Palliative Care in Rwanda: Aiming for Universal Access

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Abstract

In 2011, Rwanda’s Ministry of Health set a goal of universal access to palliative care by 2020. Toward this audacious egalitarian and humanitarian goal, the Ministry of Health worked with partners to develop palliative care policies and a strategic plan, secure adequate supplies of opioid for the country, initiate palliative care training programs, and begin studying a model for integrating coordinated palliative care into the public health care system at all levels. It also initiated training of a new cadre of home-based care practitioners to provide palliative care in the home. Based on these developments, the goal appears within reach.

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Key Words

Rwanda, palliative care, pain, equity, global health

Background

Rwanda, a small, densely populated, low-income country in East Africa, has a population of over 12 million. In 2012, there were 78,000 deaths including approximately 29,000 from infectious diseases (lower respiratory infections, HIV/AIDS, and diarrheal diseases were the most common), 10,000 from injuries, 8000 from neonatal conditions, 6000 from malignant neoplasms (cervical and liver cancers were the most common), and 5000 from stroke.1 Rwanda’s 1994 civil war and genocide against the Tutsi left the country’s economy and health care system in shambles, and the population severely traumatized. As the country rapidly rebuilt its economy over the past 22 years, its health care system—focused on health equity—has achieved astonishing results as measured by life expectancy, maternal and child mortality, and other parameters. Among its innovations is the presence in every village in the country of three community health workers (CHWs), elected by the villagers, who provide basic health services and promote access for all to the health care system.2 Most basic health services, including palliative care, are covered by Rwanda’s community-based health insurance that subsidizes

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premiums and co-payments for the very poor. In January 2011, Rwanda’s Ministry of Health (MoH) became the first in Africa to issue a National Palliative Care Policy. At the same time, it published a National Five-Year Strategic Plan for Palliative Care as well as National Standards and Guidelines for the Provision of Palliative Care that are based on the African Palliative Care Association’s Standards for Providing Quality Palliative Care Across Africa. According to the Policy, “all people—including children—living in Rwanda with a progressive life-limiting illness, their families, and caregivers will have access to a health system that provides high-quality palliative care services that are well coordinated, innovative and responsive to their needs in an affordable and culturally appropriate manner by 2020.” Since 2011, well before the World Health Assembly proclaimed access to palliative care “an ethical responsibility of health systems,” the MoH has been working toward this ambitious goal with assistance from foreign partners.

**Policy**

In keeping with the national palliative care policy, strategy, and standards of 2011, the government of Rwanda has continued to issue directives and policies to guide palliative care development. In 2012, the National Assembly passed, and President Paul Kagame signed, the “Law governing narcotic drugs, psychotropic substances, and precursors in Rwanda.” Following the World Health Organization concept of balance in national opioid policies, the law gives guidelines for supply chain security while also legalizing opioid prescription not only by all doctors at district hospitals but also by nurses working in community health centers within limits established by the Minister of Health. While not yet fully implemented, this law is designed to create universal yet safe access to opioid analgesics for those in need in the community once adequate infrastructure is in place and adequate training provided. In 2015, the MoH officially requested all referral and provincial hospitals to establish palliative care services. Thus, government policies seek to develop palliative care at all levels of the health care system.

**Opioid Accessibility**

In 2014, a Rwandan palliative care physician and a pharmacist from the MoH participated in the African Pain Policy Fellowship organized by the Pain & Policy Studies Group at the University of Wisconsin, USA. As part of this Fellowship, the Rwandan fellows studied Rwanda’s laws and regulations governing opioid accessibility, estimated the country’s opioid needs for pain relief, and drafted a plan to make an adequate supply of opioids safely accessible for medical uses. With additional support from the University of Edinburgh (U.K.) and Makerere University (Uganda), the MoH then convened meetings to review the proposed plan and to officially estimate the country’s opioid requirement in light of its development of palliative care. Using as a standard the amount of opioid consumed at the hospital with the most fully developed palliative care services, an estimate much higher than in previous years was made, submitted to the International Narcotics Control Board as per international practice and quickly approved. The MoH also decided to begin importation not only of morphine immediate-release tablets but also of inexpensive morphine powder to be reconstituted as oral morphine liquid at a single government production facility to assure quality and then distributed to hospitals. As a result, morphine consumption increased from essentially 0 mg/person/year to over 0.85 mg/capita/year within one year. We know of no reports of opioid diversion. Many hospitals have not yet ordered oral morphine from the MoH production facility, indicating a need for continued training for hospital leaders and pharmacists as well as clinicians. Injectable morphine or pethidine usually is available in hospitals with active surgery programs but is used infrequently for palliative care.

**Education/Training**

The first training in palliative care was held in 2005, but the MoH initiated organized and standardized training several years later with support from global partners. In collaboration with the University of Edinburgh (U.K.) and Makerere University (Uganda), and with funding from the Tropical Health and Education Trust (U.K.), training began in 2012 at three government hospitals. More recently, training was extended to six district hospitals and the community health centers in each of the six districts. The MoH’s Human Resources for Health Program, funded by the U.S. government, initiated palliative care training for internal medicine residents and clinical mentoring in palliative care at major teaching hospitals. In addition, several Rwandan physicians, nurses, and pharmacists obtained support to attend palliative care training programs at Mulago Hospital or Hospice Africa Uganda in Kampala or in the U.S. Access to training programs such as these, tailored to the local clinical situation, are essential for low- and middle-income countries such as Rwanda that initially lack palliative care expertise. However, training is of little benefit to patients if the trainees are not enabled to implement their new palliative care knowledge and skill as part of their official, salaried duties.

**Implementation**

Rwanda’s first hospital-based palliative care program started in 2009 when a district hospital in the
capital city, Kigali, began providing inpatient palliative care for adults and children that is linked to home services. To facilitate implementation of coordinated and effective palliative care services, the MoH issued in 2013 several standardized forms to be used by all palliative care providers, teams, and patients. The forms are designed to enhance longitudinal patient care and communication of clinical information throughout all levels of the health care system. Also in 2013, the Rwanda Palliative Care and Hospice Organization was established to foster palliative care nationwide. Toward this goal, it recently signed a memorandum of understanding with the MoH. The Rwanda Palliative Care and Hospice Organization also provides home-based palliative care in Kigali. In preparation for countrywide implementation of palliative care services, the MoH began in 2014 an implementation study of district palliative care networks in two districts. The networks include a multidisciplinary palliative care team at the district hospital, trained nurses at each community health center, and CHWs in each village trained to provide emotional support and to recognize and report any physical, psychological, or social suffering. The study will test the hypothesis that palliative care networks that include home care not only can improve patient outcomes but also provide financial risk protection for patients’ families and save money for health care systems by eliminating the need for many hospital admissions near the end of life. Finally, referral and provincial hospitals around the country now are working to comply with the MoH directive to establish palliative care services for adults and children.

Challenges and Future Directions

Despite Rwanda’s rapid economic development since 1994 and the extraordinary health care system it has created due to visionary leadership and large investment in the health care sector, important impediments remain to universal access to high-quality palliative care. These include the lack of trained staff and the many competing priorities in health care that make it difficult to allocate staff time and funds for palliative care. The MoH’s plans to overcome these impediments include required palliative care training for all internal medicine residents and integration of palliative care into chronic noncommunicable disease care. Given the already numerous responsibilities of CHWs, the MoH recently made plans to train a new cadre of home-based care practitioners to provide both noncommunicable disease care and palliative care in the home. Assuming all 30 districts in the country can implement palliative care networks that include a home-based care practitioner responsible for each village, and assuming integration of palliative care into all levels of the public health care system proves clinically effective and financially sustainable, Rwanda would become the first low- and middle-income country to fulfill an ambition to make palliative care universally accessible. And a young nation that has endured unspeakable suffering would demonstrate to the world that the suffering of all people can and should be treated.

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References


