U. Ramathuba ……………………………

ANNEXURE D: INTERVIEW GUIDE

PART 1: FOCUS GROUP: DEMOGRAPHIC DETAILS QUESTIONNAIRE

Age: ---

Are you (please tick) Male { } or Female { }

What is your professional background?

Nurse	
Psychologist	
Social worker	
Oncologist	
Other, specify	

How many years have you been in your present job? Approximately

5years	
10yrs	
>10yrs	
>15yrs	

Experience in health care (optional). Thank you for taking time to complete this questionnaire.

PART 2: Welcome: Welcome and thanking participants for partaking. Self-introductions: knowledge of who is whom in the group to enhance emotional stability. Promise of anonymity and use of tape record: assure the participants of the safe keeping of tapes and field notes.

Ground rules: important to give each other chance to speak, no right or wrong answer.

PART 3: Guiding questions

- What are the challenges in rendering psychosocial care and support in the cancer services in hospitals in Limpopo Province?
- What do you think of the care of the cancer patients in the hospitals?
- What do you think of the aim of developing the psychosocial care and support strategies in Limpopo?
- What are the main issues around provisioning of psychosocial care and support for the cancer patients?
- Do you realise the interdependence of each other's function in the patient's psychological care and support?
- Are you able to assess the care and psychosocial care needs of the cancer patients?
- Are you familiar with the needs as tabled in the diagram here presented?

Physical	Social	Psychological	Spiritual challenges
Functional state	Family distress	Control	Meaning of illness
Fatigue and sleep	Roles and relations	Anxiety states	Religiosity
Overall physical health	Affection and sexuality	Depression	Transcendence
Fertility	Appearance	Fear of recurrence	Hope
pain	Isolation	Cognition /attention	Uncertainty
	Finances and employment		Inner strength

- How in your opinion would you like to address the above challenges that should be incorporated in the strategy? What are the barriers in provisioning care?
- How can we improve psychosocial care and support in the hospitals?

Concluding question

- Of all the issues discussed today, what are the most important issues you would love to express as the real challenges and how best can they be dealt with?

Conclusion

- Thank you for participation.
- Your opinion will be valuable assets to the study.
- If questions arise after this discussion call me at 0827178190
- Any comment featuring in this report will be anonymous.
- Before leaving, please hand over the completed personal details questionnaire.

ANNEXURE E: e-Delphi consent form

RESEARCH ETHICS COMMITTEE

UNIVEN Informed Consent

LETTER OF INFORMATION

Title of the Research Study : Strategies to improve psychosocial care and support for the cancer patients at the hospitals in Limpopo.

Principal Investigator/s/ researcher : (*Ramutumbu Neo Jacqueline, M Cur*)

Co-Investigator/s/supervisor/s : (*Ramathuba DU, Maputle MS, Ndou ND, PhD*)

Brief Introduction and Purpose of the Study: To participate in the study as an expert to verify a draft strategy to improve psychosocial care and support of the cancer patients in the hospitals in Limpopo.

Outline of the Procedures: As a participant, you will be amongst other participants unknown to you, you will receive a draft strategy, a consent form and a letter of invitation and the questions that will guide in assessing the strategy to improve the strategy by coming to a consensus together with other panellists. All the inputs will be collated, and feedback will be sent back to you :

Risks or Discomforts to the Participant: There are no risk factors anticipated in your participation.

Benefits: The benefit will be that the psychosocial care and support of the cancer patients will be improved**.**

:

Reason/s because the participant may be withdrawn from the study: If the participant no longer wants to participate and does not respond to the purpose of the study at any given time.

Remuneration: There will be no remuneration for the expert participants

Costs of the Study: The participants will not be liable to pay for their participation in the study.

Confidentiality: The identity of the participants will not be revealed to other participants after the participants will have signed the consent and send it back to the researcher the signed documents will be kept by the researcher in a safe place. Apart from the consent forms no other place will the participants be expected to reveal their identity.

Research-related Injury: Non is anticipated

(Supervisor and details) Please contact the researcher: Neo Ramutumbu (0827178190.), my supervisor: Prof DU Ramathuba (tel no.015 962 8684) or the University Research Ethics Committee Secretariat on 015 962 9058. Complaints can be reported to the Director: Research and Innovation, Prof GE Ekosse on 015 962 8313 or Georges Ivo.Ekosse@univen.ac.za

General:

Potential participants must be assured that participation is voluntary and the approximate number of participants to be included should be disclosed. A copy of the information letter should be issued to participants. The information letter and consent form must be translated and provided in the primary spoken language of the research population.

CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher, Mrs NJ Ramutumbu, about the nature, conduct, benefits, and risks of this study - Research Ethics Clearance Number:SHS/18/PDG/25.

- I have also received, read, and understood the above written information letter and regarding the study and my participation.

- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.

- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.

- I may, at any stage, without prejudice, withdraw my consent and participation in the study.

- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.

- I understand that significant new findings developed during this research which may relate to my participation will be made available to me.

Full Name of Participant Date Time

Signature

I, Mrs. NJ Ramutumbu herewith confirm that the above participant has been fully.

Informed about the nature, conduct and risks of the above study.

ANNEXURE: F

LETTER OF INVITATION TO EXPERTS PARTICIPATING IN THE OUTLINING THE INSTRUCTION, STUDY OBJECTIVES, SUMMARY OF THE FINDINGS.

Dear expert participants

Invitation to participate in the study of the development of strategies to improve the psychosocial care and support of the cancer services in Limpopo province.

I am a PhD STUDENT AT THE University of Venda, Department of advanced nursing science, conducting a study on the development THE DEVELOPMENT OF STRATEGIES TO IMPROVE THE PSYCHOSOCIAL CARE AND SUPPORT OF THE CANCER SERVICES IN LIMPOPO PROVINCE under the supervision of Professor DU Ramathuba, Professor SM Maputle and Dr ND Ndou

The specific objectives that formed the basis of this study are the following according to the three phases were to:

Phase 1(a)

- Explore the psychosocial care and support needs of the cancer patients at the hospitals in Limpopo Province

- Describe the psychosocial care and support needs of the cancer patients at the hospitals in Limpopo Province

Phase 1(b)

- Identify the challenges faced by the health care professionals in rendering psychosocial care and support need at the hospitals in Limpopo Province.

Phase 2

To develop psychosocial care and support strategies for improving cancer services at the hospitals in Limpopo Province.

Phase 3

To validate the psychosocial care and support strategies for improving services at the hospitals in Limpopo.

The study is conducted in phases.

Phase 1(a)

- Explore the psychosocial care and support needs of the cancer patients at the hospitals in Limpopo Province.
- Describe the psychosocial care and support needs of the cancer patients at the hospitals in Limpopo Province.

Phase 1(b)

- Identify the challenges faced by the health care professionals in rendering psychosocial care and support need at the hospitals in Limpopo Province.

Phase 2a

To develop psychosocial care and support strategies for improving cancer services at the hospitals in Limpopo Province.

Phase 3a

To validate the psychosocial care and support strategies for improving cancer services at the hospitals in Limpopo province.

Phase 1a of the study was a face-to-face in-depth interview of the cancer patients regarding their psychosocial care and support needs to improve the psychosocial care and support services in the hospitals.

ANNEXURE G: PERMISSION FROM LIMPOPO DOH

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA
DEPARTMENT OF HEALTH

Ref: LP 201901_012
Enquiries: Stander SS Tel:
015 293 6650 Email:
research.limpopo@gmail.com

Ramutumbu N.J
University of Venda
Private Bag X5050
Thohoyandou 0950

Greetings,

RE: PSYCHOSOCIAL CARE AND SUPPORT STRATEGIES FOR IMPROVING CANCER SERVICE AT THE HOSPITALS IN

LIMPOPO PROVINCE

1, Permission to conduct the above-mentioned study is hereby granted,

2, Kindly be informed that:-

- Research must be loaded on the NHRD site http://nhrd.hst.org.za) by the researcher,
- Further arrangement should be made with the targeted institutions, after consultation with the District Executive Manager,
- In the course of your study there should be no action that disrupts the services or incur any cost on the Department.
- After completion of the study, it js mandatory that the findings should be submitted to the Department to serve as a resource.

- The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
- The above approval is valid fora 1 year period.
- If the proposal has been amended, a new approval should be sought from the Department of Health.

- Kindly note, that the Department can withdraw the approval at any time,


Your cooperation will be highly appreciated.

Head of Department

19.02.2019.
Date

Private Bag X9302 Polokwane
Fidel Castro Ruz House, 18 College Street, Polokwane 0700. Tel: 015 293 6000/12. Fax: 015 293 6211.

Website: http/www.limpopo.gov.za

ANNEXURE H: DEPARTMENT OF HEALTH: CAPRICORN DISTRICT

REF s.5/3/1/2

ENQ: Hiatshwayo MM

TEL : 015 290 9154/9096

FROM: DISTRICT EXECUTIVE MANAGER

TO : Ramatumbu NJ

University of Venda
Private Bag XSOSO
Thohoyandou, 0950 Cell.no.og27i7Si90
nramutumbu@gmail.com

SUBJECT: PERMISSION TO CONDUCT RESEARCH ON PSYCHOSOCIAL CARE AND SUPPORT STRATEGIES FOR IMPROVING CANCER SERVICE AT THE HOSPITALS IN LIMPOPO PROVINCE.

The above matter refers:-

1. Permission to conduct the above study at Seshego and Polokwane hospitals is hereby granted,
2. Kindly be informed that:

- In the course of your consultation there should be no action that disrupts the services.
  - After completion of the research, it is mandatory that the findings should be submitted to the Department to serve as a resource.
  - . The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
  - • Kindly note that the Department can withdraw the approval at any

time.

3. Your cooperation will be highly appreciated.

DISTRICT EXECUTIVE MANAGER

11.04.2019

DATE

ANNEXURE I: POLOKWANE HOSPITAL

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

UNIVERSITY OF LIMPOPO

DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT

Enquiries: Mr MA Poopedi
Manager: Clinical Research
Pietersburg Hospital
ananiaspoopedi@gmail.com

Ref: PMREC30MayUL2019/C

Date: 30 May 2018

To: Ramatumbu NJ **(Principal Investigator)**

Department of Nursing

University of Venda

Protocol Title:

Psychosocial care and support strategies for improving cancer services at the hospital in Limpopo province.

Approval Status: Approved

Kind Regards

Dr W Holtshousen

Temporary-Chair of Research: Pietersburg Mankweng Research Ethics Committee **REC300408-006**

ANNEXURE: J
REF : 8/1/1

ENQ : HOPANE N. N

TEL :015 2235141

EXT :2308

DATE :19 APRIL 2019

TO : RAMUTUMBU N.J

FROM : OFFICE OF SENIOR CLINICAL MANAGER
SESHEGO DISTRICT HOSPITAL

PERMISSION TO CONDUCT RESEARCH AT SESHEGO HOSPITAL

The above bears reference to your request to conducting research at the institution.

We hereby acknowledge reception of your research document titled: Psychosocial care and support strategies for improving cancer services in the hospitals in Limpopo Province; and a letter of approval from Limpopo Province Department of Health.

Your request is hereby granted. You may kindly communicate further with the office of Senior Clinical Management for the purposes of making logistical arrangements.

With thanks

Dr Hopane N.N
Acting Senior Clinical Manager

ANNEXURE K: VHEMBE DISTRICT

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA
DEPARTMENT OFHEALTH

VHEMBE DISTRICT

Ref: S5/6

Enq: Muvari MB,/IE

Date: 26. 03. 2019

Dear Sir/Madam: .MRS RAMUTUMBU NJ

PERMISSION TO CONDUCT RESEARCH

1. The above matter refers.
2. Your letter received on the 26/03/2019 requesting for permission to do research is hereby acknowledged.
3. The District has no objection to your request.
4. You are however advised to make the necessary arrangements with the facilities concerned.

Wishing you success in your endeavor.

P.P. ....

CHIEF DIRECTOR DATE

963 [illegible]74/4623
([illegible]15) 962

2019\03\26 ....

ANNEXURE L: MOPANI DISTRICT

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA
DEPARTMENT OF HEALTH

MOPANI DISTRICT

Ref: S4/2/2 Enq:
Mohatli IE lei:
015 811 6543

Ramatumbu NJ
University of Venda

Re: PERMISSION TO CONDUCT RESEARCH IN MOPANI HEALTH FACILITIES: YOURSELF

1. The matter cited above bears reference.
2. This serves to respond to the request submitted to research on the topic: "Psychosocial Care and support strategies for improving cancer service at the hospitals in Limpopo Province."
3. It is with pleasure to inform you about the decision to permit you to conduct research at Nkhensani hospital within Mopani District.
4. You will be required to furnish hospital authorities with this letter for purposes of access and assistance.
5. You are further advised to observe ethical standards necessary to keep the integrity of the facilities ,
6. The Mopani District wishes you well in your endeavour to generate knowledge.

pp Director: Corporate Services
Date: 2019/03/25

ANNEXURE M: NKHENSANI

LIMPOPO PROVINCIAL GOVERNMENT

REPUBLIC OF SOUTH AFRCA

DEPARTMENT OF HEALTH

NKHENSANI DISTRICT HOSPITAL

Ter (015) 811 7300

Fax: (015) 812 2461

Ref: S5/1/6/2

Enq: Mathebula K.D

Date: 28 March 2019

TO: Mrs. Ramutumbu N.J

University of Venda Private Bag X5050

Thohoyandou 0950

RE: APPLICATION FOR PERMISSION TO CONDUCT PSYCHOLOGICAL CARE AND SUPPORT STRATEGIES FOR IMPROVING CANCER SERVICES AT HOSPITALS

1 It is with pleasure to inform you that your application for the study has been approved at Nkhensani District Hospital.

The approval of your research study is subject to the following conditions:

During your research study, hospital services should not be disrupted.

Upon completion of your study, you should be prepared to assist in the interpretation and implementation of the study recommendations where possible.

After completion of the study, it is mandatory that the findings should be submitted to the Department to serve as a resource.

You should liaise with the Office of the Chief Executive Officer (CEO) as and when you intend to start research study. Your cooperation is always appreciated.

9/04/2019 CHIEF

EXECUTIVE OFFICER DATE

ANNEXURE L: MALAMULELE HOSPITAL

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

MALAMULELE HOSPITAL

REF • s 4/5

ENQ • Siwela T.S

DATE : 05/04/2019

TO WHOM IT MAY CONCERN

SUBJECT: PERMISSION TO CONDUCT A RESEARCH: RAMUTUMBU N.J

This serves to acknowledge the receipt your application to conduct a research study at Malamulele hospital and the research topic is "Psychosocial care and support strategies for improving cancer services in the Hospitals in Limpopo Province”.

The permission to conduct the study in question is recommended since has all the requirements such as : the application letter, research proposal, Training institutions Ethical clearance certificate, Provincial and District offices approvals as prescribed by departmental circular no 24 of 2015.

Hopping for an effective cooperation between the participants of this research

Thank you.

CHIEF EXECUTIVE OFFICER
MALAMULELE HOSPITAL

DEPARTMENT OF HEALTH
MALAMULELE HOSPITAL. P/BAG X9245
MALAMULELE. 0982
09 APR 2019
REGISTRY

04 291.7

ANNEXURE N: SILOAM HOSPITAL

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

SILOAM HOSPITAL

Ref : S4/2/1/1/3
Enq : Mushaphi N.T: HRD
Date : 05 April 2019

To: Ramutumbu N.J

RE: PERMISSION TO CONDUCT RESEARCH: YOURSELF.

i RTMENT OF
HEALTH
HOSPITAL

2019 -04- 05

LIMPOPO
[illegible] X [illegible]2,
MAKHADO 0920
PROVINCE

1. The above matter refers.
2. The Hospital highly acknowledges the receipt ofyour letter dated 20/03/ 2019 regarding the above matter.
3. Kindly note that the institution is granting you permission to come and conduct research in Psychosocial care and support strategies to improve cancer services, at Siloam District Hospital in Limpopo Province.
4. You are kindly requested to adhere to the conditions as set out in your approval from the Provincial Office-
5. Hoping you will find the above in order.

Chief Executive Officer

Date 05/04/2019

Private Bag X2432. Makhado, 0920
Tel (015) 973 0004/5/6, 015 973 1447/8, 015 973 1977, 015 9731892/4/9 Fax (015) 973 0607.

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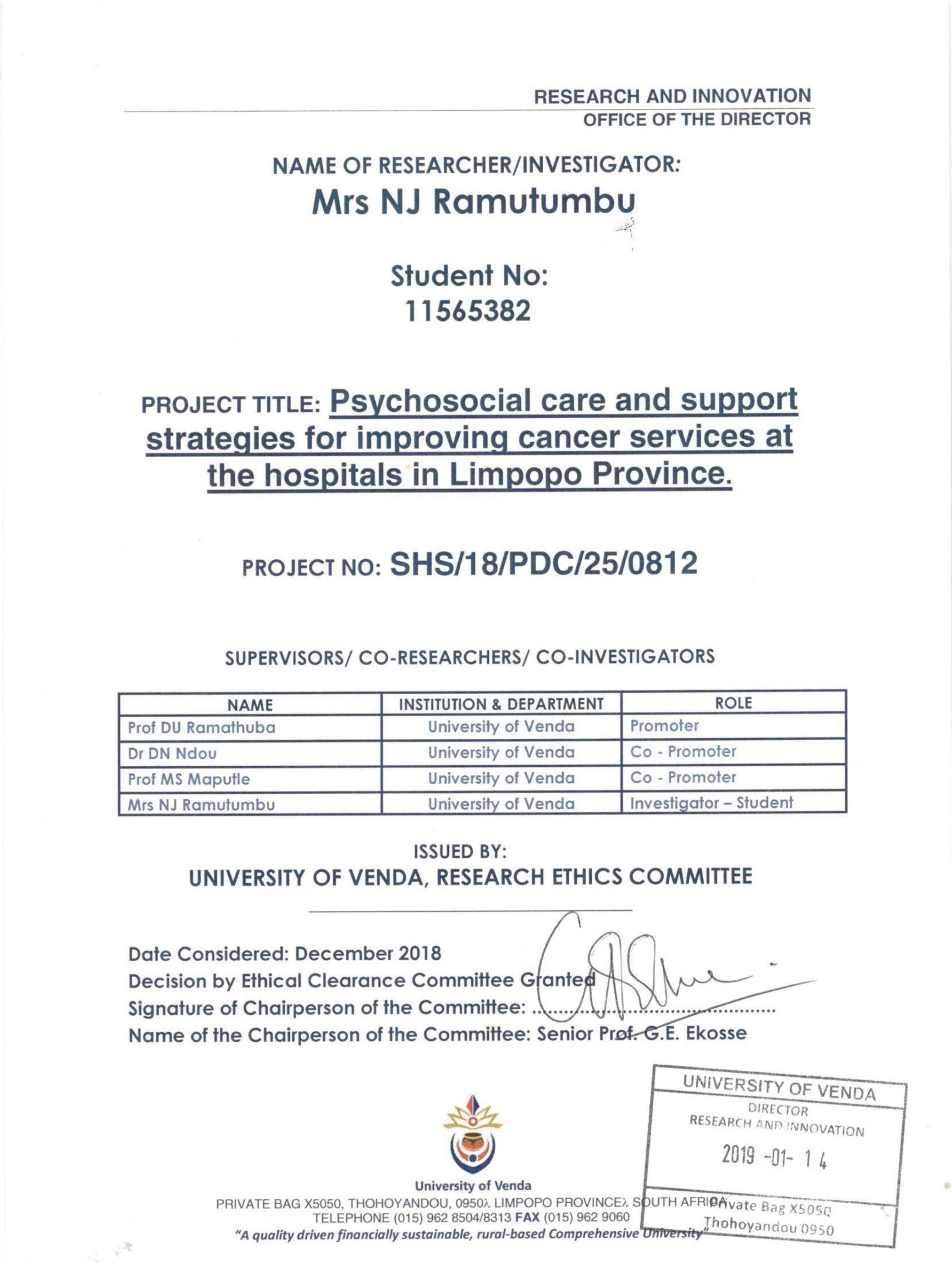

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Mrs NJ Ramutumbu

Student No:
11565382

PROJECT TITLE: **Psychosocial care and support strategies for improving cancer services at the hospitals in Limpopo Province.**

PROJECT NO: **SHS/18/PDC/25/0812**

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof DU Ramathuba	University of Venda	Promoter
Dr DN Ndou	University of Venda	Co - Promoter
Prof MS Maputle	University of Venda	Co - Promoter
Mrs NJ Ramutumbu	University of Venda	Investigator – Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: December 2018
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: ....
Name of the Chairperson of the Committee: Senior Prof. G.E. Ekosse

UNIVERSITY OF VENDA
DIRECTOR
RESEARCH AND INNOVATION
2019 -01- 14
Private Bag X5050
Thohoyandou 0950

University of Venda
PRIVATE BAG X5050, THOHOYANDOU, 0950λ LIMPOPO PROVINCEλ SOUTH AFRICA
TELEPHONE (015) 962 8504/8313 **FAX** (015) 962 9060
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