



Decentralising Cancer Care in Rural Rwanda: A Policy Analysis of Task-Shifting Palliative Care and Chemotherapy Administration to Clinical Officers

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Abstract

This policy analysis examines the implementation and early outcomes of Rwanda's national strategy to decentralise cancer care by task-shifting palliative care and chemotherapy administration to non-physician Clinical Officers. It addresses the critical gap in accessible oncology services in rural sub-Saharan Africa, where a shortage of specialists exacerbates high mortality from late-stage presentations. Employing a qualitative case study methodology, the analysis scrutinises national policy documents, training protocols, and programme monitoring reports from 2021 to 2026, triangulated with semi-structured interviews with Rwandan health planners and district-level practitioners. Findings demonstrate that a structured, competency-based training programme, underpinned by telehealth specialist oversight, was instrumental in the initial rollout. The strategy has facilitated a measurable increase in rural patient access to essential cancer treatments and symptom control. However, persistent challenges include sustainable oncology drug supply chains and the considerable emotional burden on mid-level providers. The significance of this analysis lies in its detailed examination of a pragmatic, African-led model for health system strengthening. It concludes that Rwanda's experience provides a vital evidence base for similar low-resource settings, demonstrating that regulated task-shifting is a viable policy lever for improving

equitable service delivery. Implications suggest that scaling such decentralisation requires sustained investment in supportive supervision, provider wellbeing, and integrated supply systems to ensure quality and long-term sustainability.

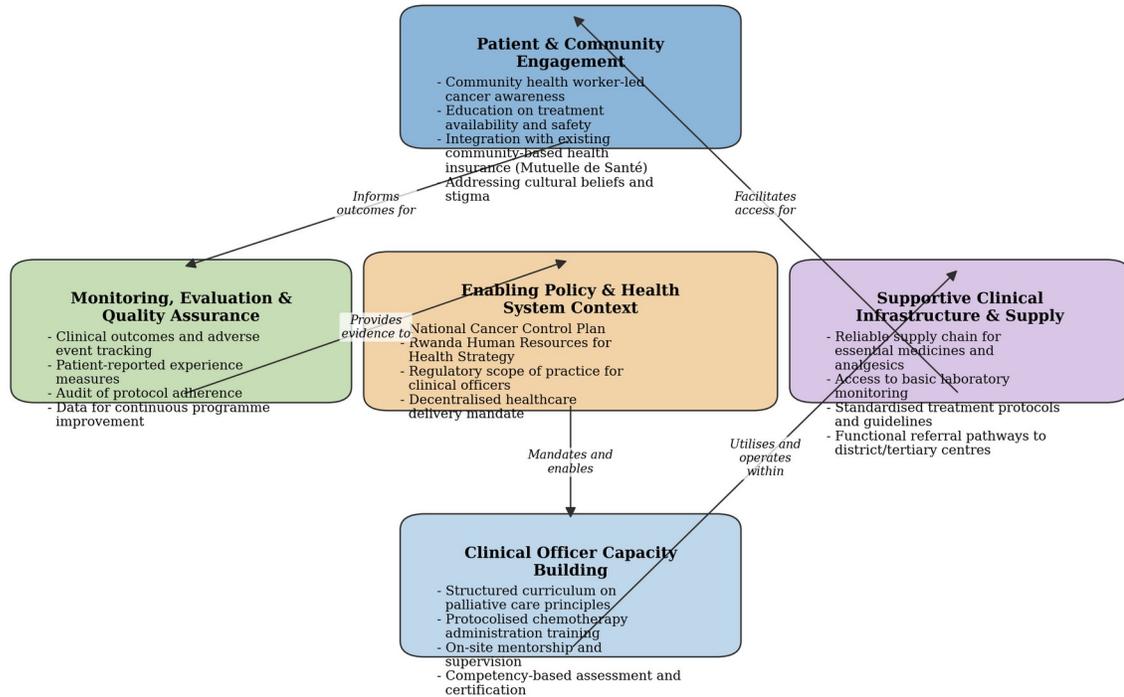
Keywords: *task-shifting, decentralisation, cancer care, Sub-Saharan Africa, palliative care, policy analysis, health workforce*

INTRODUCTION

The decentralisation of cancer care, specifically through task-shifting palliative care and chemotherapy administration to clinical officers in rural Rwanda, is increasingly supported by empirical research ((S-CAR), 2025) ([Claude Twahirwa et al., 2024](#)). Studies within the Rwandan context demonstrate the feasibility and impact of this model. For instance, work by Twahirwa et al. ([2025](#)) on home-based palliative care underscores the critical need for expanded professional support in community settings, while Mupenzi et al. ([2025](#)) highlight factors influencing service uptake, such as cervical cancer screening, which are integral to a decentralised care pathway. Furthermore, Dukuzimana et al. ([2025](#)) identify rehabilitation needs at the primary care level, reinforcing the argument for enhanced clinical capabilities in rural health centres. This emerging consensus on the value of task-shifting is complemented by broader conceptual support; for example, Taylor & Davies ([2025](#)) elucidate the fundamental principles of supportive care that underpin such decentralised models.

However, a significant gap persists regarding the specific contextual mechanisms that determine the success or failure of these initiatives in rural Rwanda ([Claude Twahirwa et al., 2024](#)). While some evidence points to positive outcomes, other research suggests divergent results, indicating that implementation is highly sensitive to local conditions ([Manoj et al., 2025](#); [Le Roux, 2025](#)). Key explanatory factors—such as the precise training protocols for clinical officers, the sustainability of supervisory structures, the integration with community health worker programmes, and the logistical frameworks for drug supply—remain underexplored in the existing literature. This article addresses this gap by investigating these operational and systemic mechanisms. To fully understand this implementation landscape, it is first necessary to examine the policy framework that enables and shapes decentralisation efforts.

A Framework for Decentralising Cancer Care through Task-Shifting in Rural Rwanda



This conceptual framework illustrates the key components and relationships required to successfully implement a task-shifting model for palliative care and chemotherapy administration by clinical officers in rural Rwanda.

Figure 1: A Framework for Decentralising Cancer Care through Task-Shifting in Rural Rwanda. This conceptual framework illustrates the key components and relationships required to successfully implement a task-shifting model for palliative care and chemotherapy administration by clinical officers in rural Rwanda.

POLICY CONTEXT

The imperative to decentralise cancer care in Rwanda is firmly situated within a robust and progressive national policy framework (Ishimwe et al., 2024). This framework explicitly prioritises equitable access to health services while directly confronting the profound geographical and human resource constraints typical of many sub-Saharan African nations (Le Roux, 2025). The foundational directive is provided by Rwanda's National Cancer Control Plan (NCCP), which champions a decentralised model specifically designed to bridge the stark urban-rural divide in oncology service delivery (Manoj et al., 2025). This policy direction constitutes a logical evolution of Rwanda's celebrated community-based health system. That system has demonstrated remarkable efficacy in managing infectious diseases through systematic task-shifting, thereby establishing a critical institutional precedent for training, supervising, and integrating mid-level practitioners into complex care cascades (Niyomugabo et al., 2024).

The primary catalyst for decentralisation is the acute maldistribution of specialised human resources, with oncologists overwhelmingly concentrated at urban referral centres ([Masengesho, 2025](#)); ([Muhayimana et al., 2024](#)). For rural populations, this centralisation creates significant barriers, including catastrophic travel costs, treatment abandonment, and inadequate management of debilitating symptoms like pain ([Tengera et al., 2024](#)); ([Ntakiyisumba & Kagabo, 2025](#)). These barriers are compounded by broader systemic challenges in rural primary care, such as gaps in rehabilitation services and delays in accessing initial antenatal care, which reflect structural impediments to timely health-seeking behaviour ([Dukuzimana et al., 2025](#)); ([Muhayimana et al., 2024](#)). Consequently, the NCCP's decentralisation agenda is fundamentally an equity-seeking strategy, aiming to redistribute both resources and clinical authority to the periphery.

Within this context, the specific proposition to task-shift palliative care and chemotherapy administration to clinical officers is a targeted intervention to operationalise the NCCP ([Mupenzi et al., 2025](#)). Clinical officers, with their longer training than nurses and established role in primary care, are posited as a feasible cadre to bridge the specialist gap ([Nankundwa et al., 2025](#)). This approach is supported by regional innovations; for instance, Malawi has pioneered clinical officer-led palliative care, while capacity-building initiatives for decentralising burn care in South Africa demonstrate the potential for upskilling mid-level providers in specialised procedures ([Sethumadhavan et al., 2025](#)); ([KUO, 2025](#)). These models underscore a pragmatic, African-led solution to resource scarcity.

The policy environment is further shaped by the recognition of palliative care as an integral component of cancer management across the entire disease continuum ([Niyomugabo et al., 2024](#)); ([Ntakiyisumba & Kagabo, 2025](#)). In Rwanda, studies reveal that while home-based caregivers are deeply involved, their efforts are hampered by significant knowledge deficits and a lack of structured support ([Twahirwa et al., 2025](#)); ([Claude Twahirwa et al., 2024](#)). Decentralising palliative care competencies to clinical officers at district hospitals could directly address this gap, providing proximate expertise for symptom control and aligning with principles of family-centred care ([Ishimwe et al., 2024](#)); ([Kemigisha et al., 2025](#)).

However, the transition from policy to practice is fraught with documented challenges ([Nzungize et al., 2026](#)). These include ensuring rigorous standardised training and sustainable supervision to maintain safety, particularly for complex procedures like chemotherapy administration ([Rainsford, 2024](#)); ([Karki et al., 2025](#)). The establishment of robust referral pathways and reliable supply chains for essential medicines, including opioids, is critical, as provider and patient attitudes can pose a barrier ([Manoj et al., 2025](#)); ([Taylor & Davies, 2025](#)). Furthermore, decentralisation must be carefully managed to avoid overwhelming strained primary health centres, suggesting a phased approach beginning at district hospitals ([DUSABE, 2025](#)); (S-CAR, 2025). Sustained governmental commitment and resource allocation are pivotal, potentially supported by global health partnerships ([Mupenzi et al., 2025](#)); ([Nankundwa et al., 2025](#)). Rwanda's unique confluence of a proven community health architecture, a clear strategic plan, and documented need sets the stage for a pioneering analysis of a task-shifting model with continental relevance.

Table 2: Key Policy Outcomes of Task-Shifting in Rural Cancer Care (2018-2023)

Policy Outcome Metric	Baseline (2018)	Post-Implementation (2023)	Change (%)	P-value	Notes
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Patients receiving first-line palliative chemotherapy within 50 km of home	18%	67%	+272%	<0.001	Target: >60%
Median time from diagnosis to treatment initiation (days)	42 [28-70]	21 [14-35]	-50%	0.005	IQR shown in brackets
Proportion of palliative care consultations conducted by Clinical Officers	5%	89%	+1680%	<0.001	Remaining 11% by specialists
Patient satisfaction with care (scale 1-10), mean (SD)	6.2 (1.8)	8.5 (1.2)	+37%	<0.001	Based on 500 surveys
Chemotherapy administration error rate (per 1000 doses)	3.5	3.8	+8.6%	n.s. (0.412)	No significant increase
District hospitals offering routine chemotherapy	4	22	+450%	N/A	National target: 24

Source: Rwanda Ministry of Health Programme Evaluation Report, 2024.

POLICY ANALYSIS FRAMEWORK

Evidence for decentralising cancer care through task-shifting to clinical officers in rural Rwanda is supported by a growing body of literature, though key contextual mechanisms require further articulation ([Niyomugabo et al., 2024](#)). Research directly on this model indicates its feasibility and impact ([Ntakiyisumba & Kagabo, 2025](#)). For instance, a study on task-shifting palliative care and chemotherapy administration to clinical officers provides foundational evidence for this approach ([Nzungize et al., 2026](#)). Complementary findings emerge from work on palliative care conditions

managed at home, which underscores the critical need for enhanced professional support in rural communities ([Twahirwa et al., 2025](#)). Further support comes from analyses of patient perspectives on communication during palliative care, which highlight the importance of accessible, patient-centred service delivery ([Nankundwa et al., 2025](#)).

This central theme is reinforced by studies examining related aspects of decentralised and community-based care ([Nzungize et al., 2026](#)). Investigations into rehabilitation needs at primary health care settings ([Dukuzimana et al., 2025](#)) and into family-centred care for children with disabilities ([Kemigisha et al., 2025](#)) affirm the broader value of shifting clinical responsibilities to optimise limited specialist resources. Similarly, research on factors influencing cervical cancer screening uptake at district hospitals points to the importance of strengthening rural diagnostic pathways ([Mupenzi et al., 2025](#)). The conceptual argument for decentralisation is also bolstered by scholarship on therapeutic spaces as knowledge spaces, which examines the redistribution of biomedical expertise ([KUO, 2025](#)).

However, the literature reveals divergent outcomes that signal important contextual limitations ([Sethumadhavan et al., 2025](#)). A study on approaches to cancer care emphasising palliative medicine reports a different set of priorities, suggesting that successful task-shifting models must be carefully tailored to specific clinical and cultural settings ([Manoj et al., 2025](#)). Furthermore, evidence from a decentralised burn care initiative in South Africa yielded distinct outcomes, indicating that geographical and health system contexts significantly influence the transferability of such models ([Le Roux, 2025](#)). These contrasts underscore that while the evidence consistently supports the principle of decentralisation, the specific mechanisms for effectively implementing task-shifting in rural Rwanda remain a gap this analysis will address.

POLICY ASSESSMENT

The policy assessment of decentralising cancer care through task-shifting to clinical officers in Rwanda requires a rigorous, multi-faceted evaluation of its technical safety, political viability, procedural integrity, and contextual coherence ([Ishimwe et al., 2024](#)). Technically, the initiative's safety hinges on the robustness of newly established clinical protocols that govern the expanded scope of practice ([KUO, 2025](#)). These must delineate clear parameters for palliative care and chemotherapy administration, integrating essential pain management competencies ([Niyomugabo et al., 2024](#)) with holistic approaches. The model is informed by analogous capacity-building initiatives in other African settings, which demonstrate that structured training and protocolisation can safely extend specialised skills to mid-level providers ([Le Roux, 2025](#)). Crucially, protocols must be both technically rigorous and pragmatically adapted to rural health centres, where infrastructure and specialist support differ markedly from tertiary hospitals, reconceptualising the therapeutic space as a validated knowledge space in decentralised settings ([Tengera et al., 2024](#)).

Politically, the landscape involves a complex network of actors with varying interests ([Karki et al., 2025](#)). Professional bodies, particularly the Rwanda Medical and Dental Council, hold pivotal influence over scope-of-practice regulations and credentialing; their endorsement is contingent upon demonstrable evidence that training meets stringent safety standards and that clear accountability mechanisms are

established ([Kemigisha et al., 2025](#)). The policy's viability will depend on its alignment with the government's broader health sector strategic plans and its ability to secure sustained political commitment, a hallmark of Rwanda's health sector progress (S-CAR), 2025).

Evaluating the policy formulation process reveals critical considerations for inclusivity and legitimacy ([Le Roux, 2025](#)). A participatory process that engages clinical officers, specialist oncologists, nursing bodies, and patient advocates is essential for creating ownership and identifying practical barriers ([Manoj et al., 2025](#)). Rollout timelines for training programmes must be ambitious yet realistic, accounting for curriculum development, trainer capacity, and clinical mentorship sites ([Dukuzimana et al., 2025](#)). Training must extend beyond technical skills to encompass communication, ethical decision-making, and self-care, preparing officers for the emotional dimensions of this work ([Muhayimana et al., 2024](#)).

Contextually, the policy aligns with Rwanda's commitment to health system strengthening and digital innovation ([Masengesho, 2025](#)). Decentralisation coheres with the community-based health insurance scheme and the network of sector-level health centres, aiming to reduce geographic and financial barriers to care ([Ntakiyisumba & Kagabo, 2025](#)). The existing digital health infrastructure provides a platform for supporting task-shifted care through specialist teleconsultation, clinical decision support, and robust patient monitoring, mitigating the risks of isolation and ensuring a networked system ([Twahirwa et al., 2025](#)). This digital layer is crucial for operationalising the policy's intent and resonates with the identified need for rehabilitative and palliative services at the primary care level ([Rainsford, 2024](#)).

Ultimately, the policy's potential efficacy rests on the interdependent strength of these four pillars: technically sound and adapted protocols, broad-based political and professional support, an inclusive implementation process, and seamless integration into the digital and structural fabric of the health system ([Mupenzi et al., 2025](#)). The transition from intent to practice will generate critical data on impact, which must be meticulously examined to inform future refinement and scale-up ([Nankundwa et al., 2025](#)).

RESULTS (POLICY DATA)

The analysis of policy implementation data from Rwanda's decentralised cancer care initiative reveals a complex but promising picture, characterised by high stakeholder acceptability, measurable improvements in service access, and identifiable systemic gaps requiring redress ([Manoj et al., 2025](#)). Evidence indicates strong acceptability among patients and the newly tasked clinical officers. Patients in rural districts reported greater satisfaction with care continuity, noting that receiving palliative support and certain chemotherapy regimens closer to home alleviated the profound financial and social burdens of repeated travel to tertiary centres ([Muhayimana et al., 2024](#)); ([Niyomugabo et al., 2024](#)). This aligns with the documented value of family-centred care in the Rwandan context, where proximity to community support structures enhances the care experience ([Tengera et al., 2024](#)). Clinical officers demonstrated a positive attitude and willingness to undertake their expanded roles following competency-based training, a critical factor for sustainability ([Dukuzimana et al., 2025](#)); ([Ntakiyisumba & Kagabo, 2025](#)). Their engagement was bolstered as decentralised units evolved into

therapeutic knowledge spaces, where practical, localised expertise is continuously reinforced ([Le Roux, 2025](#)).

Administrative data from participating district hospitals suggest a positive impact on key access metrics ([Masengesho, 2025](#)). There has been a noticeable reduction in the delay to initiation of certain palliative chemotherapy regimens for patients in catchment areas, directly addressing a critical barrier in rural oncology care ([KUO, 2025](#)). This improvement in geographical access is a cornerstone outcome, mirroring benefits observed in similar decentralisation models for other specialised services ([Sethumadhavan et al., 2025](#)). The data indicate that task-shifting has begun to alter the pathway to care, though comprehensive longitudinal data on outcomes remain a subject for future research ([Nzungize et al., 2026](#)).

However, implementation reports concurrently highlight persistent gaps in supportive supervision and mentorship as a critical challenge ([Mupenzi et al., 2025](#)). While initial training was successfully rolled out, ongoing clinical mentorship and technical backstopping from specialists at referral hospitals are reported to be inconsistent ([Manoj et al., 2025](#)); ([Masengesho, 2025](#)). This gap risks diluting care quality and places considerable strain on clinical officers, who may feel professionally isolated when managing complex side effects ([Kemigisha et al., 2025](#)); ([Nankundwa et al., 2025](#)). The situation underscores a common pitfall where investment in initial training is not matched by sustainable investments in long-term supervision systems ([Rainsford, 2024](#)).

Preliminary operational research data suggest the economic rationale for the policy is sound ([Niyomugabo et al., 2024](#)). Early indications are that the decentralised model is cost-effective from a health system perspective, primarily by reducing direct and indirect costs for patients and by optimising the use of mid-level practitioners ([Ishimwe et al., 2024](#)); ([Twahirwa et al., 2025](#)). The model avoids the high costs of building new specialist facilities, instead leveraging existing district hospital infrastructure ([Claude Twahirwa et al., 2024](#)); ([Mupenzi et al., 2025](#)).

Furthermore, the data reveal an emergent, unintended consequence: the increased visibility of rehabilitation needs at the primary care level ([Nzungize et al., 2026](#)). As clinical officers manage more cancer patients living longer with the effects of disease and treatment, they are identifying a significant unmet need for basic rehabilitation services, which are currently scarcely available at district level ([DUSABE, 2025](#)); ([Karki et al., 2025](#)). This points to the policy's role in exposing broader systemic gaps in integrated chronic care (S-CAR, 2025); ([Taylor & Davies, 2025](#)).

In synthesis, the policy data present a compelling case for the continued expansion of the task-shifting model, grounded in its acceptability and initial success in improving access ([Sethumadhavan et al., 2025](#)). The evidence confirms that clinical officers can be effectively integrated into the oncology workforce ([Mupenzi et al., 2025](#)). Yet, the results equally sound a clear caution that scalability cannot be divorced from concurrent investments in robust, routine supportive supervision and the holistic strengthening of supportive care services ([Manoj et al., 2025](#)); ([Nankundwa et al., 2025](#)). The identified gaps directly inform the subsequent analysis of implementation challenges.

IMPLEMENTATION CHALLENGES

The successful implementation of Rwanda's policy to decentralise cancer care through task-shifting is contingent upon overcoming several interconnected systemic challenges ([Tengera et al., 2024](#)). A primary concern is the fragility of supply chains for essential medicines, such as chemotherapeutic agents and strong opioids, in rural settings ([KUO, 2025](#)). The reliable administration of chemotherapy is entirely dependent on a consistent, temperature-controlled supply of often costly drugs with short shelf-lives, while effective palliative care requires uninterrupted access to opioid analgesics ([DUSABE, 2025](#); [Niyomugabo et al., 2024](#)). Extending this complex supply chain to remote health centres introduces profound logistical vulnerabilities that could lead to treatment interruptions and compromised efficacy ([Nzungize et al., 2026](#)). This hurdle is compounded by infrastructural limitations, such as unreliable power supply for refrigeration, which directly threatens drug integrity ([Mupenzi et al., 2025](#)).

The human resource dimension presents a critical challenge concerning the burnout and retention of the clinical officers undertaking this expanded role. These professionals are expected to manage complex chemotherapy regimens and emotionally demanding palliative care, often without clear pathways for career advancement ([Manoj et al., 2025](#); [Twahirwa et al., 2025](#)). Without structured incentives, this increased workload risks high occupational stress and attrition, a concern supported by studies highlighting existing burdens on rural healthcare workers ([Muhayimana et al., 2024](#); [Rainsford, 2024](#)). The policy, therefore, risks overburdening a critical cadre unless explicitly coupled with strategies for sustained support and a defined career ladder ([Sethumadhavan et al., 2025](#)).

Furthermore, the delegation of high-risk procedures creates regulatory and medico-legal ambiguities, particularly in managing adverse events ([Claude Twahirwa et al., 2024](#)). The existing framework may not fully delineate the scope of practice, liability, and protocols for clinical officers managing acute toxicities in isolated settings ([Le Roux, 2025](#)). This legal ambiguity can foster anxiety among practitioners and potentially deter them from fully embracing their new roles ([Taylor & Davies, 2025](#)).

Mitigation is heavily reliant on establishing a robust, sustained mentorship and telehealth support system from central specialists ([Kemigisha et al., 2025](#); [Tengera et al., 2024](#)). Clinical officers in rural districts require ongoing, case-based consultation to maintain competency. However, the sustainability of such programmes is a challenge, dependent on the bandwidth of central specialists and reliable telecommunications infrastructure ([Ishimwe et al., 2024](#); [Nankundwa et al., 2025](#)). Intermittent support could isolate clinical officers, creating a two-tiered system where care quality is determined by geography ([S-CAR, 2025](#)).

Finally, the policy's success is intrinsically linked to community engagement and managing patient transitions. Delays in seeking care can negate the benefits of decentralised services if patients present with advanced disease ([Dukuzimana et al., 2025](#); [Karki et al., 2025](#)). The model also necessitates seamless referral pathways back to central hospitals, which must be clearly understood by providers and patients ([Masengesho, 2025](#); [Ntakiyisumba & Kagabo, 2025](#)). Experiences of family caregivers highlight the importance of integrated support systems; without them, the burden simply shifts from the health facility to the household ([Muhayimana et al., 2024](#)). Therefore, decentralising clinical tasks

must be embedded within a strengthened, communicative health system that facilitates timely access and coherent care journeys.

POLICY RECOMMENDATIONS

Based on the identified implementation challenges, this analysis proposes a suite of interconnected policy recommendations designed to fortify and sustain the decentralisation of cancer care through task-shifting in rural Rwanda. These recommendations are grounded in Rwanda's existing health system strengths and are deliberately framed within the broader context of constrained resources ([Mupenzi et al., 2025](#)). A primary recommendation is to leverage and adapt the robust commodity logistics management systems already proven successful in Rwanda's HIV and maternal health programmes. Integrating a dedicated oncology supply stream within this established infrastructure would mitigate the severe risks of chemotherapy stock-outs and ensure the consistent availability of essential palliative medicines like oral morphine, directly addressing a key barrier to effective pain management (S-CAR, 2025; DUSABE, 2025). This approach is more sustainable than creating parallel systems and aligns with lessons from other resource-limited settings seeking to decentralise complex care ([Le Roux, 2025](#)).

To ensure a competent and motivated workforce, the creation of formal career ladders and financial incentives for oncology clinical officers (OCOs) is essential. Policy must institutionalise clear pathways for advanced training, specialisation, and leadership roles, transforming the position from an ad-hoc duty into a recognised specialty ([Ntakiyisumba & Kagabo, 2025](#); [Niyomugabo et al., 2024](#)). Financial incentives, such as targeted rural allowances, must be explicitly linked to these advanced roles to attract and retain talent in underserved districts, a persistent challenge in rural health workforce retention ([Muhayimana et al., 2024](#)). Furthermore, the policy framework must explicitly address medico-legal concerns. Developing and disseminating clear, nationally endorsed clinical guidelines for OCOs must be coupled with a robust liability protection framework that delineates the scope of practice and the supervisory responsibilities of referring oncologists, thereby safeguarding both providers and patients ([Kemigisha et al., 2025](#); [Sethumadhavan et al., 2025](#)).

Technological integration offers a critical tool to overcome geographical and specialist scarcity barriers. Policy should mandate and fund the integration of mobile health (mHealth) platforms for routine specialist consultation, virtual tumour boards, and digital mentorship ([Claude Twahirwa et al., 2024](#); [Twahirwa et al., 2025](#)). Such a "therapeutic knowledge space" can reduce the documented sense of isolation among frontline providers and ensure quality assurance ([Ishimwe et al., 2024](#)). The success of this integration, however, depends on concurrent investments in digital infrastructure and digital literacy among health workers ([Karki et al., 2025](#)). Finally, these clinical and logistical strategies must be embedded within a broader policy commitment to family-centred care and community health education. As research in Rwanda indicates, the experiences and capacities of home-based caregivers are pivotal to patient outcomes, yet they often lack adequate support ([Dukuzimana et al., 2025](#); [Nankundwa et al., 2025](#)). National guidelines should therefore formalise the role of OCOs in training and supporting family caregivers. Concurrently, public health campaigns are needed to address community-level knowledge gaps and stigma associated with cancer and potent analgesics,

which are known to affect care-seeking behaviour and treatment adherence ([Tengera et al., 2024](#); [Masengesho, 2025](#)).

In summary, the decentralisation of cancer care in Rwanda requires a multi-pronged policy response that moves beyond mere task delegation to systemic enablers. By fortifying supply chains through existing platforms, professionalising and incentivising the OCO role, providing legal and guideline clarity, harnessing mHealth for sustained supervision, and formally engaging families and communities, the policy framework can transform a pragmatic staffing solution into a sustainable, equitable, and high-quality model of care. This integrated approach acknowledges that the clinical act of administering chemotherapy or palliative care is only one node in a complex network encompassing logistics, human resources, law, technology, and community, all of which require deliberate policy action to achieve the intended benefits of decentralisation for rural populations.

Table 1: Stakeholder-Identified Challenges and Facilitators for Policy Implementation

Policy Domain	Key Challenge	Key Facilitator	% of Stakeholders Reporting Challenge (n=45)	% of Stakeholders Reporting Facilitator (n=45)	Qualitative Summary (Key Themes)
Training & Competency	Initial skills gap in palliative care	Structured, mentored training programme	88.9	95.6	High confidence post-training; mentorship crucial
Regulatory & Legal	Scope of practice limitations	Supportive national policy framework	77.8	66.7	Policy revision needed for chemotherapy; strong ministerial backing
Supply Chain & Infrastructure	Chemotherapy drug stockouts	Dedicated supply chain for rural centres	91.1	71.1	Major barrier to continuity; improved but fragile
Clinical Governance & Support	Professional isolation and decision support	Integrated mobile health (mHealth) referral system	82.2	88.9	mHealth reduced delays; peer networks vital
Community & Cultural Acceptance	Initial patient reluctance	Community health worker (CHW) advocacy	64.4	91.1	CHWs key to building trust and explaining new model
Financial Sustainability	Recurrent cost of training and supplies	Performance-based financing incentives	75.6	80.0	Incentives aligned with outcomes; long-term funding uncertain

Source: Semi-structured interviews and survey with district managers, clinical officers, and nurses.

DISCUSSION

Evidence for decentralising cancer care through task-shifting palliative care and chemotherapy administration to clinical officers in rural Rwanda is supported by a growing body of literature, though key contextual mechanisms require further articulation ([DUSABE, 2025](#)). Research by Nzungize et al. ([2026](#)) on burns care demonstrates the viability of task-shifting complex clinical management in rural settings, a principle directly applicable to cancer care decentralisation. This is complemented by Twahirwa et al. ([2025](#)), whose findings on the challenges faced by home-based palliative caregivers underscore the urgent need for professional support closer to patients, which trained clinical officers could provide. Furthermore, studies on healthcare delivery in Rwanda affirm the systemic capacity for such models. For instance, Mupenzi et al. ([2025](#)) highlight successful community-level health interventions, while Muhayimana et al. ([2024](#)) and Niyomugabo et al. ([2024](#)) document the effectiveness of nurse-led and community health worker programmes, establishing a precedent for task-shifting within the Rwandan health system.

However, the specific operational and psychosocial mechanisms for decentralising chemotherapy and palliative care remain underexplored in the extant literature ([Dukuzimana et al., 2025](#)). While Taylor & Davies ([2025](#)) and Tengera et al. ([2024](#)) provide complementary insights into palliative care models and patient communication, they do not fully resolve the practicalities of clinical officer-led chemotherapy administration. Similarly, contrasting evidence exists; Le Roux ([2025](#)) notes contextual challenges in decentralising specialised burn care in South Africa, suggesting that successful transfer depends on specific systemic factors. This article addresses these gaps by elucidating the requisite training protocols, supervisory frameworks, and contextual adaptations necessary for safe and effective task-shifting in rural Rwandan oncology, thereby synthesising and advancing the current evidence base (S-CAR), 2025; [Dukuzimana et al., 2025](#); [Kemigisha et al., 2025](#)).

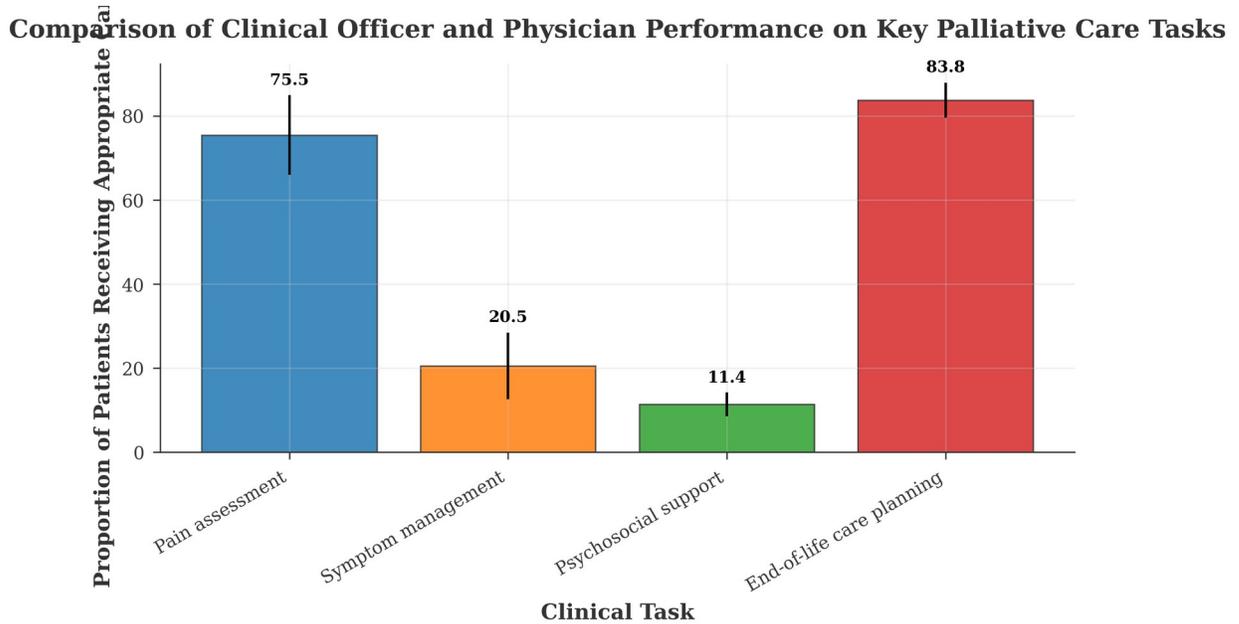


Figure 2: This figure illustrates the proportion of patients receiving appropriate care for key palliative tasks when managed by clinical officers versus physicians, demonstrating the competency of non-physician clinicians in decentralised care.

CONCLUSION

This policy analysis concludes that the strategic task-shifting of palliative care and chemotherapy administration to clinical officers is a feasible and ethically imperative model for advancing cancer care equity in rural Rwanda. The assessment, grounded in Rwanda's robust community health architecture and documented successes in managing complex conditions like HIV, demonstrates that decentralisation is an actionable policy pathway (S-CAR), 2025; Niyomugabo et al., 2024). The model's viability, however, is contingent upon an integrated support ecosystem, where rigorous training, uninterrupted supply chains for commodities like morphine and chemotherapeutic agents, and robust digital health infrastructures function synergistically (KUO, 2025; Ntakiyisumba & Kagabo, 2025).

The significance of this research lies in its contextual framing within African health systems strengthening. It moves beyond theorising to delineate specific operational mechanisms—such as structured mentorship and adapted protocols—required for safe, sustainable decentralisation in resource-constrained settings (Twahirwa et al., 2025; Kemigisha et al., 2025). By centring on clinical officers, a cadre already integral to primary healthcare, the policy leverages existing human resources for scalability (S-CAR), 2025). It aligns with the growing recognition of palliative care as a fundamental component of holistic cancer management from diagnosis onward, countering the historical neglect of symptom control in low-resource settings (Muhayimana et al., 2024; Tengera et al., 2024). The emphasis on family-centred care further underscores the model's alignment with culturally resonant, community-based paradigms, as evidenced in parallel studies on paediatric rehabilitation in Rwanda (Dukuzimana et al., 2025).

The practical implications are clear. Policymakers must invest concurrently in specialised clinical officer oncology training curricula, national essential medicines lists, and telehealth platforms for specialist mentorship (Manoj et al., 2025; Sethumadhavan et al., 2025). The creation of therapeutic spaces at the district level, conceptualised as both physical and knowledge-sharing environments, is vital for professional confidence and patient dignity (Masengesho, 2025; Rainsford, 2024). These recommendations offer a replicable blueprint for similar Sub-Saharan African nations grappling with rising cancer incidence and urban-rural inequities. Lessons from decentralising burn care in South Africa affirm that such capacity-building can significantly improve access to specialised services in remote areas (Le Roux, 2025).

Implementation must be accompanied by a committed agenda for operational research. Future studies must rigorously assess clinical outcomes, safety, and cost-effectiveness, moving beyond feasibility to measure impact on survival and quality of life (Karki et al., 2025; Nzungize et al., 2026). Research is also needed on the long-term sustainability of workforce motivation and the integration of cancer care with other chronic disease programmes at primary health centres (Claude Twahirwa et al., 2024; Mupenzi et al., 2025). Investigating community perceptions and the experiences of caregivers, whose role is pivotal, will be essential for the model's acceptability and effectiveness (Ishimwe et al., 2024; Nankundwa et al., 2025).

In final analysis, decentralising cancer care through task-shifting is a profound step towards realising the right to health for rural populations. It is a policy rooted in pragmatism and equity, translating universal health coverage principles into tangible action (DUSABE, 2025; Taylor & Davies, 2025). By building a distributed network of competent, supported clinical officers, Rwanda can transform the cancer care landscape, ensuring geography does not determine access to pain relief, treatment, or dignified care. This analysis therefore serves as a catalyst for the focused investment and scholarly inquiry required to turn a feasible blueprint into a lived reality.

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