

Original Article

Cite this article: Beesley VL, Staneva A, Nehill C, Milch V, Hughes F, Webb PM (2020). Patterns of, and barriers to supportive care needs assessment and provision for Australian women with gynecological cancer and their caregivers: a mixed-methods study of clinical practice. *Palliative and Supportive Care* **18**, 170–177. <https://doi.org/10.1017/S147895151900052X>

Received: 10 December 2018

Revised: 3 March 2019

Accepted: 13 May 2019

Keywords:

gynecological cancer; supportive care needs; care plans; survivorship plans; barriers to care

Corresponding Author: Vanessa L. Beesley, PhD, QIMR Berghofer Medical Research Institute, Gynaecological Cancers Group, Locked Bag 2000 Royal Brisbane Hospital, QLD, Australia. Email: Vanessa.Beesley@qimrberghofer.edu.au

Patterns of, and barriers to supportive care needs assessment and provision for Australian women with gynecological cancer and their caregivers: a mixed-methods study of clinical practice

Vanessa L. Beesley, PH.D.¹ , Aleksandra Staneva, PH.D.¹, Caroline Nehill, M.P.H.², Vivienne Milch, MHPOL², Felicity Hughes, B.A.² and Penelope M. Webb, DPHIL¹

¹Gynaecological Cancers Group, QIMR Berghofer Medical Research Institute, Brisbane, Australia and ²Cancer Australia, Sydney, Australia

Abstract

Objectives. To document the current clinical practice in 2017 for assessment of supportive care needs and provision of supportive care to women with gynecological cancer and their caregivers in Australia, and to identify the main enablers and barriers to care provision.

Methods. A total of 64 health professionals who care for Australian women with gynecological cancer responded to an electronic survey which explored their use of needs assessment, service-level processes and protocols for support service provision, and identified enablers and barriers to provision of care to both patients and caregivers. Eight respondents underwent an additional in-depth interview to elaborate on enablers, barriers, and gaps in the provision of supportive care.

Results. Mostly, needs assessment for women and caregivers was part of current practice but done without validated tools or a checklist. Only 30% of respondents reported having documented referral pathways. Most respondents simply recorded a plan for meeting needs within the patients' medical record (63% for patients; 46% for caregivers) rather than using a formalized care plan (15% for patients; 6% for caregivers). The interviewees' comments supported survey results that having sufficient time to discuss issues was both the most important enabling factor and the greatest barrier to successful supportive care provision. The interviewees further discussed variations in needs based on age, cultural background, and phases within the cancer care continuum, and that best practice supportive care should involve a multidisciplinary team and customizable protocols.

Significance of results. There is much room for improvement in the assessment of needs and provision of supportive care to women with gynecological cancer and their caregivers. Approaches to optimize use of consultation time (e.g., needs assessment tools and referral protocols) are necessary. Flexibility in the form and mode of delivery of support may be required to meet diverse personal preferences and incorporate caregivers.

Introduction

Gynecological cancers account for approximately 10% of all reported cancer cases in females in Australia, equating to approximately 17 Australian women diagnosed with a gynecological cancer every day (Cancer Australia, 2017a). In addition to the many common experiences of people diagnosed with cancer (such as pain, fatigue, anxiety, coping with hair loss, financial stress, and managing treatment regimens), women with gynecological cancers may face specific problems associated with lower leg lymphoedema, surgically- or chemically-induced menopause, loss of fertility, sexual dysfunction, bowel dysfunction, fecal and urinary incontinence, and emotional and psychological issues related to body image, sexuality, and relationships (Cancer Australia, 2016). Their caregivers may also face specific issues related to the effects of the disease and treatment on their relationship, role, and future plans (Teskereci and Kulakaç, 2016). In order to deliver best practice person-centered healthcare that addresses the needs of the person with cancer and maximizes survival, guidelines recommend systematic assessment of the supportive care needs of people affected by cancer at key points across the continuum of care, with appropriate interventions and referral as required to promote optimal quality of life (Australian Institute of Health and Welfare, 2012; Department of Health and Human Services, 2015; Clinical Oncology Society of Australia Model of Survivorship Care Working Group, 2016; Department of Health and Human Services, 2016; Cancer Australia, 2017b). Ideally, needs assessment should be applied to both women with gynecological cancer

© Cambridge University Press 2019. This is an Open Access article, distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives licence (<http://creativecommons.org/licenses/by-nc-nd/4.0/>), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is unaltered and is properly cited. The written permission of Cambridge University Press must be obtained for commercial re-use or in order to create a derivative work.

and their caregivers. It should enable women, caregivers and health professionals to establish an effective partnership where the woman is an active participant in her health and treatment (Clinical Oncology Society of Australia Model of Survivorship Care Working Group, 2016), as well as meeting the additional needs of caregivers (Given et al., 2001; Tanco et al., 2017). It is also important to assess needs that are both generic to cancer patients and specific to the type of cancer experienced by an individual and their caregiver. Furthermore, it has been recommended that during the transition from intense, regular contact with the cancer care team to follow-up care, needs assessment should be conducted and documented in a survivorship care plan that includes a treatment summary, a summary of the main concerns of the survivor and their health care professional(s), recommendations for other education, supportive care and healthy lifestyle interventions, and referral to other health professionals (Clinical Oncology Society of Australia Model of Survivorship Care Working Group, 2016).

A recent review of the scientific literature showed that women with gynecological cancers have a number of unmet needs (Beesley et al., 2018). However, it is unknown whether needs are routinely assessed within clinical practice. Furthermore, health professionals report barriers to the delivery of supportive care for people with any cancer, with the most common problems occurring at an organizational level, followed by cultural and then individual clinician-related barriers (Dilworth et al., 2014). Therefore, the objective of this project was to better understand the current practice for the assessment of supportive care needs and provision of supportive care to Australian women with gynecological cancer and their caregivers across the cancer continuum. We also explore in detail the healthcare providers' views on the significant barriers and enablers to supportive care provision.

Methods

This study was overseen by a Project Working Group (see acknowledgments) and approved by QIMR Berghofer Medical Research Institute Human Research Ethics Committee. A mixed-method design was used which included a clinical practice electronic survey (e-survey) of health professionals caring for women with gynecological cancer and in-depth follow-up interviews with a subset of respondents. In March 2017, members of the Australia New Zealand Gynaecological Oncology Group (ANZGOG), the Agency for Clinical Innovation (ACI) Gynaecological Oncology Network, Cancer Australia's Gynaecological Cancer Advisory Group, and the project working group were invited to participate in the e-survey via electronic newsletters and correspondence which included a direct link to the survey. Both targeted and snowball sampling were used to ensure the broadest possible reach across the sector. The e-survey was available on-line for approximately three weeks with weekly reminder emails sent to the potential respondents.

Within the e-survey, respondents were asked if they would participate in an additional short telephone interview. All those who consented were subsequently interviewed over the telephone using semi-structured questions focused on enablers, barriers, and gaps in the provision of supportive care. Prior to each interview, the participant's responses to the e-survey questions regarding enablers and barriers to service provision were reviewed, and further elaboration on their answers was sought during the interview. Interviews were audio-recorded and notes were taken to produce a short summary after each consultation.

Measures

The clinical practice e-survey covered four areas of interest: characteristics of respondents (location, type of service they work in, their role, years of experience); respondents' current practice of needs assessment of women with gynecological cancer and their caregivers; service-level process and protocols in place to guide service provision; and questions about enablers and barriers to the provision of supportive care in their practice.

The semi-structured interviews consisted of open-ended questions which explored themes identified in the e-survey around enablers and barriers to care provision for both women with gynecological cancer and their caregivers. Specific issues that affect population subgroups, especially potentially vulnerable groups, were further discussed.

Data analysis

Current practice was considered against a best practice service delivery framework comprising the following five criteria considered separately for a) women with gynecological cancer and b) their caregivers:

1. having a documented protocol in place for assessment of supportive care needs (Butow et al., 2015; Clinical Oncology Society of Australia Model of Survivorship Care Working Group, 2016);
2. always conducting assessment of supportive care needs at all of the following time-points: diagnosis, start of treatment, end of treatment, periodically during follow-up, time of recurrence, and during palliative care (and bereavement for caregivers) (Butow et al., 2015; Clinical Oncology Society of Australia Model of Survivorship Care Working Group, 2016; Cancer Australia, 2017b);
3. using validated instruments to assess common and gynecological cancer-specific supportive care needs (Butow et al., 2015; Department of Health and Human Services, 2015; Clinical Oncology Society of Australia Model of Survivorship Care Working Group, 2016; Department of Health and Human Services, 2016);
4. using a standardized supportive care plan template (Clinical Oncology Society of Australia Model of Survivorship Care Working Group, 2016);
5. taking personal preferences into account when developing the supportive care plan (Butow et al., 2015; Clinical Oncology Society of Australia Model of Survivorship Care Working Group, 2016; Cancer Australia, 2017b); and as meeting two additional criteria:
6. having documented referral pathways for all relevant providers to manage supportive care needs (Butow et al., 2015);
7. discussing and developing a survivorship care plan in consultation with women with gynecological cancer to summarize their diagnosis and treatment and provide self-management information for possible long-term side effects and ideas for staying healthy (Clinical Oncology Society of Australia Model of Survivorship Care Working Group, 2016; Cancer Australia, 2017b).

An overall "best practice" variable was created as a score of the total number of individual best practice criteria that the respondents met. This variable ranged from 0 (met none of the best practice procedures) to 12 (met all of the best practice criteria).

Descriptive analysis was performed on background sample characteristics (i.e., service location, remoteness, access to multidisciplinary teams, current role, and years of experience of the health professionals), the overall best practice variable, and the individual elements of practice including: supportive care needs assessment (personal assessment, method of assessment, tools used, timing and frequency, specific needs items, and assessment process within different cohorts), data on referral pathways and plans, and enabling and limiting factors for the provision of supportive care.

Data from interviews were analyzed using thematic analysis which organizes and describes themed patterns within the data (Braun and Clarke, 2006). Author AS conducted the interviews and qualitative analyses. The main enablers and barriers to care provision that were reported by each respondent in the e-survey were explored in the interviews for clarifications and elaborations. Further elaboration was sought on specific factors, examples, and potential aspects that the respondent reported needed improvement to provide successful support services. During the analysis, author AS grouped emergent patterns of the data with common keywords and phrases to generate a set of codes. In discussion with author VB, the codes were grouped together under general themes, following an iterative revision and refinement process. A final report was shared with other members of the research team for consensus on the interpretation until a definitive set of themes was reached.

Results

Respondent characteristics

A total of 72 people responded to the survey invitation. Eight respondents were excluded: one who self-identified as a patient and seven who reported that they were not currently involved in the care of women with gynecological cancer. A total of 64 health professionals were thus included in the e-survey analysis. Respondents worked in all states and territories of Australia, with more than half from New South Wales, and most were part of a specialist gynecological cancer service, within a metropolitan area with access to an onsite specialist gynecological cancer multidisciplinary team (Table 1). There was a wide representation of health professional roles including gynecological oncologists, medical and radiation oncologists, nurses and a range of specialists in allied health including clinical psychologists and social workers, and about one-third of respondents had more than 20 years experience in oncology.

Participants were asked to complete all questions. However, the total number of respondents for each question does not always sum to 64 due to some respondents choosing not to respond to some questions.

Meeting best practice criteria

No respondents reported meeting all 12 of the best practice criteria, and 39% reported not meeting any of the criteria (Figure 1). Respondents were almost twice as likely to report meeting at least one best practice criterion for patients than for caregivers (59% versus 31%).

Assessing supportive care needs at the respondents' service (meeting best practice criteria 1–3)

One-in-three respondents (34%) reported that their service had a documented protocol in place for needs assessment of patients

Table 1. Respondents' characteristics (n = 64).

Characteristics	n (%) median (range)
State/Territory	
Australian Capital Territory (ACT)	1 (2%)
New South Wales (NSW)	35 (55%)
Northern Territory (NT)	1 (2%)
Queensland (QLD)	8 (12%)
South Australia (SA)	5 (8%)
Tasmania (TAS)	1 (2%)
Victoria (VIC)	12 (19%)
Western Australia (WA)	1 (2%)
Remoteness of location	
Metropolitan	41 (64%)
Regional	20 (31%)
Rural	3 (5%)
Type of service	
Specialist Gynecological Cancer Service	38 (60%)
General Cancer Service	13 (20%)
Other (Specialist palliative care, Cancer genetics, GP, Survivorship center)	13 (20%)
Access to specialized multidisciplinary team (MDT)	
Yes (Onsite specialized gynecological MDT)	45 (70%)
Yes (Link to specialized gynecological MDT, higher level/external)	11 (17%)
No (Access to generic onsite MDT)	3 (5%)
No (No access to MDT)	5 (8%)
Service volume (newly diagnosed women per year)^a	
Median (Range)	200 (0–1000)
Caseload (newly diagnosed women, personally seen per year)^a	
Median (Range)	50 (0–800)
Role	
Gynecological Oncologist	11 (17%)
Medical Oncologist	8 (13%)
Radiation Oncologist	4 (6%)
Clinical Nurse Specialist	5 (8%)
Clinical Nurse Consultant	12 (19%)
Allied Health (Clinical Psychologist, Social Worker, Radiation Therapist)	11 (17%)
Other (Palliative Care, Research Nurse, GP, Cancer genetics)	13 (20%)
Years of experience in oncology	
<5	8 (13%)
6–10	15 (23%)
11–15	11 (17%)
16–20	8 (13%)
>20	21 (33%)

^aSome respondents worked in palliative care and did not see *newly diagnosed* women with gynecological cancer.

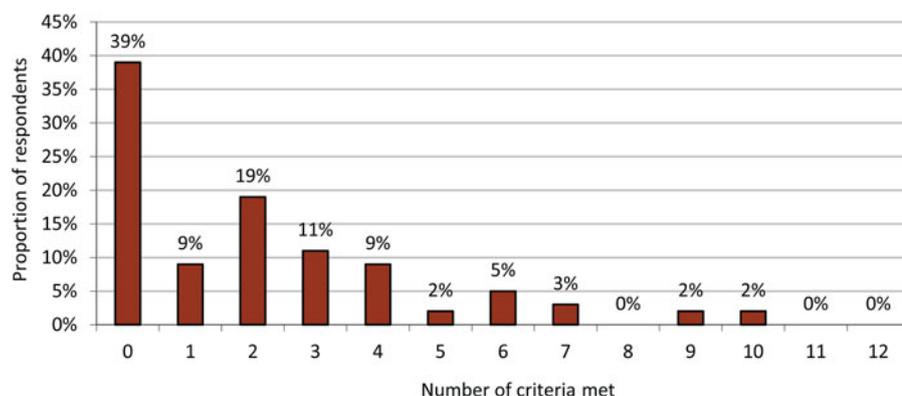


Fig. 1. Percentage of respondents whose service meets the twelve best practice criteria (n = 64).

and 10% did so for caregivers. Mostly, the assessment of needs for women and caregivers was part of current practice at respondents' services but was not done via a documented protocol for patient (50%) and caregivers (60%). Respondents who worked in services in metropolitan areas, who worked at specialist gynecological oncology services, or who had a larger caseload were substantially more likely to meet this best practice criteria (Figure 2a and b), although the differences were not statistically significant due to the small sample size.

Almost half (42%) of the respondents indicated that needs assessment was conducted during unstructured individual consultations, without validated tools or checklists used at all. Nurses (47%) were much more likely to use validated tools to assess supportive care needs, distress, and/or symptoms of women with gynecological cancer than oncologists (30%) or other health professionals (21%). Needs assessment, via unstructured consultation or otherwise, was however being conducted by respondents across most phases of the care continuum for women with gynecological cancer and their caregivers (Figure 3a and b). Only 3% of respondents indicated needs assessment was not part of current practice for women with gynecological cancer, while 17% indicated it was not part of current practice for caregivers.

Approximately one in four respondents (22%) reported conducting care in line with best practice service delivery through screening for psychological distress and/or supportive care needs assessment of a patient's desire for help or information at key points across the care continuum, and 5% of respondents reported doing this for caregivers. Furthermore, less than 20% of all respondents reported that assessment of need for help was done very well or well for each of the following specific issues: lymphoedema 17%; menopausal symptoms 12%; emotional/psychological issues 5%; sexuality issues 16%; loss of fertility 15%; body image issues 11%; relationship issues 9%; bowel dysfunction/incontinence 15%; urinary dysfunction 18%; malnutrition 14%; fear of recurrence 17%.

Supportive care needs assessment within potentially vulnerable subgroups

On a scale of 1 = very poor to 5 = very well, respondents generally rated needs assessment for potentially vulnerable populations as being poor to average, with mean scores of assessment among women from rural and remote locations being the poorest (2.4), followed by Aboriginal and Torres Strait Islander women (2.6), culturally and linguistically diverse women (2.8), refugee women (2.8), lesbian, gay, bisexual, transgender, and/or intersex people

(2.8), women with pre-existing mental health disorders (2.8), and women from other vulnerable groups (sexual abuse victims, frail aged, young adults) (3.4).

Access, referral pathways, care plans, and survivorship plans (meeting best practice criteria 4 –7)

Most respondents reported having good access to specialist services for specific needs associated with having or caring for someone with gynecological cancer (good access to services for lymphoedema 59%; menopausal symptoms 75%; emotional/psychological issues 90%; sexuality issues 62%; loss of fertility 67%; body image issues 61%; relationship issues 70%; bowel dysfunction/incontinence 72%; urinary dysfunction 80%; malnutrition 85%; fear of recurrence 77%). However, only 30% of respondents reported that their service had documented referral pathways to manage the supportive care needs that can arise from gynecological cancer. Although the differences were not statistically significant, respondents appeared substantially more likely to have documented referral pathways if they were from services in metropolitan areas or if they worked at specialist gynecological oncology services (Figure 4).

More than half of respondents reported that they document a plan of how to meet the supportive care needs of both the woman and her caregiver (78% did so for the patients and 52% for caregivers). However, only 15% used formal templates to develop care plans for women with gynecological cancer and 6% did so for caregivers, with the majority reporting that they document a plan within the patient records.

Two in five (41%) respondents indicated they develop survivorship plans for self-management of long-term effects and/or staying healthy, although advice about how to promote wellness was only included in some survivorship plans (20% included dietary advice and 16% included exercise plans). Oncologists (56%) compared to nurses (25%) and other health professionals (36%), and respondents with a higher caseload of women with gynecological cancer appeared to be more likely to develop survivorship plans.

Enablers and barriers to supportive care provision

In addition to current practice, the clinical practice survey also considered enablers and barriers to successful supportive care provision. Respondents indicated that the most important enabling factor and the greatest barrier was having sufficient time to discuss issues with patients. In particular, the top five barriers to provision of care for women with gynecological cancer and their caregivers,

Fig. 2a. Respondents with documented protocol in place at their service for needs assessment of women with gynecological cancer by their characteristics (n = 60).

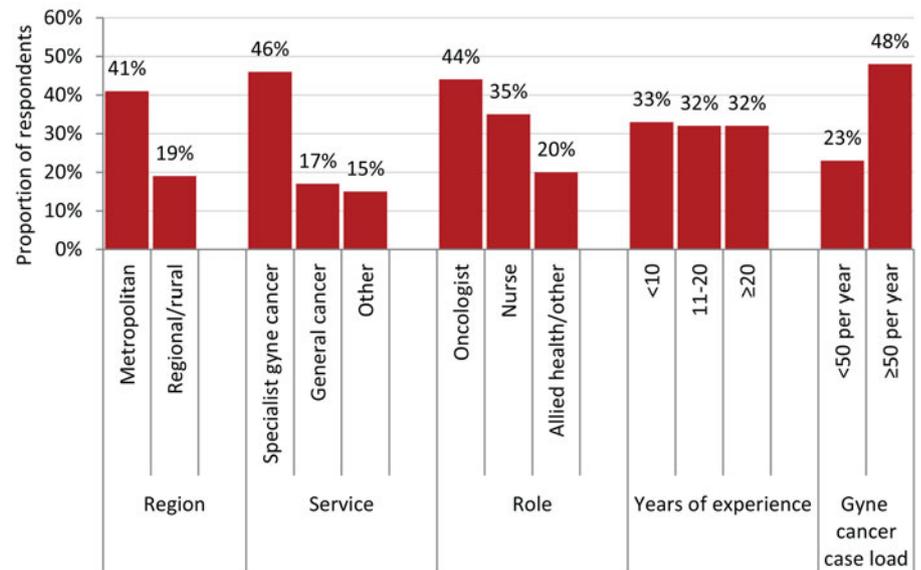
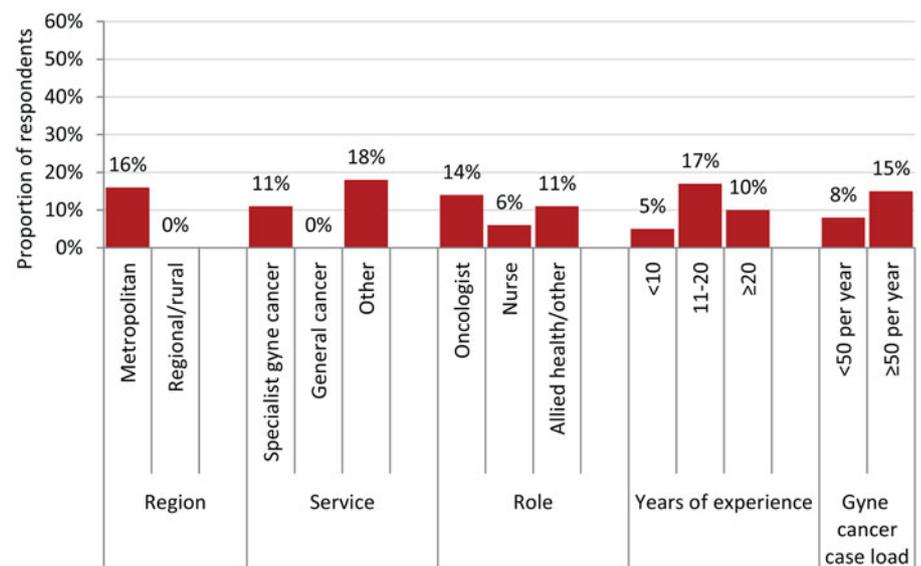


Fig. 2b. Respondents with documented protocol in place at their service for needs assessment of caregivers by their characteristics (n = 58).



rated by respondents as very important were lack of: time to discuss issues (61% for women; 36% for caregivers); other workforce (59%; 52%); availability of psycho-oncology/allied health professionals (44%; 39%); availability of specific gynecological cancer services (40%; 39%); and protocols for needs assessment (36%; 38%). No or insufficient access to a directory of services, training for needs assessment, availability of information resources, established referral pathways, and care plan documents were rated as very important barriers for supportive care provision to women and caregivers by 20–36% of respondents.

Qualitative interview elaborations

The interviewees included two gynecological oncologists, a medical oncologist, a radiation oncologist, two clinical nurse specialists, one clinical nurse, and a senior clinical psychologist. Four

interviewees were based at specialist gynecological cancer services in metropolitan locations, and four were from regional locations with one based in each of the following service types: specialist gynecological cancer service, general cancer service, cancer survivorship center, and radiation oncology unit. Three themes emerged from the interviews: key barriers to providing supportive care; important factors to consider when providing care; and what constitutes best practice care.

Key barriers to providing supportive care

The interviewees confirmed that the limited time available for individual consultations with each woman (and/or her caregivers) was a major barrier, along with the lack of short, simple, and culturally appropriate tools to assess needs relevant/specific to women with gynecological cancer. Moreover, all interviewees reported a need for developing and delivering proper assessment

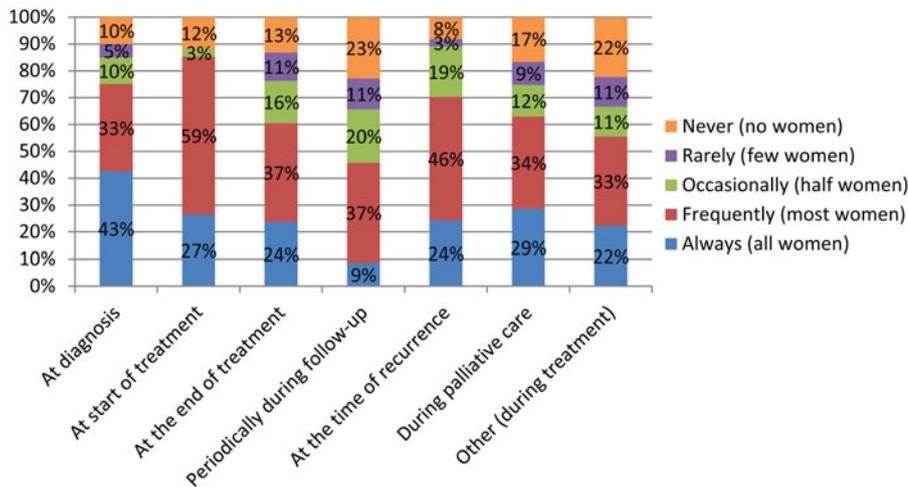


Fig. 3a. Assessment of supportive care needs, timing, and frequency for women with gynecological cancer (n=64).

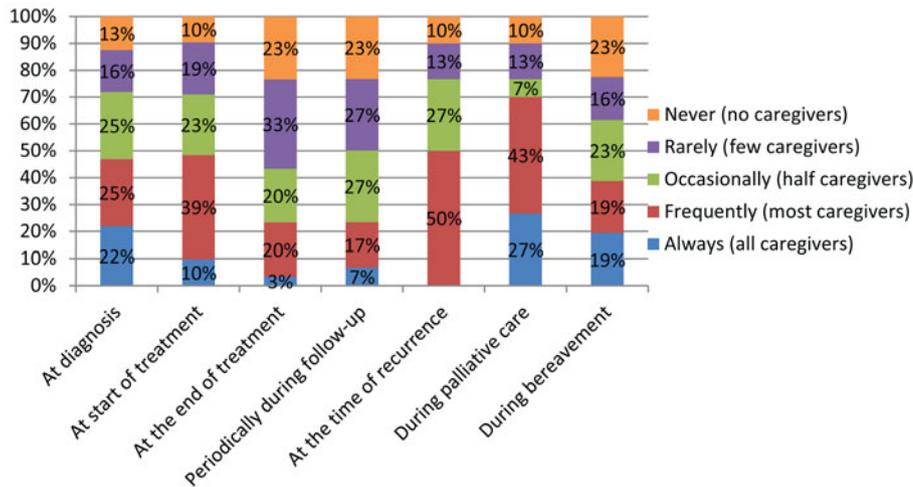


Fig. 3b. Timing and frequency of assessment of supportive care needs for caregivers of women with gynecological cancer (n = 64).

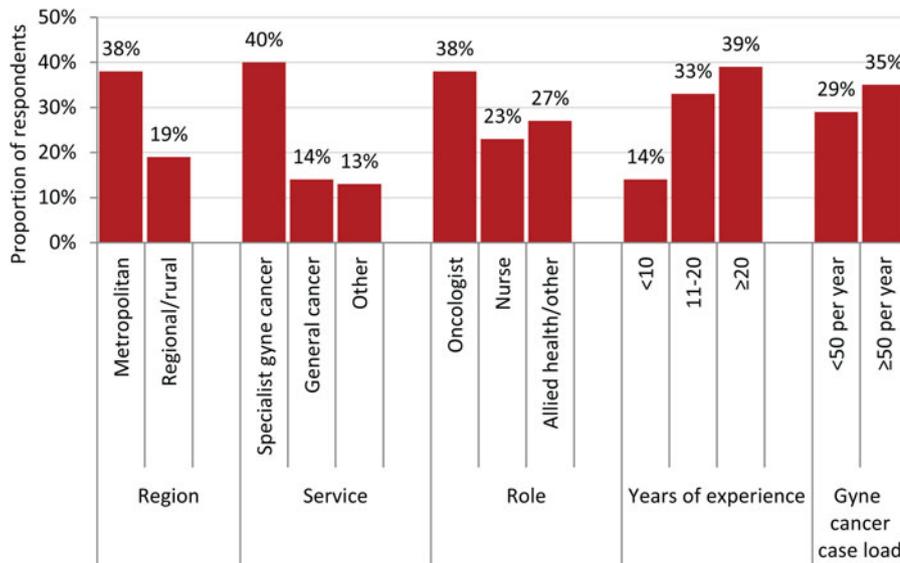


Fig. 4. Respondents whose services have documented referral pathways to manage supportive care needs (n = 40).

and administration of supportive care needs for caregivers, as this aspect of care was generally overlooked. It was further identified that ineffective directories of services with limited information on specialists, complicated processes for referrals, and the lack of onsite psychologists or counseling services were major barriers.

Important factors to consider when providing care

Interviewees reported wide variability in the profile of women with gynecological cancers they see at their practice. Women differed in age, cultural and ethnic background, and phases within the cancer care continuum, as well as specific types of gynecological cancer. As a result, interviewees considered a wide range of issues important to providing care to this population. For example, although the majority of women with gynecological cancers are aged over 50 years, interviewees reported a growing number of younger women presenting with distinct supportive care needs, particularly related to sexuality, loss of reproductive function, early onset of menopause, and hormonal issues. Additionally, this group of younger women tended to share more problems related to interpersonal relationships, financial needs, and work arrangements, as well as issues related to communicating with young children. Post-menopausal women were described as having slightly different supportive needs, such as social isolation (due to transportation and logistics), difficulties in maintaining social networks, and staying physically active. Women from diverse backgrounds were also considered to have unique supportive care needs. Interviewees reported that supportive needs differ across cultures, resulting in unique and potentially complex sets of needs in indigenous and refugee women. The importance of applying cultural sensitivity around issues related to gender, family, and sexuality for indigenous women, and traumatic events and social isolation for refugee women was also reported. Furthermore, respondents reported that resources available to women with gynecological cancers were not seen to be culturally appropriate and/or accessible for indigenous women or refugee women.

Best practice care

While interviewees made it clear that women's supportive care needs varied across the cancer care continuum, some interviewees stated that success in meeting needs depends on referrals being made during the treatment phase, so that support is established for the post-treatment period. It was the opinion of some interviewees that if this support was in place early, late side effects of treatment, such as impact on sexuality, could also be met in a timely manner. Interviewees reported that, ideally, best practice should involve a multidisciplinary team approach and customizable protocols when addressing the needs of each woman (and her caregivers), with regular follow-up. Interviewees also noted that there is an added element of shame and taboo when discussing issues specific to gynecological cancer experiences, such as incontinence, body image, or sexual problems. Interviewees additionally recommended psychosocial support in multiple forms (small support groups or individual consultations) and modalities (face-to-face or telephone) to allow for diverse personal preferences and discussion of sensitive topics. It was considered that this should be facilitated by health professionals and specific to gynecological cancers and age of the women, and that this support should allow for caregivers' participation.

Discussion

The findings from this survey of clinical practice indicate that while assessment of supportive care needs for women with gynecological cancer and caregivers is part of current practice, most health professionals tend to rely on their own skills to do this rather than using formal screening tools. We also found only 30% of respondents reported that they had documented referral pathways at their service to manage supportive care needs and that they were less likely to have documented referral pathways if their service was in a regional or remote area or a non-specialist gynecological cancer service. Arrangements for service provision to meet needs and promote wellness was largely reported to be noted in the patients' medical record rather than formalized with care or survivorship plans. Similar to findings from a recent systematic review (Dilworth *et al.*, 2014), a range of barriers were identified with the most important being lack of time to discuss supportive care issues. When interviewed, health professionals elaborated that a simple and quick supportive care needs instrument specific for women with gynecological cancer would enable women to open up about issues and assist with a better referral system. Interviewees also stated that the needs of caregivers were generally overlooked and that a specific need assessment tool for caregivers and inclusion of caregivers in psychosocial care was required. Lack of onsite workforce, in particular, psychologists and/or counseling services, was pinpointed as a key barrier in the provision of supportive care. Although, contrary to this, most respondents reported having good access to specialist services for specific needs associated with gynecological cancer at their service. Cultural and communication issues were also identified as barriers to the provision of care to indigenous and refugee subgroups.

This study included both an e-survey and interviews with health professionals who care for Australian women with gynecological cancer. The strength of this mixed-method design was that it enabled quantification of nationwide current practices as well as exploration of issues in further depth. This work had a number of limitations, notably that the e-survey sample size was relatively small and so may not be representative of all health professionals, and due to the nature of the recruitment through professional associations, we are unable to report response rates or precise service capture. However, respondents worked in all states and territories of Australia, and they varied widely in the remoteness of their location and their service type. This suggests respondents included health professionals from many of the 43 Australian services listed by ANZGOG as providing care for women with gynecological cancer (Australia New Zealand Gynaecological Oncology Group, 2016). However, the relatively small sample size meant that confidence intervals around the results would have been very wide and thus uninformative so they have not been reported. Furthermore, these findings are relevant specifically to gynecological cancer. Supportive care needs assessment and provision is likely to be different in other cancer settings. While the qualitative interviews gave health professionals a voice and allowed for a follow-up discussion about the enablers and barriers to care provision that were outlined in the e-survey, only eight respondents agreed to be interviewed. It is therefore possible that there are other important aspects of supportive care provision that have not been identified here.

Against the backdrop of national cancer control policy frameworks and models of care (Australian Institute of Health and

Welfare, 2012; Butow et al., 2015; Department of Health and Human Services, 2015; Clinical Oncology Society of Australia Model of Survivorship Care Working Group, 2016; Department of Health and Human Services, 2016; Cancer Australia, 2017b), our findings provide an important understanding of current supportive care practices for Australian women with gynecological cancer and their caregivers. They indicate that there is still much room for improvement in the assessment of needs and provision of supportive care to this population. The results highlight the wide range of disease-specific issues, some of which are still considered “taboo” to discuss and speak to the importance of assessing the current state of needs assessment in specific populations. Organizational level barriers, particularly with regard to the time available to health professionals when interacting with women and their caregiver(s), must be overcome to enable further uptake of best practice needs assessment and follow-up supportive care planning and provision. Key recommendations by health professionals include the need for a culturally appropriate, simple assessment tool to identify the supportive care needs of women with gynecological cancer and separately, their caregivers; a multidisciplinary team approach; availability of multiple forms and modalities of psychosocial support; and customizable service-level process and protocols, with psychosocial care a key component of regular and well established follow-up care.

Acknowledgments. This work was funded by the Australian Government through Cancer Australia. For their expert guidance, we thank the Project Working Group members including Chair, Professor Patsy Yates (Academic Nurse), Professor Susan Carr (Consultant, Sexual & Reproductive Health), Ms. Bronwyn Grout (Consumer Representative), Ms. Kim Hobbs (Clinical Specialist Social Worker), Dr. Laura Kirsten (Principal Clinical Psychologist), Ms. Tish Lancaster (Clinical Nurse Consultant), and Dr. Cath Shannon (Medical Oncologist). Thank you also to Dr. Helen Gooden for advice and input.

References

- Australia New Zealand Gynaecological Oncology Group** (2016) *ANZGOG Annual Report*. Sydney, Australia: Australia New Zealand Gynaecological Oncology Group.
- Australian Institute of Health and Welfare** (2012) *Gynaecological Cancers in Australia: An Overview*. Canberra: Australian Institute of Health and Welfare.
- Beesley VL, Alemayehu C and Webb PM** (2018) A systematic literature review of the prevalence of and risk factors for supportive care needs among women with gynaecological cancer and their caregivers. *Supportive Care in Cancer* 26(3), 701–710.
- Braun V and Clarke V** (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology* 3(2), 77–101.
- Butow P, Price MA, Shaw JM, Turner J, Clayton JM, Grimison P, Rankin N and Kirsten L** (2015) Clinical pathway for the screening, assessment and management of anxiety and depression in adult cancer patients: Australian guidelines. *Psycho-Oncology* 24(9), 987–1001.
- Cancer Australia** (2016) *National Framework for Gynaecological Cancer Control*. Surry Hills, NSW: Cancer Australia.
- Cancer Australia** (2017a) *Gynaecological Cancer in Australia*. Available at <https://canceraustralia.gov.au/affected-cancer/cancer-types/gynaecological-cancers/gynaecological-cancer-statistics> (accessed April 2017).
- Cancer Australia** (2017b) *Principles of Cancer Survivorship*. Surry Hills, Australia: Cancer Australia.
- Clinical Oncology Society of Australia Model of Survivorship Care Working Group** (2016) *Model of Survivorship Care: Critical Components of Cancer Survivorship Care in Australia Position Statement*. Sydney, Australia: Clinical Oncology Society of Australia.
- Department of Health and Human Services** (2015) *Optimal care pathway for women with ovarian cancer*. Available at http://www.cancer.org.au/content/ocp/health/Optimal_cancer_care_for_women_with_ovarian_cancer.pdf (accessed 29 September 2016).
- Department of Health and Human Services** (2016) *Optimal care pathway for women with endometrial cancer*. Available at http://www.cancer.org.au/content/ocp/health/Optimal_cancer_care_for_women_with_ovarian_cancer.pdf (accessed February 2017).
- Dilworth S, Higgins I, Parker V, Kelly B and Turner J** (2014) Patient and health professional’s perceived barriers to the delivery of psychosocial care to adults with cancer: a systematic review. *Psycho-Oncology* 23(6), 601–612.
- Given BA, Given CW and Kozachik S** (2001) Family support in advanced cancer. *CA: A Cancer Journal For Clinicians* 51(4), 213–231.
- Tanco K, Park JC, Cerana A, Sisson A, Sobti N and Bruera E** (2017) A systematic review of instruments assessing dimensions of distress among caregivers of adult and pediatric cancer patients. *Palliative & Supportive Care* 15(1), 110–124.
- Teskereci G and Kulakaç O** (2016) Life experiences of caregivers of women with gynaecological cancer: a mixed-methods systematic review. *European Journal of Cancer Care* 27(1).