



# The Patient Navigation project in Kigali, Rwanda

A C/Can Case Study

## Project overview

When Kigali first joined C/Can, one of the goals identified was to improve the care coordination for women with breast or cervical cancer in Rwanda's five main cancer centres. C/Can's needs assessment process revealed critical gaps that were resulting in late diagnoses, under-informed decision-making, and treatment delays due to the fragmentation of patient pathways and treatment plans across the different institutions.

In 2021, the Rwanda Biomedical Centre (RBC) in collaboration with the City Cancer Challenge Foundation (C/Can) and All Medical Inc (ALLM), launched a digitally enabled cancer patient navigation programme for breast and cervical cancer (BCC) patients. The programme aimed to strengthen the capacity and communication of five cancer referral health institutions in Rwanda – University Teaching Hospital of Butare (CHUB), Butaro Cancer Center of Excellence, University Teaching Hospital of Kigali (CHUK), King Faisal Hospital (KFH), and Rwanda Military Hospital (RMH). The programme trained and introduced 5 patient navigators who were deployed in each hospital to aid the flow of patients in the care pathway, in addition to a new digital platform called JOIN, developed by ALLM, a Japanese technology provider. The digital platform was intended to improve internal and external data sharing across institutions and healthcare personnel, and thus enhance coordination of care across the participating hospitals.

Through the programme's digital platform, data was collected along patients' care journey which was previously held in individual institutions. A total of 65 clinicians were registered on the platform, and 103 healthcare providers were trained on principles of multidisciplinary care and patient navigation principles. Using the data on the platform, they were able to access patient information across institutions, discuss cases for multidisciplinary care, and implement appropriate treatment.

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**Project to be  
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The patient navigation programme was designed for more effective use of human resources, greater ease in communicating across care centres, an overall better patient experience, and greater retention in the cancer care journey. It aimed to provide support to patients with the challenges of a dispersed system and increase their understanding of their diagnosis and cancer care journey. With the integrated information shared across facilities and the assistance of patient navigators, the programme empowered patients to take responsibility for their care journey by providing basic information that had previously been lacking. Psychosocial support provided by patient navigators to patients and family members helped create a more comprehensive care experience that provided guidance, increased knowledge, informed decision-making, and reduced delays in both diagnosis and treatment.

The Rwanda Biomedical Centre and Ministry of Health have made patient navigation a national priority for the healthcare system and are currently looking to expand the programme to lower care levels.



## Outcomes and Achievements



**The navigator was helping me throughout. I nearly gave up because of financial difficulties, but the navigator linked me with Butaro hospital, where I was able to get help. She even communicated with my husband and daughter to encourage us.**

Patient who was supported by a Patient Navigator

The patient navigation programme supported more than 1,354 patients. Patients benefited from timely diagnosis and prompt treatment, consistent continuation of treatments, and psychosocial support from patient navigators. The programme was adaptable to individual hospitals and created a connection and an information pathway among the five participating care centres in the city, and was supported by local, public, and private stakeholders.

The programme significantly **decreased delays in treatment initiation**. The quantitative data revealed that the mean duration to treatment initiation was reduced from 82 days before implementation to about 28 days after implementation of the patient navigation programme.

The **deployment of a digital platform** was widely accepted and compatible across participating health facilities, filling a critical gap in health service provision. It merged a previously fragmented system into a more cohesive, communicative and collaborative one.

In addition to creating an **information pathway** within individual hospital workflows, it was key for health care providers to share information at the various stages of the patient care journey across the different institutions. This integration resulted in better coordination of care between the different health facilities and reduced delays in patient treatment. It enabled navigators to provide **valuable human resources services** such as counselling and follow up, which in turn provided more comprehensive care and contributed to fewer setbacks in the care pathway.

The digital platform was **easily adaptable in the care centres** since it was viewed as a much-needed service for both patients and clinicians. The work of the navigator was essential to patient monitoring and was used to inform decision making on patient management in hospital tumor boards. The DCPN was flexible and adaptable with various services incorporated into the programme depending on the need at each site.

The **psychosocial support** provided by patient navigators enabled a **more comprehensive care experience** and contributed to the positive impact on patient adherence to screening and treatment plans. These services included counselling for patients and families, making appointments and follow-up calls, providing information when wait times or locations for testing or treatments changed, and explaining treatments and their significance. Similarly, navigators coordinated care between the various stages of care and facilities as patients progressed from one stage or centre to another, thereby helping clinicians manage the challenge of individual patient follow up and further contributing to timely diagnosis and treatment. These navigation services led to increased patient awareness, understanding, and empowerment of their individual care journey. Patients reported satisfaction with the quality of the health services provided by patient navigators.

**Local ownership and leadership commitment** was essential for the success of the Kigali patient navigation programme. Meetings were held throughout the implementation phase to provide project progress and collaboratively address any challenges that arose. This cooperation also demonstrates the value of bringing people and sectors together to identify the various issues to be addressed and implementing programmes to create a more comprehensive, efficient, and sustainable cancer care journey.

The C/Can-Kigali collaboration brought to light the vital role patient navigation plays in effective cancer care. The patient navigation programme has **contributed to the country's digital healthcare transformation process**. In October 2023, Rwanda Biomedical Centre announced their active commitment to fundraise for project extension among their existing partners. In February 2024, on World Cancer Day, the Rwandan government announced that patient navigation is a national priority for cancer care.





<https://citycancerchallenge.org/>



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