Nurse-led breast cancer survivorship care in low- and middle-income countries

A scoping review

Ambili Nair, Prof Georgia Halkett, Prof Janie Brown

Presenter: Ambili Nair

PhD Candidate | Lecturer

Curtin School of Nursing, Curtin University, Australia

elevate cancer nursing
innovate | integrate | educate | advocate

28th ANNUAL CONGRESS • 17-19 JUNE 2026
Perth Convention and Exhibition Centre

Disclosures

- No financial conflicts of interest to declare
- PhD research supported through the Curtin School of Nursing
- Co-authors: Prof Janie Brown and Prof Georgia Halkett (Curtin University)
- No commercial sponsorship of this presentation

Why nurse-led survivorship care in LMICs?

The survivorship challenge

- Breast cancer survival is improving globally, including in LMICs
- Women in LMICs face higher symptom burden, lower HRQoL, and persistent unmet supportive care needs
- Specialist-led follow-up is fragmented and resource-intensive
- Survivorship is still treated as an extension of treatment, not a distinct phase of care

The nurse-led opportunity

- In HICs, nurse-led follow-up is well-evidenced: improved continuity, reduced specialist workload, better HRQoL
- In LMICs, evidence is sparse and dispersed
- Scalable, resource-sensitive models are urgently needed
- Nurses are the largest health workforce and well-positioned to lead supportive care

Review questions

To what extent has nurse-led follow-up care for breast cancer survivors been implemented and described in LMICs?

Sub-questions

a. Characteristics of nurse-led interventions for breast cancer survivors in LMICs? (Duration, mode of delivery and content)

b. Physical and psychosocial outcomes reported following these interventions?

c. Health service outcomes such as feasibility and acceptability?

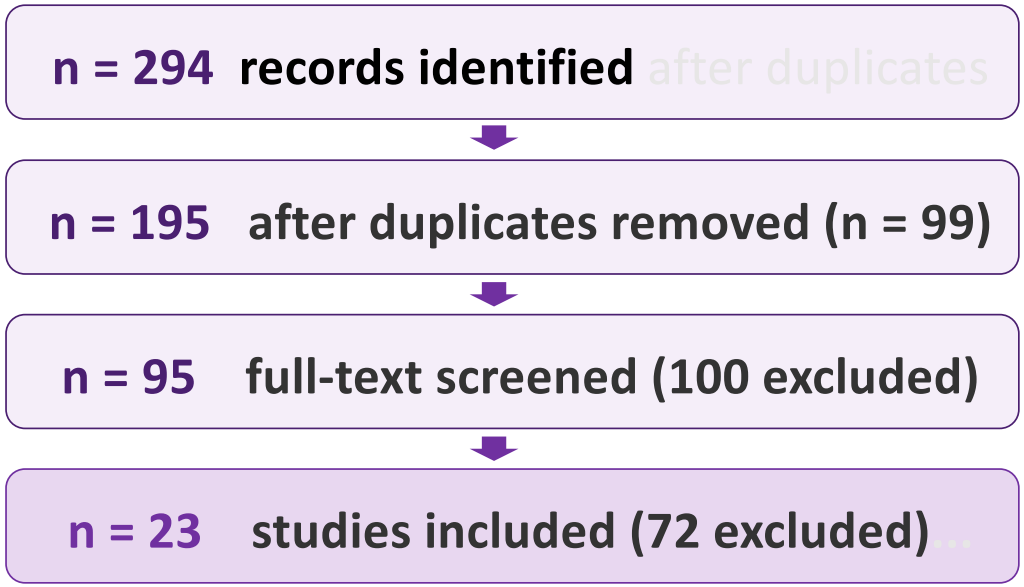
d. Extent to which interventions incorporate a structured survivorship care plan and oncology training capabilities of nurses?

Methods

Review process

- JBI methodology for scoping reviews
- Reported per PRISMA-ScR (McGowan et al., 2020)
- PCC framework — Population, Concept, Context
- MEDLINE, Scopus, CINAHL + Google Scholar + citation searching
- Studies published 2015 – November 2025, English-language
- Two reviewers independently screened in Covidence
- Descriptive and narrative synthesis

PRISMA-ScR flow



The 23 included studies

10	11	2	2
Randomised controlled trials	Quasi-experimental	Retrospective cohort	Mixed-methods (within studies)

Distribution by World Bank income classification

- Upper-middle-income (n = 16): China 6, Turkey 5, Iran 3, Brazil 1, Mexico 1
- Lower-middle-income (n = 5): India 2, Vietnam 1, Egypt 1, Nigeria 1
- Low-income (n = 2): Pakistan 2

How interventions were delivered

Duration

- Mostly acute survivorship phase

4–6 weeks to 6 months most common

- Limited extended phase (up to 12 months)
- No interventions in permanent phase (> 5 years)

Mode of delivery

- Predominantly remote or hybrid (n = 20 of 23)

Telephone, mobile apps, web platforms, ePRO systems

- Face-to-face (n = 3)

What nurses did — content of interventions

Education & self-management

- Disease and treatment literacy
- Symptom recognition and help-seeking
- Wound care, lymphedema prevention
- Lifestyle, exercise, nutrition
- Self-surveillance, breast self-exam

Psychosocial support

- Universal across all 23 studies
- Relaxation, mindfulness, music, breathing
- Counselling with family/peer involvement
- Body image and emotional disclosure
- Culturally informed approaches

Care coordination

- Nurse-initiated triage and escalation
- Referral pathways to MDT
- Ongoing reminders and follow-up
- ePRO-based remote monitoring
- Limited prescribing authority noted

Outcomes assessed in nurse-led follow-up interventions

- Physical & functional well-being ↑
- Symptom burden & side effects ↓
- Psychological distress and fear of recurrence ↓
- Social, family and sexual functioning ↑
- Overall HRQoL and empowerment ↑

Feasibility, facilitators and barriers

Facilitators

- User-friendly digital platforms
- Family involvement and culturally tailored care
- Rapid nurse response to symptom alerts
- Flexible scheduling
- Availability of trained oncology nurses
- Improved nurse-physician collaboration

Barriers

- High symptom burden and treatment toxicity
- Limited digital and health literacy
- Financial constraints; out-of-pocket costs
- Restricted nursing scope of practice
- Unclear nursing roles, limited prescribing authority, advanced oncology training, out-of-hours support

Take-home message

1. Nurse-led follow-up interventions in LMICs were associated with improvements in symptom burden, psychosocial outcomes and health-related quality of life.
2. Despite promising findings, interventions and outcome measures were highly heterogeneous.
3. Evidence was concentrated in upper-middle-income countries, with limited evidence fror low-income settings.
4. Few studies described structured survivorship care plans or the oncology training and capabilities required for implementation.
5. Findings support further development and evaluation of context-specific nurse-led survivorship models in LMICs.

Where this fits — my PhD and what comes next

1. Scoping review identified major evidence gaps in LMICs
2. PhD explored survivorship experiences and nurse-led care in India
3. Findings aligned with review and supported nurse-led survivorship care
4. Postdoctoral focus: nursing capabilities for survivorship care in LMICs and implementation of nurse-led survivorship care model
5. Potential collaborations: Indian nursing academics and CNSA

Thank you

Questions and discussion welcome

Ambili Nair

ambili.nair@curtin.edu.au

Curtin School of Nursing | Curtin University

Acknowledgement: Supervisors Prof Georgia Halkett and Dr Janie Brown