Global Oncology Volunteering: Making an Effective Contribution

Annette Galassi, RN, MA, OCN®, Rachna Pradhan, BSN, Gayatri Palat, MBBS, and Virginia T. LeBaron, PhD, ACNP-BC, AOCN®, ACHPN®, FAANP

As countries scale up to meet the demand for cancer services, some ministries of health have turned to non-governmental organizations (NGOs) and high-income country academic medical centers, cancer centers, and medical and nursing schools to provide volunteers to teach students, work with faculty, develop and deliver continuing education programs, and provide clinical teaching and mentoring in hospitals and clinics. Some NGOs also provide volunteers to deliver direct patient care to people with cancer. This article provides an overview of the healthcare challenges in low- and middle-income countries (LMICs) likely to be encountered by oncology volunteers and insights about how to be a successful global health volunteer. Perspectives are offered from oncology nurses from high-income countries who have volunteered globally and LMIC healthcare providers who have served as hosts for global volunteers.

Elements of a good health system are lacking in most low- and middle-income countries (LMICs) and in many high-income countries, including the United States.

A good health system delivers quality services to all people, when and where they need them. The exact configuration of services varies from country to country, but in all cases requires a robust financing mechanism; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; well-maintained facilities and logistics to deliver quality medicines and technologies. (World Health Organization, 2017, para. 1)

A major problem is financing health care. On average, about 50% of healthcare financing in low-income countries comes from out-of-pocket payments, compared to 30% in middle-income countries and 14% in high-income countries (Mills, 2014). Even if a social health insurance program exists, cancer screening, early detection, and treatment are not always covered services. In many LMICs, a two-tier system of health care exists—public (government) facilities, which are seriously under-resourced, and private/corporate facilities with better resources for the few who can afford them. The public system is structured step-wise so that complicated cases are referred to a higher-level facility. Gaps in the system are filled by private and faith-based nongovernmental organizations.

The LMIC healthcare workforce may include lay health workers, who provide basic health education and oversee medication compliance in their community, and midlevel providers, such as clinical officers, who staff health centers and district hospitals. Specialist physicians, such as oncologists, usually are found only in national referral hospitals, and typically only one such hospital exists in the country’s capital city. Nurses have variable training from a secondary certificate (two years) to a bachelor’s degree (Malvárez & Castrillón, 2005; Munjanja, Kibuka, & Dovlo, 2005). There are few opportunities and many barriers to advanced nursing education, specialty certification, or continuing professional development. In many LMICs, nursing is generally considered a low-status occupation, a view often held beyond the healthcare system, extending to the public and policymakers. Nursing’s contribution to patient care is subsequently undervalued. Advanced practice and specialist nurses may exist but are restricted in their scope of practice (All-Party Parliamentary Group on Global Health, 2016). Multiple factors contribute to these issues, including the dominance of the medical profession, gender-based inequities, cultural taboos related to the intimacy of bodily care, and the undervaluing of direct hands-on care and emotional support. Inspiring examples of nurses overcoming these challenges exist, such as in

Galassi is a nurse consultant for Armand Global Consulting in Rockville, MD; Pradhan is a clinical nurse at the Jigme Dorji Wangchuck National Referral Hospital in Thimphu, Bhutan; Palat is a director of palliative care for the MNJ Institute of Oncology and Regional Cancer Centre in Hyderabad, India, and the Two Worlds Cancer Collaboration (INCTR Canada) in Vancouver, British Columbia, Canada; and LeBaron is an assistant professor in the School of Nursing at the University of Virginia in Charlottesville.

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Galassi can be reached at agalassi57@gmail.com, with copy to editor at ONFEditor@ons.org.

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