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Nursing Partnership to Enhance Oncology Nurse Expertise and Capacity in Kampala, Uganda

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Purpose:

The incidence of cancer is a growing problem throughout the world. According to Ferlay et al. (2013), it is estimated that there were 14.1 million newly diagnosed cancers and 8.2 million deaths in 2012. The World Cancer Report (2014) states that the number of new cases is expected to rise to 22 million in 2032. The burden of this disease will be felt disproportionately in low- and middle-income countries (LMIC) where 58% of the new cases will be diagnosed and 65% of cancer deaths will occur. With a workforce severely lacking in sufficient numbers of healthcare professionals, there is inadequate care provided where it is needed most, (Galassi & Challinor, 2015). The death rate is elevated partially due to the late stage of cancer at the time of first diagnosis and so rendering the care needed much more complex and demanding, especially when considering the lack of oncology clinically ready workforce in these LMICs.

Nurses form the largest group of healthcare providers and deliver 90% of all healthcare services according to the World Health Organization (WHO), (2012). Nurses are crucial to any country's cancer control program. According to Galassi and Challinor (2015), until recently, little has been done to strengthen and develop the cancer nursing workforce in LMICs, where 80% of the patient with cancer now live. International organizations and professional associations across the world have moved this concern forward on their agendas and have presented a mandate to address this outstanding need. The United Nations has included in the World Health Organization Sustainable Development Goals item #3.4, the aim to reduce by one-third the premature mortality from noncommunicable diseases, such as cardiovascular disease, diabetes, and cancer, through prevention and treatment. The global mandate to address the significant needs across the cancer continuum from prevention to end-of-life care in LMICs has been established as a collaborative goal. "The potential for nurses to contribute to the improvement in population health across the world through attention to chronic disease prevention and care has never been greater" (Rosa, 2016, p. 213). Galassi and Challinor write, "We believe that initiatives to develop a cancer control workforce in LMICs must not only include nursing but must begin with nursing" (p.888).

Uganda is a country in sub-Saharan east African of about 37 million people with 80% of the nation being rural. It has one of the highest rates of cancer of any country in the world. This is likely due in part to the high rate of cancers from infectious diseases such as human papillomavirus, human immunodeficiency virus, and Epstein-Barr virus. Sixty percent of the tumors in Uganda are infection related, according to the Fred Hutchinson Cancer Research Center (FHCRC) Web Site (2018). What follows is a bit of the history and background about the ongoing Ugandan physician and research collaboration with FHCRC.

The Uganda Cancer Institute (UCI) was founded in 1967 by the Ugandan Ministry of Health, physicians from Makerere University Medical school and physicians from the National Cancer Institute in the United States. It is now a publicly owned entity of the Ugandan Ministry of Health. It is the only cancer center serving five east African countries (UCI Website, 2018). A physicians' fellowship program for exchange of expertise has blossomed in these years. One of the missions of the collaboration is: "Create an enabling environment to address the rising cancer burden in low- and middle-income countries." (FHCRC website, 2018). However, what was clearly lacking in this long-standing international and inter-agency collaborative partnership was nursing engagement. This project aims in part to bridge this gap and expand the collaboration to include nursing. Would nursing engagement to enhance expertise and capacity catalyze the energy to address the rising cancer burden?

Methods:

With a vision of relationship building, we created a new model of engagement based on the concepts discussed by anthropologist, sociologist and philosopher, Pierre Bourdieu (1984). His writings about his observations about social and cultural capital and habitus helped us understand '*difference*' and '*power*' in a new way. His thoughtful work guided us to try alternative relationship-building skills for a change from the traditional ethnocentric viewpoint. After a habitus analysis of these old-style mission-focused global nursing partnerships, we aimed, instead to shift our attention to listening and being-with rather than talking and doing. We did not do a facility or competency assessment. The idea was to listen and hear what the *nurses* saw as the needs of UCI nurses. We planned to work alongside the UCI nurses for years to come, sharing the potential progress, promoting structural competency over an individual's skill.

Results:

During our busy visit (January 26-February 6th, 2018) to Kampala and UCI, we met key-stakeholders in each department and had inter-professional discussions with leadership in the nursing and medical departments. We were toured throughout the hospital and clinic. We shared curriculum topics in three classes that had been requested by nurse leadership, Principal Nursing Officer, Sister Allen Naamala. These classes were on Ethics, Infection Control, and Suffering and Moral Distress. During our class time, we asked the nurses present to fill a survey which we titled *Nurse Satisfaction Survey*. In the 11-question document, we asked for information about work-week, overtime hours, patient load, student nurse oversight, and commute information. We inquired about motivating factors for the career choice of the nurse in oncology at UCI. The UCI nurses were also asked to share what they found most rewarding about their work. We also asked for information on what the nurses wanted for future educational topics.

Conclusions:

Our methods revealed an eager, enthusiastic nursing workforce craving more knowledge and expertise in caring for their oncology patients and families. It was also revealed to us what a huge burden is borne by these nurses delivering care, carrying enormous patient assignments on every shift and working significant overtime hours. They travel up to two hours to get to work in central Kampala. In the narrative sections of the survey, hand-written in, nurses identified the many gaps in their clinical care knowledge and expertise. A significant need exists to continue to develop our relationship with the UCI nurses and their leadership team for a collaborative program of oncology curriculum and research readiness for the oncology nurse capacity building. To this end, a strategic plan has been created with the Global Oncology Program at FHCRC for the next five years.

Title:
Nursing Partnership to Enhance Oncology Nurse Expertise and Capacity in Kampala, Uganda

Keywords:
Global (USA/Uganda) oncology nursing collaboration., Nurse assessment of workforce and clinical practice. and Nursing capacity building in an under-resourced country.

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Abstract Summary:
Understanding international nursing collaboration is vital to enhance nurse workforce capacity and improving outcomes for cancer patients in Uganda. Does consideration of nurse role and working conditions through visit and survey guide curriculum and inquiry for improved patient outcomes and nursing expertise?

Content Outline:
Can Nursing Partnership Enhance Oncology Nurse Expertise and Capacity in Kampala, Uganda?

I. Introduction

1. The incidence of cancer is a growing problem throughout the world. The burden of this disease will be felt disproportionately in low- and middle-income countries (LMIC's) where 58% of the new cases will be diagnosed and 65% of cancer deaths will occur.
2. Nurses are central to the delivery of health care and form the largest group of healthcare providers and deliver 90% of all healthcare services according to the World Health Organization. The cancer control program of any county hinges necessarily on educated and clinically skilled nurses. Little has been done to strengthen and develop the cancer nursing workforce in LMIC's, where 80% of the patient with cancer now live.
3. The United Nations has included in Sustainable Development Goal # 3.4, the aim to reduce by one-third the premature mortality from noncommunicable diseases, such as cardiovascular disease, diabetes, and cancer, through prevention and treatment.

II. Body

1. **Main Point** Uganda has one of the highest rates of cancer of any country in the world, largely due to cancers related to infectious diseases. Sixty percent of cancers are caused by viruses.
    1. **Supporting point:** Interprofessional inter-agency collaboration started between physicians and scientists at the Uganda Cancer Institute (UCI) and Fred Hutch Cancer Research Center (FHCRC) in 2004. Strong work was done to build the physician and scientist resources. What was clearly lacking in this long-standing international and inter-agency collaborative partnership was nursing engagement and development.
    2. **Supporting point:** Nurse leadership at the UCI lobbied the medical leadership for assistance in strengthening oncology nursing capacity through partnership and education to decrease patient suffering and improve outcomes. By working together, can this goal be accomplished at the UCI?
2. **Main Point** With the study of the French philosopher and sociologist Pierre Bourdieu, a new model for engagement in global partnership was developed to guide the interactions of leaders meeting to initiate the collaboration.

1. **Supporting point:** Understanding Bourdieu's key concepts of social capital, cultural capital and habitus guided cross-cultural interactions.
2. **Supporting point:** Designing a creative, new model for these interactions, we developed a plan for our initial trip to Kampala in January-February 2018. Shifting from a traditional ethnocentric approach to one that is based on cultural humility, we arrived prepared to listen and to learn from the nurses at UCI.

3. **Main Point** Getting to know the nurses and their working environment was the primary goal of our initial visit. We had many meetings with staff leadership from most departments within the organization. We conducted a nurse survey regarding work conditions and attitudes. We asked for input on what the nurses would like more training on to enhance their oncology practice.

III. Conclusion

Through the survey results, gaps were identified in clinical care knowledge and expertise. From this work emerged a proposal of a strategic plan designed to create a program of education and continued assessment with the UCI nurses to guide the resource creation. A week-long curriculum designed around increasing clinical knowledge and research readiness was developed and implemented in October 2018.

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