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9 September 2024

Bridging the gaps in cancer care: UCT's academic calls for a comprehensive, patient-centered approach



Associate Professor Tasleem Ras

Photo: Robyn Walker

Associate Professor Tasleem Ras of the University of Cape Town (UCT) has presented a real-life case study that illustrated some of the difficulties that South African cancer patients encounter while trying to access the public health system and the extreme pressure that front-line healthcare providers endure.

His presentation formed part of the third African Awareness of Cancer and Early Diagnosis (AWACAN-ED) Southern Africa School for Cancer Research event that took place at the UCT Graduate School of Business (UCT GSB). AWACAN-ED is a global health research group funded by the National Institute for Health and Care Research. It focused on advancing

early diagnosis of cancer in Southern Africa. The team comprises researchers from UCT, the University of Zimbabwe and Queen Mary University of London in the United Kingdom.

Associate Professor Ras devoted his presentation to exploring why cancer patients often fall through the cracks, offering practical solutions to improve their experience – and, hopefully, their outcomes – and with those of their families.

The African patient's story

The case study at the heart of his interactive session told the tragic story of a woman in her 50s. In need of medical attention, she hitchhiked to a local clinic in Hopefield on the West Coast, believing the non-healing lesion on her left breast was simply an insect bite.

During a physical examination, Ras said, a healthcare worker – who had been treating the patient's list of non-communicable diseases for years – discovered a fungating wound attached to a hard mass in her left breast. Suspecting cancer, the health worker acted swiftly, contacting the district hospital and securing an appointment for two weeks later. Unfortunately, the patient was diagnosed with incurable stage four cancer and passed away in hospice care just a few weeks later. Ras noted that she died alone, as the nearest hospice facility was 37 km from her home, and her family could not afford the transportation costs to visit.

"This is the African story – late presentation [of disease], lack of capacity at the clinic, [and] the referral process [between healthcare facilities] is a bit jumbled. And [when the patient eventually reached a district hospital for care] that was the last time her family saw her [alive]," Ras said. "In many ways there are certain problems here."

The pitfalls of care

Ras divided the pitfalls for the Hopefield patient's care into three factor categories and unpacked each of them:

- Patient factors: the patient was unaware of the lesion's cancer risk and therefore self-assessed it incorrectly from the get-go; she had no knowledge on how to perform a self-breast examination; and when she eventually visited a healthcare facility, it was too late. The latter is often because of certain cultural beliefs and social norms.
- Healthcare worker factors: nursing practitioners provide generalist care at primary healthcare facilities; due to the high volume of patients who visit clinics, there's little scope for individual attention; they also receive inadequate training in early cancer detection and diagnosis.
- Health system factors: a lack of cancer education exists in under-resourced communities; there's no access to screening programmes; the referral process to an appropriate level of care facility is often delayed.

"Our systems are very curative focused. Yes, education is one of the ways to getting our clinicians to be thinking more preventative. And you can train students to think in a particular way, but when they come and work in a health system which doesn't operate in that way, within two weeks they will be doing whatever everyone else is doing. So, we need to ensure that the curative mindset is continued into [healthcare] services," Ras said.

Adopt a comprehensive approach to cancer care

He advocated for a comprehensive approach to cancer care that addresses the needs of patients at an early stage – whether newly diagnosed, in remission, or facing metastasis.

This approach, he said, should be interdisciplinary, involving a range of healthcare professionals – such as clinicians, nursing practitioners and social workers – who contribute to patient care in healthcare facilities at different stages of their journey. He said this must be implemented dynamically and coordinated, ensuring that both the patient and the family fully understand the diagnosis and the steps ahead. Additionally, he said psychosocial support should be readily available to help them navigate emotional and practical challenges of the road ahead.

“Comprehensive cancer care [should] expand all dimensions of care [and should] not just [be] focused on one [form]. If we are thinking about cancer care in general, we are talking about comprehensive care, which spans all dimensions across multiple levels. And it needs to be dynamic [because] the patient’s condition changes. So, the system needs to be nimble enough to manage someone who is in survivorship and now has a recurrence [of cancer] that has spread. There needs to be some level of nimbleness in the system that responds to the patient’s emerging needs,” he said.

“The system and the humanistic approach to how we practice must be person and relationship centred. [This patient] could’ve been your mother and that personal approach to our clinical practice, to our research, to our teaching, bring home how important this type of work is to our community.”

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