

REPUBLIC OF RWANDA



MINISTRY OF HEALTH

**Five-Year (2010-14) Strategic
Plan for Palliative Care for
Incurable Diseases**

January 2011

TABLE OF CONTENTS

ACRONYMS	iii
FOREWORD	iv
1. INTRODUCTION	1
1.1. BACKGROUND	2
1.2. THE POSITION OF HEALTH FACILITIES	2
1.2.1. Historical background	2
1.2.2. Characteristics of care and health services.....	2
1.2.3. Priorities of the Ministry of Health.....	2
1.2.4. Health system organization.....	3
1.2.5. Partnerships.....	4
1.3. CURRENT SITUATION OF PALLIATIVE CARE.....	5
1.3.1. Generalities	5
1.3.2. Supplying palliative care.....	6
1.4. SITUATIONAL ANALYSIS OF PALLIATIVE CARE IN RWANDA	7
1.5. MISSION, VISION, AND OBJECTIVES	9
1.5.1. Mission	9
1.5.2. Vision	9
1.5.3. Goals.....	10
1.5.4. Objectives.....	10
1.6. GUIDELINES OF THE PALLIATIVE CARE POLICY	10
1.6.1. Guiding principles of the country policy	10
1.6.2. Principles of medical ethics	10
1.6.3. Levels of palliative care in Rwanda.....	11
1.6.4. Institutional framework and coordination for the development of palliative care	12
2. FIVE-YEAR (2010–14) STRATEGIC PLAN	14
2.1. FIVE PRIORITY AREAS.....	14
2.2. RESULTS-BASED MANAGEMENT: IMPACT, OUTCOME, AND OUTPUTS.....	15
2.3. GOVERNANCE AND IMPLEMENTATION.....	18
2.3.1. Institutional framework	18
2.3.2. Coordination	18

2.3.3. Institutional capacity-building.....	20
2.3.4. Monitoring and evaluation.....	22
2.3.5. Strategic plan financing.....	24
CONCLUSION.....	27
APPENDIX 1: LOGICAL FRAMEWORK ACTION PLAN: STRATEGIC PLAN 2010-14.....	29
APPENDIX 2: HEALTH PROFESSIONALS TRAINED IN PC ACROSS DIFFERENT HEALTH FACILITIES	36

ACRONYMS

CHU	University Teaching Hospital
FOSA	Formation Sanitaire/Health Facility
MMI	Military Medical Insurance
MOH	Rwandan Ministry of Health
PC	Palliative Care
PCP	Palliative Care Policy
RAMA	La Rwandaise d'Assurance Maladie
SWAA	Society of Women against AIDS
UK	United Kingdom
WHO	World Health Organization

FOREWORD

1. INTRODUCTION

The Five-Year (2010-14) Strategic Plan for Palliative Care for Incurable Diseases maps out and prioritizes the efforts required from the Rwandan Ministry of Health (MOH), health professionals, caregivers, and other health sector stakeholders to enhance the quality of health services delivered to people living with chronic illnesses in Rwanda.

In 2002, The World Health Organization (WHO) defined palliative care (PC) as “an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.” This approach takes on pain and other symptoms while considering every aspect of a person. It does not hasten or delay death; its goal is to preserve the highest possible quality of life until death.

Symptoms must be better managed. Patients living with life-threatening diseases have certain desires such as dying at home that should be taken into account.

This strategic plan sets goals for the five-year period from 2010 to 2014. MOH annual reports will monitor and report on national progress toward these goals.

This document outlines major contextual realities that have had an impact on the development of health services thus far in Rwanda. It also describes the mission, vision and objectives that should inspire and guide the action of the MOH. This plan is based on guiding principles, orientations, and areas of specific interventions; we have identified performance indicators for each step that help to measure the plan’s progress and track its success. This strategic plan should link the socio-health system and overarching governmental strategic orientations.

1.1. BACKGROUND

Situated in the Great Lakes region of East Africa, Rwanda shares its borders with four countries: Burundi to the south, Tanzania to the east, Uganda to the north and the Democratic Republic of Congo to the west. Rwanda has an estimated population of 9.3 million living in an area of 26,338km², a density of 350 inhabitants per km². Its economy is mainly agrarian: 83% of the population lives in rural areas. The country has a growth rate of 2.6%, a fertility rate of 5.5, and life expectancy at birth of 51.2 years. It is ranked among the most densely populated countries of the world.

The literacy rate is 64.7% and primary school enrollment is at 95%. The population is young: 63.4% of the population is under 25 years of age. Only 2.4% are 65 or older, yet that percentage will increase in the near future, and dementia-related illnesses requiring PC will consequently increase.

1.2. THE POSITION OF HEALTH FACILITIES

1.2.1. Historical background

Before the colonial era, the health care system in Rwanda was based primarily on traditional medicine using plants, herbs and powders. During the colonial period and until the 1970s, evidence-based medicine gained prominence. In the 1980s, the Government of Rwanda implemented primary health care as the key strategy to improve the health of the population.

In February 1995, the MOH initiated reforms in the health sector based on the Lusaka Declaration, which were later adopted by the government in 1996. The stated goal of this policy was to contribute to population welfare by ensuring quality services that are accessible to the majority of the population. The policy was based on the following key strategies:

- Moving toward a decentralized health system in which the district is the basic operational unit
- Developing primary health care through eight major components
- Strengthening community participation in management and financing of services.

1.2.2. Characteristics of care and health services

Characteristics of care include continuity, mainstreaming care, comprehensiveness, and appropriateness of care. Service characteristics include decentralization, permanence, versatility, and efficiency of services.

1.2.3. Priorities of the Ministry of Health

The MOH undertook the seven programs briefly described below as priorities of the health sector.

Human resources

The MOH wishes to increase the availability of qualified health professionals throughout the country, particularly in rural areas and areas poorly served. It intends to develop a human resources plan to reinforce basic training of medical and paramedical staff and strengthen continued training of staff at work.

Drugs, vaccines, and consumables

The MOH seeks to improve the availability of quality medications, vaccines, and consumables, particularly essential drugs, routine vaccines, and family planning products.

Development of community-based health structures

The government facilitates initiatives supporting community involvement, such as the creation of community dispensaries upon request.

Affordability of health services

The government has looked to improve the affordability of health services, particularly among poor and vulnerable populations, by fostering programs such as community financing mechanisms that strengthen solidarity and share risks (namely *mutuelle* insurances, prepaid systems, and medical insurance).

Quality and demand of health services to fight against diseases

The MOH aims to enhance the quality and demand of health services within the framework of fighting against diseases. This program emphasizes on controlling diseases that highly contribute to the burden of morbidity and mortality and lessen productivity in the country.

Referral hospitals, treatment and research centers and institutional capacity

The government will strengthen referral hospitals and specialized treatment and research centers. Research and specialized skills shall be reinforced in light of country priorities.

Strengthening institutional capacity in the health sector

Institutional capabilities cover various areas, including management, planning, monitoring and evaluation (M&E), ICT, Health Information Systems, and training of administrative staff.

1.2.4. Health system organization

The Rwandan health system is pyramidal with a structure of three levels: central, intermediary, and peripheral and by the end of 2008 was composed of four referral hospitals, 39 district hospitals and 387 health centers with 1,089 physicians and 7,177 nurses.

The main level comprises central management and programs of the MOH which has in its attributions health and the national referral hospitals. This level develops policies and strategies, ensures monitoring, evaluation and regulation of the sector. It organizes and coordinates activities carried out at the intermediary and peripheral levels.

The intermediary level (provincial) coordinates district activities and ensures technical and logistical support. It deals with political and management issues but is not responsible for health care supply. Provincial management in charge of health is responsible for implementation of health policies, coordination of activities, and the supply of administrative, technical and logistical support. It ensures equitable distribution and effective use of resources. In relation to her/his responsibilities, the director in charge of health advises the district mayor/prefect in health matters.

The peripheral level is represented by the district and comprised of the administrative entity, a district hospital, and the network of health centers (public, licensed and private). Functions of the district health unit include:

- Organization of health services for health centers and district hospitals based on minimum and supplementary packages of activities;
- Administrative and logistic operations, including management of resources and supply of drugs under supervision of health centers and community health workers (CHWs).

At all levels of the district health unit, decisions are jointly made through committees that serve as channels of community participation in the health sector. Community involvement has a role to play in planning, implementation and M&E of primary health activities, including implementation of services at the community level and in search of appropriate solutions to local health problems and resource mobilization.

1.2.5. Partnerships

The MOH understood that agreement and collaboration with various partners is indispensable to implementing core programs of health. Hence, it undertook:

- A sectoral approach to different levels of health system
- Local, regional and international cooperation
- Collaboration with networks and professional associations
- Collaboration with private and licensed sectors and the sector of traditional medicine

In a nutshell, to comply with its programs, the government has accomplished satisfactory progress in public health improvement in general between 2000 and 2005. The infant mortality rate (IMR) declined by 19.6%, the under-five child mortality rate fell by 22.4% while the maternal mortality rate (MMR) decreased by 29.9%. The current mortality rate among children under five years is comparable to rates in 1992.¹

Access to health services and other related services as well as their use have improved in some regions while not in other regions. 75% of inhabitants stay at least 5 kilometers from the health center when 56% of nurses live in rural areas. Shorter distances would facilitate collaboration

¹ 1992 is the date of the first Demographic and Health Survey (DHS). The MMR in 2005 cannot be compared to that of 1992 due to a change in the methodology of the DHS in 2000

between health centers and the community, which is beneficial for PC implementation. Marked improvement in the health sector was led by a strong strategic plan from the beginning of the PRSP period together with targeted actions, for instance the extension of the *mutuelle* health insurance program.

1.3. CURRENT SITUATION OF PALLIATIVE CARE

1.3.1. Generalities

In Rwanda, PC development has been delayed. Initial development began in 2005 at a workshop held in Gitarama, but little advancement took place until 2008 when IntraHealth International initiated PC work including trainings in four district hospitals (Kibagabaga, Nyagatare, Rutongo and Byumba) as well as their respective health centers.

Though created in 2004 the Palliative Care Association in Rwanda (PCAR) was not officially recognized as professional association and local NGO until 2009. It was founded to support and promote development of caregivers. From its creation, the association has been managed by an executive committee comprising volunteers committed to working in various organizations involved in dispensation of PC and support, namely IntraHealth, CHF, FHI, Care International, SWAA Rwanda and some hospitals of Rwanda.

In 2009, the MOH organized a survey of the situation of PC². The survey identified gaps in management of PC both on the side of health professionals and in the community at large. There was a lack of concepts and models for the proper management of country health facilities and on the level of the MOH, and this resulted in slow progress in PC organization. Due to a lack of documentation on PC, the survey was based on qualitative and quantitative data collected from patients and caregivers.

The survey was conducted at 31 sites, and 236 patients and 31 caregivers responded to questionnaires. The patients described their chronic diseases, and six frequent incurable pathologies were observed in 119 females and 117 males.

The survey found that many incurable diseases directly threaten the lives of patients and require PC. HIV and cancer are the most prevalent, respectively representing 45% and 28% cases of the sample, followed in descending order by heart disease, liver cirrhosis, kidney infections and paraplegia, all of which combined to represent 27% of cases.

Results of this study show that improvements and initiatives must be made in some areas and in all health facilities, including community and home care.

² Survey Report, "Current Situation of Palliative Care in Rwanda," produced in August 2009 by Dr. Nyamwasa Daniel, revealed gaps in knowledge of palliative care in Beneficiaries, and lack of palliative Care Policy, a strategic plan, as well as guidelines and procedures.

This study shows the need to take action in six areas:

- The concept of PC
- The means to offer PC
- Funding for PC
- Awareness and information
- Training and research.

1.3.2. Supplying palliative care

Currently, PC is provided on the initiative of each individual caregiver without any guidelines, procedures, laws or policies. However, caregivers of basic PC include health centers, public, and private hospitals. The majority of people in need of services are treated in facilities offering basic care because Rwanda does not have facilities specializing in PC.

Complementary packages, which are nearly inexistent, aim to support primary health caregivers by dispensing guidance and training. Volunteers' work (which is also rare) falls in the category of complementary packages. People who need sophisticated care (e.g. specialized packages) are referred to referral hospitals where they will obtain non-holistic care. However, the Rwandan health structure does not have units offering PC in hospitals, or palliative home care, or ambulant PC capable to satisfy the demand of patients.

Unequal access to care

Not everyone has equal access to PC services in Rwanda; access remains variable depending on one's socioeconomic conditions. Those who do not have any health insurance have little hope of obtaining PC. Patients affected by HIV/AIDS have easier access to basic PC, though it is unsophisticated in its scope.

Criteria governing rights to palliative care

There are presently no criteria for measuring PC. Caregivers are not always able to determine if/when a person is ill enough to necessitate specialized PC, to such extent that patients are deprived of care that would be of great use to them.

Planning of care

There is no general planning establishing availability of PC.

Financing

Financing PC is not done on a case-by-case basis. Therefore, some services (e.g. radiotherapy, currently few machines exist in our country, but are very indispensable for all district hospitals) provided as part of PC are not supported by insurances.

Currently, funding raises two issues:

- Some PC aspects are not part of mandatory services and are thus not covered by insurance.

- For some services, expenses related to treatment of patients under PC are so high as to render inaccessible care at some facilities (Intensive Care at King Faysal Hospital, Dialysis at Butare CHU).

In turn, people with limited financial means are disadvantaged because of difficulties related to financing PC.

Awareness

The population is less sensitive to PC issues. Findings of the survey of August 2009 show that the concept of PC and services in that area are scantily known.

If health professionals and practitioners even know what PC is, they do not know much about its objectives or procedures. They do not know specific alternatives of treatment offered by such care in relation to pain management.

In sum, both basic knowledge of PC, and subsequently PC services, are severely lacking in Rwanda. Additionally, the topic of PC is feebly covered by media.

Training and research

Elementary training, postgraduate training or masters programs as well as continued education for professionals and volunteers constitute a very important scope.

However, there is no concept of national training on PC which has among other objectives of training common to all occupational categories. Nevertheless, some staff of some hospitals have benefited from short period training (2 weeks to 1 month) in PC. In effect, of 31 sites visited, only four had at least one person trained in PC management.

Nine health institutions (29% of those surveyed) had at least one staff member trained in PC. At Kibagabaga Hospital, one third of staff members were trained. However, it is unclear whether even this training was at a level sufficient to provide care properly. Therefore, the entire country should accept a single vision of PC, and of PC training, that would be shared by all categories of professionals involved in PC.

In conclusion, there is a lack of postgraduate qualifications in PC (specialist physicians, capability certificate, etcetera). A combination of various disciplines is needed to teach PC, which does not exist at elementary levels of education.

1.4. SITUATIONAL ANALYSIS OF PALLIATIVE CARE IN RWANDA

PC in Rwanda is in its early phases, and there is a large gap between what currently exists and what we consider an ideal situation. Rwandan public health policymakers should undertake adequate measures to cope with those gaps. The following analysis discusses internal strengths and weaknesses, and external opportunities and threats—referred to as a SWOT Analysis.

1. Internal factors

Weaknesses

- Lack of policies, laws, standards, and procedures that would lead to better management of PC for incurable diseases
- No training plan for the staff in all health facilities
- Scarce supply of qualified human resources to ensure management of PC in homes and in health facilities
- Poor PC skills management at all levels of the health system, particularly at the health center level, which does not have any physicians trained specifically in PC
- Poor monitoring of chronic pathologies threatening life (cancer, heart failure, kidney failure, liver cirrhosis, and paraplegia), except AIDS
- Weak coordination mechanisms affecting the ability to offer guidance to patients and refer them for services in a timely manner
- Gaps in the continuum of care and services, especially when it is a matter of counter referral to return the patient to a lower level or home
- The ability to prescribe strong opiates is restricted to the district level and referral hospitals, while home-based care providers and those at health centers are restricted to prescribing oral or injectable opioids. In fact, 17 institutions (54.8% of those surveyed) were not authorized to prescribe any strong opiate, even for terminally ill cancer patients who were at home or who were transferred by referral hospitals to health centers.
- Lack of oncologists, shortage of radiotherapy to manage PC, and financial inaccessibility to dialysis for kidney failure cases
- Provision of services does not optimally respond to beneficiaries and their relatives' needs.

To find solutions to these weaknesses, there should be an adequate strategy allowing access to quality care, training for practitioners using short courses focusing on care, and regulations governing PC – especially the dispensation of opiates.

Strengths

- Some hospitals do have a small number of staff trained in PC
- Some NGOs are collaborating with health facilities to establish PC services, particularly at the community level
- Hospice care is available for chronic diseases in some FOSA
- Health centers conduct and ensure follow-up on HIV-positive patients at the community level and in their homes
- Psychosocial management is needed in all health facility
- A significant number of public health staff interface between the community and FOSA countrywide.

2. External factors

Opportunities

- There is political will to improve public health which allows allocating sufficient resources to this sector, and therefore ensure better management.
- The government ratified conventions and protocols related to human rights, women's rights, and children's rights which should be respected. These can be used as tools to advocate for equity in access to PC.
- There exists strong partnership opportunities with international organizations, local NGOs, and community-based organizations that offer services and support, both financially and technically
- At least six health workers serve each village (*umudugudu*) and other volunteers are in service at the community level. Capacity-building in the workforce is an asset in successful management of PC at home and in community.
- Performance-based funding (contractual and top-up approach) leads to enhancing the quality of health services.
- Health insurances (namely RAMA, MMI and Community Based Health Insurance [*mutuelle de santé*], etc.) allow their members to access healthcare, and now permit access to PC services which were hitherto unavailable.

Threats

- Sharp increase in diseases like HIV and cancer, contravening the government's goodwill to ensure management of these patients, attributable to limited financial resources
- The majority of Rwandans are poor, hence patients cannot afford healthcare costs
- PC is a relatively new branch of medicine that remains unknown to the vast majority of Rwandans (the public, caregivers and beneficiaries)
- Caregivers do not have the skills to properly assess pain; consequently they dispense inappropriate care
- Decision-makers are reluctant or unwilling to broaden the ability to prescribe opioids/opiates in all health facilities.

1.5. MISSION, VISION, AND OBJECTIVES

1.5.1. Mission

To offer support and quality care to people and their relatives in a family setting, and to streamline physical, psychological and spiritual care, and dispensation of that care, to these people so that they may achieve their living potentials, even if they are terminally ill.

1.5.2. Vision

To promote PC as much as possible through a multidisciplinary team of caregivers such that each person has the right to live and die peacefully, decently, painlessly, surrounded by her/his relatives in the circle/environment/place of her/his choice.

1.5.3. Goals

To relieve grief and symptoms, and guarantee comfort and quality of life of the patient and of her/his relatives

1.5.4. Objectives

Main objective

To relieve physical pain and other symptoms, and also take into account psychological, social and spiritual grief by enhancing quality of life of the patient through multidisciplinary care.

Specific objectives

- To ensure that PC is offered by multidisciplinary teams countrywide
- To foster equity in access to services
- To establish a package of services in various health institutions
- To introduce a genuine culture of pain management.

1.6. GUIDELINES OF THE PALLIATIVE CARE POLICY

1.6.1. Guiding principles of the country policy

PC should be developed under the supervision of the MOH, in all health institutions, units, and in community and home-based care, by facilitating management of patients requiring PC and follow-up by their relatives. These principles imply partnership with the beneficiary, relatives and stakeholders in planning and service delivery. They make it possible to make decisions on some aspects, and to establish a perspective by which PC organization shall be approached. Components of the PC approach are as follows:

- Conducting needs assessments and implementation of PC projects
- Setting up patient management and approaches as well as support of caregivers particularly those in a crisis situation
- Ensuring equity in access to care and financing of health for the population as whole and particularly PC
- Ensuring quality safe, effective, accessible, and adequately resourced care
- Planning, organizing and delivering services centered on the needs and choices of beneficiaries
- Keeping beneficiaries in their usual life context for those who wish
- Putting in place multidisciplinary and multiprofessional care units.

Abiding with these principles, each health professional requires basic and continued training in deontology and medical ethics.

1.6.2. Principles of medical ethics

The Rwanda National PC Policy is based on principles of ethics and a medical code of conduct whose goal is to strengthen the provision of humane care. These principles include:

- Respect for the dignity and integrity of the person
- Respect for the freedom and the will of the person
- Respect for the privacy and confidentiality of the person
- Respect for the skills of the physician and medical team.

These ethical issues are very critical. The beneficiary and her/his relatives or caregivers must be able to exercise their own control to manage the disease and death. Major issues include refusal and termination of treatment, use of intensive medication, continued sedation, and euthanasia.

Concepts of refusal and termination of treatment provide the beneficiary with the right to refuse any treatment, including those whose objective is nothing else but prolonging life. As far as the use of intensive medication is concerned, it is an obstacle to PC from the moment curative care is no longer effective. Maintaining the best quality possible is thence pushed behind other preoccupations.

On the contrary, abandoning medication is the potential threat, most particularly to the most vulnerable groups. In spite of quality palliative care, drugs and different therapies may not have the desired effect on the beneficiary, on her/his physical and moral grief. Some physicians may therefore resort to continued sedation, which consists of coma status artificially provoked by pharmacopoeia. When it is prolonged to death, continued sedation poses ethical problems, simply because it risks being confused with euthanasia in all but name.³ It is recommendable to have standards that will foster more pertinent use of this option without cause of concerns to stakeholders in PC.

1.6.3. Levels of palliative care in Rwanda

PC management is spread out among different levels of the Rwandan health system and several disciplines of health professionals (physicians, nurses, psychologist, social work assistants, physiotherapists, and chaplain, etc.) must be involved.

- The first level is a palliative support in a hospital or health center, where hospitalization does not exceed three days.
- District hospitals are the second level. Though they do not have services exclusively dedicated to PC, they do incorporate some basic PC services into their package, as they are frequently exposed to gravely ill patients or those near death. These services consist in large part of measuring pain and, when needed, referring patients to other health structures that have specialized PC services.

³ Margaret Van Dyck, RN, BScN, CHPCN. Hospice Palliative Care in Sub-Saharan Africa. Part 2, East- Africa. October 2008,

- Referral hospitals are among the third order in care management, according to complexity of the cases encountered. Referral hospitals take care of the more advanced and sophisticated cases of terminally ill patients.

Networks of PC services are also necessary, because they play a main role in organizing delivery of PC to the community, in health institutions, at home and in medical-social structures. These networks make it possible to coordinate the various actors, whether they are health institutions including home care, independent stakeholders or associations. They facilitate continuity and quality of care management in order to permit at-home care whenever possible, or in health facilities according to the needs of patients and their neighbors.

1.6.4. Institutional framework and coordination for the development of palliative care

The main/central level shall ensure coordination of country policy implementation supported by other management and M&E structures. The organigram of those structures can be organized as follows:

- The MOH
- PC technical working group

At the peripheral level, coordination shall be ensured by decentralized structures of the MOH (Provincial head offices and district head offices) with the support of NGOs and partners.

Table 1: Service levels upon which the strategies are based

DESCRIPTION	CAPABILITY REQUIREMENTS	RESOURCE REQUIREMENTS
Community Level		
<p>This level represents what is essential or the minimum package for palliative care.</p> <p>It provides basic clinical and supportive care services and relies heavily on referral of patients and their families to level 2 service providers for more clinical care. At this level the Community Health Workers and family care givers will provide this care.</p> <p>General and basic health care services, including primary services providing care to people living with chronic illness and their families as well as those with other life-threatening conditions, are required to meet the criteria for level 1 for all standards</p>	<p>Uses a holistic approach to manage basic clinical and nonclinical problems of the patient, caregivers, and families.</p> <p>Provides basic clinical services for opportunistic infections (OIs) and uses WHO analgesic ladder level 1 pain assessment and management guidelines.</p> <p>Refers to level 2 service providers for management beyond own capability.</p>	<p>Relies mainly on community care providers and a small team of general health care providers</p> <p>In general, relies heavily on community resources to provide services.</p> <p>Clinical supervision is provided by qualified and experienced professionals from health center.</p>
Health Center		

DESCRIPTION	CAPABILITY REQUIREMENTS	RESOURCE REQUIREMENTS
<p>This represents intermediary service providers, which are providing a wide range of service components for different chronic disease and other life-threatening conditions. Have well-developed collaborations with community and other service providers. All of the same that are in level 1, plus: At least one team member has had a 1-2 week orientation course in palliative care Ongoing availability of any Step 2 analgesics on-site Availability of ART OIs management Receives referrals from, and makes referrals to, level 1 and level 3 service providers, via formal links. Examples: Integrated community-based home care (ICHC) programs Community home-based care programs (CHBC) programs There are limited specialized services</p>	<p>Interdisciplinary team or at least regular access to medical, nursing and psycho-social and spiritual input on-site or through a functional and documented referral network</p> <p>Access to palliative care medications like step 2 and step 3 of WHO recommended Pain management like Morphine and other medications on-site or through referral and a well-documented procedure for follow-up on adherence.</p>	<p>Relies mainly on community care providers and a small team of general health care providers</p> <p>In general, relies heavily on community resources to provide services</p> <p>Clinical supervision is provided by qualified and experienced professionals.</p>
<i>District Hospital</i>		
<p>This represents intermediary and Advanced service providers, which are providing a wide range of service components for different chronic disease and other life-threatening conditions. Have well-developed collaborations with H.C and other service providers. All of the same that are in level 2, plus: A Multidisciplinary team trained in palliative care Ongoing availability of any step 2 and 3 analgesics on-site</p> <p>Receives referrals from, and makes referrals to, level 2 and level 4 service providers, via formal links.</p> <p>There are some specialized services</p>	<p>Interdisciplinary team or at least regular access to medical, nursing and psycho-social and spiritual input on-site or through a functional and documented referral network</p> <p>Access to palliative care medications like step 2 and step 3 of WHO recommended Pain management like Morphine and other medications on-site or through referral and a well-documented procedure for follow-up on adherence.</p>	<p>Relies mainly on H.C and Community care providers and a small team of general health care providers</p> <p>In general, relies heavily on H.C resources to provide services</p> <p>Clinical supervision is provided by qualified and experienced professionals. At this level the supervision is from National level.</p>
<i>Reference hospital</i>		

DESCRIPTION	CAPABILITY REQUIREMENTS	RESOURCE REQUIREMENTS
<p>This level provides the full range of palliative care services: comprehensive care for the needs of patients, care providers, and families with complex needs.</p> <p>It comprises all elements in levels 1 and 2 plus:</p> <p>Access to ART on-site or through referral</p> <p>Availability of Step 3 analgesics for use at site and in the home (e.g., oral morphine, methadone)</p> <p>Availability of palliative radiation and certain palliative chemotherapies at site or a clear procedure of referral for access to such treatments</p> <p>Certificate or degree-level training in palliative care represented in the team.</p> <p>Specialist palliative care services are required to meet the criteria for level 4 for all standards.</p> <p>Examples of services:</p> <p>Specialist palliative care centers</p> <p>Hospital-based palliative care units/teams</p> <p>Palliative care home-based care programs (e.g., ICHC*)</p>	<p>Provides specialized palliative care for patients, care providers and families, Especially those with complex needs. Physical, social, psychological, and spiritual care is all accessed from the same point.</p> <p>Services have the capability to meet the most complex needs and provide a leadership role in palliative care service provision.</p> <p>Receives and manages referrals from level 1 and 2, with clear documentation on the management of such referrals. Can also make referrals back to level 1 and 2 for ongoing joint care</p> <p>Has formal links with level 1 and level 2 service providers and provides them with consultant support, training and mentorship</p>	<p>A multidisciplinary team with specialist training, skills and experience in palliative care</p> <p>The actors include doctors, specialist nurses, allied health professionals, spiritual leaders, social care professionals, etc.</p> <p>A professional team working together with trained community care providers through a well-structured</p>

2. FIVE-YEAR (2010–14) STRATEGIC PLAN

2.1. Five priority areas

Considering the gap between the current and targeted situations, a policy has been made to guide all stakeholders operating in the health sector. In order to translate the objectives of this policy into tangible actions, this strategic plan was developed, and covers the following five priority areas:

- Integrating PC into the health system
- Informing the public (public awareness)
- Improving accessibility and quality of PC services
- Developing human resources
- Reinforcing operations research.

2.2. Results-Based Management: Impact, Outcome and Outputs

Impact: All patients with incurable diseases (and their families) have the best quality of life to death

Outcome: PC scaled-up countrywide

Output 1: The health system has integrated PC

Output 2: Public has increased knowledge about PC services

Output 3: All needy patients have access to quality PC services

Output 4: Health professionals have increased capacity in PC

Output 5: All health teaching institutions have enhanced operations research in PC

Output 1: The health system has integrated PC.

Strategies

- Establishing facilities which guarantee PC activities at each level of health structure
- Setting up structures for home and community care
- Following up evaluation of provision at all levels.

Table 2: Indicators and targets for Output 1

Target population	Indicators	Partners
Facilities	% of existing facilities that are able to practice PC activities by the end of 2014 (disaggregated by type of facility, urban versus rural) [Targets: at least 70%, n = 500 Facilities].	USAID UNICEF WHO Global Fund European Union
Homes and community structures	% of homes and community structures that are able to practice PC by the end of 2014 (disaggregated by urban/rural, and by type of disability) [Targets: at least 70%, n = 514 community structures].	USAID UNICEF WHO Global Fund European Union
Research	% of PC provision evaluation studies carried out by the end of 2014 (disaggregated by type of facility) [targets: one study each year]	USAID UNICEF WHO Global Fund European Union

PC will be guaranteed in all establishing facilities at each level of the health system. First of all, the MOH will set up appropriate structures for home and community care, will carry out regular supervisions, and will guarantee the provision of follow-up evaluation mechanisms at all levels.

Output 2: Public has increased knowledge about PC services.

Strategies

- Informing the public about the value of PC and existing services in that area
- Informing and communicating with the patient and family about her/his health
- Establishing a legal framework for PC in the country.

Table 3: Indicators and Targets for Output 2

Target population	Indicators	Partners
General population	% of people reached by sensitization campaigns on PC that have knowledge on PC definitions, PC services and pain management by the end of 2014 (disaggregated by urban/rural, by gender and by type of disability) [Targets: at least 70%, n = 3 million people].	USAID UNICEF WHO Global Fund European Union CDC
The health system	A legal framework for PC exists in Rwanda	USAID CDC
IEC materials	% of existing IEC materials that are informing and communicating with the patient and family about her/his health and that are distributed and utilized by professionals by the end of 2014 (disaggregated by type of facilities and by type of disability) [Targets: at least 50%, n = 5,000 IEC materials].	USAID UNICEF WHO Global Fund European Union CDC

Findings of the survey of August 2009 show that the concept of PC and services in that area are scantily known at present. Through these steps, the population will become more sensitive to PC issues. Health professionals will know what PC is, they will adequately know about its objectives and procedures. They will know specific alternatives of treatment offered by such care in relation to pain management. In sum, the concept and services will be clear for all. The population and health professionals and health policymakers will become more sensitive. Equally, the topic will be strongly covered by media.

Output 3: All needy patients have access to quality PC services

Strategies

- Setting up equal conditions to access regardless of social status or financial condition of the patient
- Initiating a true culture of pain management
- Establishing and maintaining a continuum of PC
- Establishing a system of quality assurance in health facilities providing services.

Table 4: Indicators and Targets for Output 3

Target population	Indicators	Partners
Health professionals	% of health staff trained in pain management that are able to manage pain by the end of 2014 (disaggregated by type of facilities, by urban/rural, by gender, by type of disability and by age group) [Targets: at least 50%, n = 1000 people].	USAID UNICEF WHO Global Fund European Union CDC
	A system of quality assurance in health facilities providing PC exists	USAID/ IntraHealth

Target population	Indicators	Partners
Health facilities	% of existing health facilities that are able to provide continuum PC by the end of 2014 (disaggregated by type of facilities and by type of disability) [Targets: at least 70%, n = 700 health facilities].	USAID UNICEF WHO Global Fund European Union CDC

All patients will have equal access: access likelihood will not vary depending on one's socioeconomic conditions; those without any health insurance will still have access. Patients affected by HIV/AIDS will have access for even sophisticated care offered by caregivers.

Measurement criteria will be set up and caregivers will always be able to determine when a person's illness necessitates specialized PC, and will provide useful care for such patients.

The general planning will be established for availability. Financing will no longer be for a particular case. Moreover, some services (e.g. radiotherapy, an indispensable service, but currently unavailable in Rwanda) will be provided as part of PC and will be supported by insurance schemes. People with limited financial means will not be disadvantaged because of difficulties related to financing.

Output 4: Health professionals have increased capacity in PC.

Strategies

- Endowing professionals and volunteers operating in area of PC with required and appropriate skills for their duties
- Integrating PC in curricula at nursing schools, schools of medicine at NUR, etc.
- In-service training for health professionals.

Table 5: Indicators and targets for Output 4

Target population	Indicators	Partners
Health professionals	% of health professionals skilled in PC that are able to provide PC services by the end of 2014 (disaggregated by type of facilities, urban /rural, by gender, by type of disability and by type of professionals) [Targets: at least 70%, n = 10,000 health staff].	USAID UNICEF WHO Global Fund European Union CDC
The health system	A system of quality assurance in health facilities providing PC exists	USAID/ IntraHealth
Health volunteers	% volunteers skilled in PC that are able to provide PC services by the end of 2014 (disaggregated by type of facilities, urban/rural, by gender, by type of disability) [Targets: at least 70%, n = 40,000 volunteers].	USAID UNICEF WHO Global Fund European Union CDC

This output focuses on the fact that the MOH will assist professionals and volunteers operating in an area of PC to get required and appropriate skills for their duties.

Output 5: All health teaching institutions have enhanced operations research in PC.

Strategies

- Incorporating PC research within existing structures such as universities, teaching hospitals and referral hospitals.
- Making greater use of existing statistical basis for analyzing and improving PC.

Table 6: Indicators and Targets for Output 5

Target population	Indicators	Partners
Teaching institutions	% of existing teaching structures that are able to carry out applied research in PC by the end of 2014 (disaggregated by type of structures: universities, teaching and referral hospitals, by urban/rural) [Targets: at least 70%, n = 9 institutions].	USAID UNICEF WHO Global Fund European Union CDC
Teaching institutions	% of existing teaching structures that use statistical basis for analyzing and improving PC by the end of 2014 (disaggregated by type of facilities, urban/ rural) [Targets: at least 70%, n = 9 institutions].	USAID UNICEF WHO Global Fund European Union CDC

Elementary training, postgraduate training, or masters programs as well as continued education, for professionals and volunteers will constitute a very important scope. Moreover, there will be national training on PC which will be common to all occupational categories. Furthermore, some staffs of some hospitals will undergo short-term training session of two weeks to one month in length.

2.3. GOVERNANCE AND IMPLEMENTATION

Good governance and well established structures will lead to the implementation of effective PC in Rwanda. One should have a good strategic plan, but the success in terms of achieving expected outcomes is linked to good leadership.

2.3.1. Institutional framework

Management and M&E of implemented activities are under the supervision of existing organs and structures in the national health system; coordination of policy implementation is at the central MOH level. At the peripheral level (operational Level), coordination is ensured by the Ministry’s decentralized structures, NGOs and other stakeholders.

2.3.2. Coordination

Community level: Identify palliative care stakeholders; provide palliative care services and supervise morphine prescription and use at home level; provide pain management services; monitor, evaluate and report palliative care activities to the next level (health center).

Health center level: Set up a structure of governance that is the palliative care multidisciplinary team and strengthen its capacity; train health staff in palliative care at community level; quantify and procure morphine; supervise palliative care activities at community level; distribute MER tools including Morphine Manual and guidelines on distribution and use of morphine at community level; provide pain management services; monitor, evaluate and report palliative care activities to the next level (district hospital).

District hospital level: Set up a structure of governance that is the palliative care multidisciplinary team and strengthen its capacity; train health staff in palliative care at health center level; quantify and procure morphine; supervise palliative care activities at health center level; distribute MER tools including Morphine Manual and guidelines on distribution and use of morphine at health center level; provide pain management services; evaluate and report palliative care activities to the central level (MOH).

Medical schools (NUR and nursing schools): Develop training curricula and teaching materials including updated guidelines on palliative care and on morphine management; organize palliative care e-learning system; organize in-service training workshops in palliative care; document best practices in palliative care including morphine management.

Private sector: Set up a structure of governance that is the palliative care multidisciplinary team and strengthen its capacity; train health staff in palliative care at private health clinic level; quantify and procure morphine; supervise palliative care activities at private health clinic level; distribute MER tools including Morphine Manual and guidelines on distribution and use of morphine at private health clinic level; provide pain management services; evaluate and report palliative care activities to the central level (MOH).

Reference hospitals: Set up a structure of governance that is the palliative care multidisciplinary team and strengthen its capacity; train health staff in palliative care at district hospital level; quantify and procure morphine; supervise palliative care activities at district hospital level; prepare MER tools including Morphine Manual and guidelines on distribution and use of morphine; participate in the development of training curricula and teaching materials including updated guidelines on palliative care and on morphine management; organize a palliative care e-learning system; organize in-service training workshops in palliative care; document best practices in palliative care including morphine management; provide pain management services; evaluate and report palliative care activities to the central level (MOH).

Ministry of Health: The MOH sets up policies, strategic frameworks, guidelines, standards and regulations related to palliative care. It supervises palliative care services at referral and district hospitals. It identifies sources of funding and ensures equitable distribution of those funds. The MOH is responsible for other resource management including qualified human resources. It is

also responsible for regulations in terms of morphine abuse by establishing morphine abuse regulations, policy and implementation mechanisms.

In summary, PC will be coordinated at the national and district levels. At the national level and at the reference hospital level, this is done by the national PC technical working group under the supervision of the MOH. The PC technical working group is composed of a representative from the pharmacy, a physician, a member from the drug purchasing agency CAMERWA, a member from the unit in charge of nursing, one representative from the medical school and one member from the police headquarters. At the district level, there are directors of district hospitals, a representative from the unit in charge of pharmacy at the district level, the representative of nurses, and a representative from the private pharmacies.

Activities in the first year include, but are not limited to:

- Identifying important PC stakeholders
- Reinforcing the capacity of the PC stakeholders
- Collecting and compiling data on PC
- Preparing PC training modules at all levels, including curricula for different teaching institutions (medical school, nursing schools)
- Documenting best practices and disseminating them amongst stakeholders and to external partners
- Developing M&E tools (including Morphine Manual and guidelines on distribution and use of morphine).

One key element to strengthen operational plans is the alignment to district priorities and plans in PC. Planning should be based on local needs and priorities by:

- Avoiding duplication with other organisations and activities
- Ensuring each targeted population is effectively reached with a comprehensive package of services.

2.3.3. Institutional capacity-building

2.3.3.1. Planning and reporting

The MOH unit in charge of planning will construct a capacity-building plan for their staff in order to meet their responsibilities to coordinate and plan PC activities and conduct M&E. At the decentralized level, the medical chief of staff will also strengthen their coordination capacities in order to become the primary coordinating body at the district and to ensure that planning and implementation of local response is based on evidence and local situation analysis. Specific trainings will be organized to improve the effectiveness of district sub-committees in different health facilities.

2.3.3.2. Community service provision

Members of community-based organizations (CBOs) involved in the provision of services at community level will also need to receive standardized trainings to ensure the quality of their interventions. A general observation is that a systematic training plan should be elaborated at the MOH level on the basis of needs identified during regular supportive supervision. The best approach for complementary trainings should be selected according to specific situations and constraints. In all cases, the quality of the content of trainings and the competence of trainers will be verified.

2.3.3.3. Community systems strengthening

The size and the diversity of the constituencies of CBOs and of CHWs involved in PC (morphine management for instance) are a challenge in terms of effective coordination of interventions. The CBOs in a district elect representatives to the district level that are mandated to facilitate communication between their organizations and other PC actors present in the district.

Together with the health supervisor, who oversees the activities of CBOs, there will therefore be two agents in each district whose role will be to strengthen the civil society response and to ensure its effective coordination with other local actors.

In keeping with the diversity of situations described above, asymmetric support adapted to each reality will be provided to help it play its respective roles more efficiently. Institutional strengthening of communities will also help them become more autonomous so that they can improve and scale up the technical support that they should provide to their members.

Community systems will be strengthened at two levels:

- Implementing CBOs/CHWs
- Member CBOs coordinating the interventions of their constituencies.

Strengthening the implementation of CBOs will improve the quality of interventions and adaptability to new innovative approaches through stronger technical programming skills, and sustainability of interventions through institutional development. The MOH needs to be strengthened institutionally so that in turn it can provide its district entities with technical support on organizational issues and fully coordinate health facilities.

The strengthening of community systems will include the following elements:

- **Human resources**
 - Recruitment and retention of personnel: qualified personnel will be recruited by implementing health facilities at the district level based on the needs identified for each implementing agency and on cost-effectiveness criteria.
 - Training: Training needs have been identified in general to strengthen both implementing agencies in the following areas: planning, M&E, financial and morphine program management systems, advocacy and resource mobilization. However capacity analysis and capacity development plans will be conducted for each agency in order to define exactly in which areas staff should be trained.

- **Information systems**

- The strengthening of information systems is particularly important for community organizations to improve bidirectional communication with local and national coordination structures, so that their interventions are better integrated in the overall PC response.

2.3.3.4. Community systems partnerships

In order to improve networking, sharing of experiences and lessons learned and to strengthen the negotiation capacities, a consultative committee on PC will be set up, composed of the heads and deputy heads of agencies. An organization with proven experience in institutional development will be selected to provide technical support to others during the first two years of this strategic plan.

2.3.4. MONITORING AND EVALUATION

2.3.4.1. Monitoring and review mechanisms

The framework for M&E and review is an integral part of this strategic plan. It provides for progress measurement toward goals both during and after the period of its implementation. It solves questions of accountability and guarantees that policy makers are sufficiently informed and able to reflect and analyze performances, to carry forward lessons learned when developing future strategic plans. Given that partners are increasingly using performance indicators to measure their return on invested capitals, it is imperative to establish strong mechanisms to monitor, review, and evaluate.

In general, the organizational structure of the M&E system at the national level is well established and functional, but has not been adequately decentralized to the district and community levels. Community and district-level stakeholders need to reinforce data collection and reporting measures from the district to national level. This would result in better instances of data use for decision making at all levels.

2.3.4.2. Organizational framework of the M&E system on palliative care

The framework is divided into twelve main components, following the organizing framework of a functional national M&E system. The twelve components are organized into three broad areas with sub-components in each area:

People, partnerships and planning

- Organizational structures with PC M&E functions
- Human capacity for PC M&E
- Partnerships to plan, coordinate, and manage the PC M&E system
- National multisectoral PC M&E plan

- Annual costed national PC M&E work plan
- Advocacy, communications, and culture for PC M&E

Collecting, verifying, and analyzing data

- Routine PC program monitoring
- Surveys and surveillance
- National and sub-national PC databases
- Supportive supervision and data auditing
- PC evaluation and research

Using data for decision-making

- Data dissemination and use.

2.3.4.3. Joint meeting review

Performance review is done annually with partners both internal and external and performance indicators from mutual agreement are taken into consideration. The main purpose of this joint meeting is:

- To exchange information on future plans and strategies
- To align action plans of partners and reduce costs associated with various displacements
- To coordinate the flow of funds in supporting drugs production and procurement.

2.3.4.4. Performance indicators

This list includes some of most important indicators, and aims to measure progress towards achieving direct results. Such a set of indicators cannot measure all aspects of service delivery and support rehabilitation that is also complex. Basic indicators were selected to cover the main areas provided they are valid, reliable, specific, sensitive, affordable and feasible.

The main sources of data for monitoring, review and evaluation are: health information systems, investigations through supervision reports, especially operational research studies.

List of indicators:

- Percent of facilities that practice PC [disaggregated by type of facility (urban /rural)]
- Percent of home and community structures, disaggregated by urban/rural
- Percent of PC provision evaluation studies carried out (disaggregated by type of facilities, urban/rural)
- Percent of people reached by sensitization campaigns on PC (disaggregated by urban/rural, age group, gender, and by type of disability)
- Existence of a legal framework for PC
- Percent of IEC materials informing and communicating with the patient and family about her/his health (disaggregated by type of facilities, urban/rural and by type of disability)

- Percent of health staff trained in pain management (disaggregated by type of facilities, urban/rural, age group, gender and type of disability)
- Existence of a system of quality assurance in health facilities providing PC
- Percent of health facilities with a continuum of PC (disaggregated by type of facilities, urban/rural)
- Percent of health professionals skilled in PC (disaggregated by type of facilities, urban/rural)
- Percent of volunteers skilled in PC (disaggregated by type of facilities, urban/rural, age group, gender and by type of disability)
- Percent of schools that have integrated PC in their training modules (disaggregated by type of schools, urban/rural and by type of trainings)
- Percent of health professions trained in PC (disaggregated by gender, urban/rural and by type of disability)
- Percent of existing teaching structures carrying out applied research in PC (disaggregated by type of structures: universities, teaching hospitals and referral hospitals, urban/rural)
- Percent of existing structures that use statistical basis for analyzing and improving PC (disaggregated by type of facilities, urban/rural)
- Number of radiotherapy machines that exist.

2.3.5. STRATEGIC PLAN FINANCING

The projected costs and sources of funding of the strategic plan must be assessed to give a picture of expenditures, funding sources, and targeted activities.

The financing framework shows internal capital, private funding resources, and external funding. Internal funds show funds from the MOH; those from donors and from health facilities will be assessed on financial decentralization budgets.

The flow of funds shows both sources of financing: National referral hospitals, central services for PC, district hospitals, private clinics, health centers (private and faith-based), centers for PC, funding for public administration and insurance companies.

2.3.5.1. Costing the strategic framework

Methodology

The costing was carried out at the activity level. The cost of each activity was estimated using a standardized framework involving two sets of assumptions: 1) Unit Cost Variables, and 2) Quantitative Assumptions. Both sets of assumptions for all activities are linked to a single costing model to ensure consistency, transparency, and reproducibility.

Unit cost variables

In order to ensure that the costing was as accurate and uniform as possible, the unit cost of individual items and activities were estimated. Costs for items such as salaries, drugs and consumables, infrastructure, and equipment were drawn directly from the budgets of relevant institutions and organizations. Other unit costs were estimated through expert consultation with relevant actors and verified by multiple sources.

Quantitative assumptions

To estimate the full cost of each activity, the unit cost was multiplied by an objective, predetermined quantitative assumption. Where appropriate, program targets were used to estimate the costs over the years.

Assumptions regarding staffing, facilities and infrastructure, and clinical activities were based upon the strategic plans of relevant MOH agencies, other organizations, and implementing partners. Whenever possible, rather than estimating costs using these assumptions, financial data were drawn directly from institutional budgets to ensure the costing was aligned directly with real expenditures.

Cost categorization

Each activity was categorized along several dimensions.

Level of intervention-community-based interventions vs. those of the MOH and health facilities: The home and/or community-based intervention activities are those principally implemented at home and/or at the community level.

Cost type-investments vs. operational costs: Investment costs are one-time costs, mainly related to infrastructure and equipment, but also including certain trainings such as training of trainers, surveys and research, etc. Operational costs are recurrent costs necessary to ensure the on-going functioning of activities and programs such as human resources, drugs and commodities, etc.

Cost Category: Inputs for each activity were also broken down into several cost categories as in Table 7.

Table 7: Cost categories

Drugs, Commodities & Consumables	All drugs, commodities, and lab consumables
Human Resources	Healthcare work force, MOH and national institutions staff, secondments to the MOH, district positions and other incentives offered to personnel.
Infrastructure	Investment in, rehabilitation of and maintenance of medical facilities, and other buildings/offices such as labs, pharmacies, etc.
Medical Equipment	Investment, maintenance, spare parts of medical equipment
Administrative Equipment (e.g. ICT)	Investment, maintenance of computers, internet connection, etc

Training	Workshops, onsite training, offsite training, mentoring
Running costs - fuel, electricity, communication, office supplies	Maintenance / running costs of existing facilities (except infrastructure, medical, IT and vehicles), e.g. generators, travel costs
CHW support	All investment or operational costs to support CHW system (training, compensation, equipment, support to cooperatives or Community PBF)
Other	Includes activities such as the development of guidelines, protocols, policies, IEC material, etc.

Given the level of details involved and the complex nature of any such exercise, the costing remains an estimate and will continue to be refined as the strategic framework is translated into operational plans.

2.3.5.2. Costing

The main costing data executive summary is as follows.

Table 8: Cost by Type (RwF x 10⁶)

Overall cost by year	2010	2011	2012	2013	2014	Total	%
ICT & HIMS	1174	1724	2241	2913	3001	3091	17.0
Operations	6646	8442	10976	14269	14697	15138	83.0
Total	7820	10166	13217	17182	17698	18228	100.0

Operations cost estimates are more than 83% of expected costs.

Table 9: Cost by implementing level (RwF x 10⁶)

Implementing Level	2010	2011	2012	2013	2014	Total	%
Health centers	4698	6102	7932	8170	8415	35317	60.0
District Hospitals	2349	3051	3966	4085	4208	17659	30.0
Other Special centers (including referral hospitals)	782	1017	1322	1362	1403	5885	10.0
Total	7829	10170	13220	13617	14025	58861	100.0

In terms of the levels of implementation, the reference hospitals and specialized centers are responsible for 10% of activity costs, while the remaining 90% of the total estimated costs will be under the responsibility of decentralized levels.

Table 10: Costing by Cost Category, 2010

Category	%
Workforces : training, compensation, equipment, support to CBOs or Community PBF	25.0
ICT equipment and HIMS: Investment, maintenance of computers and internet connection	15.0
Human Resources for supporting others services: permanent staff	15.0
Others: Development of guidelines, protocols, policies and IEC materials, drugs and other	45.0

consumables	
Total	100.0

The largest cost category is for development of guidelines, protocols, policies, IEC materials, drugs and other medical consumables (45%).

Table 11: Cost by Outputs (RwF x 10⁶)

Output	2010	2011	2012	2013	2014	Total	%
Integration	1100	1430	1859	1915	1972	8276	14.9
Public awareness	30	39	50	52	53	224	0.4
Access/quality	3007	3926	4119	4243	4370	19664	35.5
Human resources	28	34	42	43	45	192	0.3
Enhanced Research	126	164	213	219	226	948	1.7
Coordination	1500	1900	2470	2544	2620	11035	19.9
M&E	2009	2603	3384	3486	3590	15072	27.2
Total	7800	10096	12137	12501	12876	55410	100.0

Despite the ambitious nature of this framework and the fact that refinements will need to be made to the designed activities and their costing estimates as we move towards implementation, the costing exercise has shown that the outputs are achievable. Due to a series of new initiatives that will increase operations efforts, this area will bear the highest expected costs. As mentioned throughout this plan, the MOH has to play a crucial role in the planning process, guidelines development, coordination of activities, and supervision.

CONCLUSION

Chronic disease will certainly take prominence in the near future. Undeniably, the proliferation of incurable diseases in our country will encourage the development of our response. In order to best accommodate a growing number of patients, the MOH must consider how to ensure provision of services to the terminally ill. This will facilitate a health system that can provide quality services in a timely fashion to dying people and their families. It is in this context that this Five-Year (2010-14) Strategic Plan for Palliative Care for Incurable Diseases will improve the quality of life of people with incurable diseases, and will serve to:

- Educate the public, caregivers, and patients about PC
- Improve access to diagnosis and good care
- Improve the availability of PC in health facilities and communities
- Ensure capacity-building for involved stakeholders, because health workers should well equipped to recognize when a palliative approach is appropriate
- Promote the establishment of a genuine dialogue between stakeholders, beneficiaries, and their relatives, and between health professionals themselves.

This plan provides a framework for the provision of PC at the community and clinical levels. However, the government must ensure that everything is in compliance with the Rwandan legal

framework and quality standards. Activities will be supervised and coordinated by the MOH. M&E will be carried out through oversight of activities and investigations. The cost of implementing the strategic plan will amount to 7,820,000,000 Rwandan Francs. The source of financing will be the Government of Rwanda and partners. Partnerships with community organizations and private sector will be needed to ensure the plan is enacted.

APPENDIX 1: LOGICAL FRAMEWORK ACTION PLAN: STRATEGIC PLAN 2010-14

Strategic Objective 1: To integrate PC in all health structures of the country, home and community

Output 1: The health system has integrated PC

Priority Activities	Expected output	Indicators	Means of verification	Responsible party	Budget (in million RWF)	Source of funds	Timeline
Specific Objective 1: Establish facilities that guarantee PC at each level of the health facility							
Set up a multi-domain team of professionals at each health facility	Countrywide, each health facility has a team in charge of PC	Number of health facilities that have PC teams	Progress Report	UNIT IN CHARGE OF POLICIES	800	MINECOFIN, ONG, Development Projects	2010
Allocate beds for PC in each district and referral hospitals	Beds available in each health facility	Number of PC-allocated beds	Progress Report	UNIT IN CHARGE OF POLICIES	225	MINECOFIN, NGOs, Development Projects	In progress till December 2011
Make more flexible the time table for visiting in-patients	Patients are visited as they wish	Flexible schedule for visits	Evaluation Report	Health facilities	NA	NA	2010
Supply appropriate equipment and drugs to health facilities offering PC according to services they provide	All health facilities have equipment and appropriate drugs	Number of health facilities supplied	Progress Report	UNIT IN CHARGE OF POLICIES	400	MINECOFIN, NGOs, Development Projects	In progress till December 2014
Put in place in each health facility a nutritional service for indigent patients	Nutritional Team is operational at each level	Number of clients benefiting from nutrition services	Progress Report	UNIT IN CHARGE OF POLICIES	180	MINECOFIN, NGOs and Development project	Continued since July 2010
Establish a hotline in each health facility	A hotline is available at each health	Number of clients benefiting from	Progress Report	UNIT IN CHARGE OF	324	MINECOFIN, MTN,	2011

available 24 hours a day, toll free	facility	hotline per facility		POLICIES		RWANDATEL, NGOs and Development Projects	
Specific Objective 2: Set up structures for home and community care							
Establish a volunteer team capable of dispensing medical, psychological, spiritual services to patients and their family members at home and in the community	A team of volunteers is available at each village/ <i>umudugudu</i>	Number of volunteer teams	Progress Report	UNIT IN CHARGE OF POLICIES and MINALOC	200	MINECOFIN, NGOs and Development project	2011
Put in place a nutritional service that can assist indigent patients at home and in the community	A nutritional service is operational at each cell	Number of clients benefiting from cell-level nutrition service	Progress Report	UNIT IN CHARGE OF POLICIES and MINALOC	180	MINECOFIN, NGOs and Development project	Continued since July 2010
Specific Objective 3: Follow up evaluation of PC provision at all levels							
Develop supervision and M&E tools	Tools are developed and used by relevant structures	Number of structures using tools	Progress Report	UNIT IN CHARGE OF POLICIES	5	MINECOFIN, NGOs and Development project	2010
Organize data collection	Structures/facilities have data collection guidelines	Number of data reports	Report	UNIT IN CHARGE OF POLICIES, Health structures	5	MINECOFIN, OMS, NGOs and Development project	2010

Clearly identify roles and responsibilities for PC stakeholders, nationally	- The role of each stakeholder is set - Supervision/M&E frequency is clear for each structure	Number of supervision/M&E visits per structure per year	Report	UNIT IN CHARGE OF POLICIES	100	MINECOFIN, NGOs and Development project	2010
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Strategic Objective 2: To sensitize the public to the development of PC

Output 2: The public has increased knowledge about PC services

Priority Activities	Expected output	Indicators	Means of verification	Responsible party	Budget (in million RWF)	Source of funds	Timeline
Specific Objective 1: Inform the public about the value of PC and existing services in that area							
Conduct a large scale dissemination of PC Policy	Policy documents are reproduced and disseminated	Number of facilities with documents	Evaluation Report	UNIT IN CHARGE OF POLICIES	15	MINECOFIN, NGOs & Development Projects	2010
Organize media campaigns through radio and television	At least 4 media campaigns through radio and television organized on yearly basis	Number of media campaigns organized	Progress Report	UNIT IN CHARGE OF POLICIES	10	MINECOFIN, NGOs & Development Projects	Continued till 2014
Produce advertisement broadcasts and billboards	At least 6 advertisement broadcasts and 6 billboards produced	Number of advertisement broadcasts and billboards produced	Progress Report	UNIT IN CHARGE OF POLICIES	5	MINECOFIN, NGOs & Development Projects	Continued till 2014
Organize information and discussion sessions during community activities (<i>Umuganda</i>)	Information and discussion sessions organized on monthly basis in each village (<i>umudugudu</i>)	Number of information and discussion sessions organized	Report	UNIT IN CHARGE OF POLICIES, MINALOC	NA	NA	In progress since July 2010

Strategic Objective 3: Improve access to PC and quality of PC provided to the needy
Output 3: All needy patients have access to quality PC services

Priority Activities	Expected output	Indicators	Means of verification	Responsible party	Budget (in million RWF)	Source of funds	Timeline
Specific Objective 1: Establish same conditions for access to PC regardless of socioeconomic status of the patient							
Develop fundraising strategy to support PC Programs	Fundraising strategy developed	Existence of fundraising strategy	Progress Report	UNIT IN CHARGE OF POLICIES	6	MINECOFIN, NGOs, Development Projects	2010
Put in place a transportation solutions through a free ambulance for clients	450 ambulances are available	Number of ambulances available	Progress Reports	UNIT IN CHARGE OF POLICIES	4 500	MINECOFIN, NGOs, Development Projects	2010
Streamline PC amongst mandatory services	PC is covered by insurance schemes	Number of beneficiaries facilitated by health insurance schemes	Evaluation Reports	UNIT IN CHARGE OF POLICIES, RAMA, <i>Mutuelle de Santé</i> , MMI	NA	NA	2011
Reproduce and standardize PC public health documents	PC standards and guidelines are produced	Existence of PC standards and guidelines	Progress Reports	UNIT IN CHARGE OF POLICIES	3	MINECOFIN, NGOs, Development Projects	2010
Specific Objective 2: Initiate a true culture of pain management							
Legitimize opiate prescription at all levels	Opiates are prescribed at all levels	Number of beneficiaries receiving opiates in FOSA and home care	Evaluation Report	UNIT IN CHARGE OF POLICIES, Health Structures	NA	NA	2011
Avail and use pain assessment scale at all levels	Pain assessment scale is available and used at each level	Number of health facilities using pain assessment scale	Evaluation Report and Progress	UNIT IN CHARGE OF POLICIES,	PM	MINECOFIN, NGOs, Development	2011

			Report	Health Structures		Projects	
Specific Objective 3: Establish and maintain a continuum of PC							
Carefully write referrals and counter referrals	Referrals and counter referrals are clearly written	Number of patients who answered the same questions and sit for the same exams	Evaluation Report	Health Structures	NA	NA	In progress
Regularly update patient files	Files are well kept and updated	Existence of an updated file for every patient	Evaluation Reports	Health Structures	NA	NA	In progress
Regularly write health facility reports	Daily reports written and submitted to the head of each health facility	Existence of daily reports	Evaluation Report	Health Structures	NA	NA	In progress
Access complementary exams and medication as needed	Every patient has access to complementary exams and medication	Number of patients with access to complementary exams and medication	Progress Reports and Evaluation Reports	UNIT IN CHARGE OF POLICIES, CAMERWA and Health facilities	PM	MINICOFIN, NGOs, Development Projects	In progress
Specific Objective 4: Establish a system of quality assurance in health facilities providing PC							
Develop quality self-evaluation at each health facility	Self-Evaluation system exists at each level	Number of self-evaluation reports produced	Progress Reports and Evaluation Reports	Health Structures	NA	NA	In progress

Strategic Objective 4: To develop human resources dispensing PC

Output 4: Health professionals have increased capacity in PC

Priority Activities	Expected output	Indicators	Means of verification	Responsible party	Budget (in million RWF)	Source of funds	Timeline
Specific Objective 1: Endow professionals and volunteers operating in PC with required and appropriate skills for their duties.							
Develop PC curricula	Curricula are	Availability of PC	Progress	UNIT IN	10	MINECOFIN,	2010

	developed	curricula	Report	CHARGE OF POLICIES		NGOs, Development Projects	
Integrate PC curricula in elementary training, university and continued education	PC curricula are taught	Number of curricula available and taught	Progress Report	UNIT IN CHARGE OF POLICIES, MINEDUC,	PM	MINECOFIN, NGOs, Development Projects	In progress since 2011
Mobilize caregivers for compliance to ethics and deontology codes.	6 workshops for awareness are organized	Number of awareness workshops organized	Progress Reports	UNIT IN CHARGE OF POLICIES	18	MINECOFIN, NGOs, Development Projects	In progress since 2010
Organize training sessions for professionals from health facilities, volunteers serving in home care and the community	12 training sessions for professionals from health structures and volunteers are organized	Number of training sessions organized	Progress Reports	UNIT IN CHARGE OF POLICIES	PM	MINECOFIN, NGOs, Development Projects	In progress since 2010

Strategic Objective 5: Enhance research in PC

Output 5: All health teaching institutions have enhanced operations research in PC

Priority Activities	Expected output	Indicators	Means of verification	Responsible party	Budget (in million RWF)	Source of funds	Timeline
Specific Objective 1: Integrate PC research into existing structures such as universities, teaching hospitals and referral hospitals.							
Collaborate with existing structures to initiate research topics in PC	At least two publications per year per structure are produced	Number of annual publications	Progress Report	Teaching and Referral Hospitals	120	Hospitals	In progress since 2010
Mobilize funds to finance research	A strategy to mobilize funds is	A fund mobilization strategy is available	Progress Reports	Teaching and Referral	6	Donors	In progress since 2010

	developed			Hospitals			
Utilize research results in order to improve provision of PC	PC provision is continually improved	Number of innovations in PC	Progress Report	UNIT IN CHARGE OF POLICIES, Health Structures	NA	NA	In progress since 2011
Conduct PC data collection	Data have been collected	Number of reports written	Progress Reports	UNIT IN CHARGE OF POLICIES, Health Structures	NA	NA	In progress since 2010
Specific Objective 2: Make greater use of existing statistical basis for analyzing and improving PC.							
Analyze existing PC Data	Evaluation reports produced	Number of reports written	Progress Reports	UNIT IN CHARGE OF POLICIES, Health Structures	NA	NA	In progress since 2010
Use results to guide future planning	Planning takes into account results	Number of programs produced	Progress Reports	UNIT IN CHARGE OF POLICIES	NA	NA	Continued from 2011

APPENDIX 2: HEALTH PROFESSIONALS TRAINED IN PC ACROSS DIFFERENT HEALTH FACILITIES

Health facility	Staff trained in Palliative Care		Total
	Physicians	Nurses	
KFH	0	2	2
CHUB	1	1	2
CHUK	0	2	2
HMK	0	1	1
Kibagabaga Hospital	2	47	49
Nyagatare Hospital	1	1	2
Nyagatare Health Center	0	1	1
Rubungo Health Center	0	3	3
Caritas Hospice	0	1	1
Total	4	59	63

Source: Nyamwasa 2009.