

Voices of Hope From Rural Rwanda: Three Oncology Nurse Leaders Emerge

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Committed, longitudinal, and respectful partnerships between low- and high-income countries can significantly strengthen cancer care capacity and oncology nursing. This article describes a partnership between the United States and Rwanda and the impact the program has had on three Rwandan oncology nurses.

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The cancer burden in low- and middle-income countries (LMICs) has been well described in the literature (International Agency for Research on Cancer, 2012; Ott, Ullrich, Mascarenhas, & Stevens, 2011; Thun, DeLancey, Center, Jemal, & Ward, 2010). According to the World Health Organization ([WHO], 2015), about 14 million new cancer cases occurred in 2012, and more than 60% of those cases were in Africa, Asia, and Central and South America; of the 8.2 million cancer-related deaths in 2012, more than 70% occurred in these regions (Bray & Møller, 2006).

Rwanda is a small country in East Africa, comparable to the size of Maryland in the United States, with a population of about 11 million people, making it one of the most densely populated countries in Africa. The country is primarily rural, with subsistence farming being the main economy and tea and coffee as the major cash crops (Our Africa, 2016). The genocide in 1994, which killed about 1 million people, had devastating effects on healthcare delivery. Devastation occurred in the rise of diseases, such as HIV, tuberculosis, and cholera. In addition, Rwanda had the highest mortality rate for infants aged younger than five years in the world, and most healthcare workers either fled the country or were killed during the genocide. The dramatic postgenocide revival of Rwanda's healthcare system in the early 2000s, supported by

the Rwandan government, foreign governments, multilateral funders, international academic consortia, and other nongovernmental organizations, provided the foundation for a cancer care delivery system to build on the existing infrastructure (Binagwaho & Farmer, 2014; Binagwaho et al., 2014).

In addition to having a high cancer burden, LMICs are also in the greatest need for healthcare professionals. For example, Sub-Saharan Africa accounts for 24% of the global disease burden but only employs 4% of the global health professional resources (WHO, 2006). The WHO recommends a minimum health service provider density of 2.3 providers per 1,000 population. In 2011, Rwanda's health service provider density was 0.84, far below the WHO recommendations. In 2012, the country of Rwanda partnered with the Clinton Health Access Initiative and began the Human Resources for Health (HRH) program. The main components of this partnership between the United States and Rwanda focus on knowledge transfer, sustained collaboration, medical residency, nursing, health management, and oral health programs. The HRH program will continue for seven years, with broad goals to train hundreds of healthcare providers, strengthen health professional curricula, and improve the health of the country (Binagwaho & Farmer, 2014).

Nursing educational preparation in Rwanda has historically consisted of three levels, but little