Report laid on 27/10/16
by Hon. Manoah Mbaki
PCA (CH&P)
27/10/16

NAIROBI CITY COUNTY ASSEMBLY

REPORT OF THE COMMITTEE ON HEALTH SERVICES
ON
THE STUDY VISIT TO THE REPUBLIC OF RWANDA

4TH TO 10TH SEPTEMBER, 2016

SCA
Include in the
weekly Schedule.
PCA (CH&P)
27/10/16

CLERK'S CHAMBERS,
CITY HALL,
NAIROBI.

SEPTEMBER, 2016

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Abbreviations and acronyms

CHW	Community Health Worker
EDPRS	Economic Development and Poverty Reduction Strategy
IDSR	Integrated Disease Surveillance and Response
MDGs	Millennium Development Goals
MINCOFIN	Ministry of Finance
MININFRA	Ministry of Infrastructure
MINSANTE/MOH	Ministry of Health
RBS	Rwanda Bureau of Statistics
W.H.O	World Health Organization

Preface

1. The Sectoral Committee on Health Services is one of the Sectoral Committees established under Standing Order 191. Under the Second Schedule it is mandated to consider matters related to County Health services: County health facilities and pharmacies, ambulance services and promotion of primary health care.
2. Investigate, inquire into, and report on all matters relating to the mandate, management, activities, administration, operations and estimates of the assigned departments;
3. Study the programme and policy objectives of departments and the effectiveness of the implementation;
4. Study and review all county legislation referred to it;
5. Study, assess and analyze the relative success of the departments as measured by the results obtained as compared with their stated objectives;
6. Investigate and inquire into all matters relating to the assigned department as they may deem necessary, and as may be referred to them by the County Assembly;
7. To vet and report on all appointments where the Constitution or any law requires the County Assembly to approve, except those under Standing Order 185 (*Committee on Appointments*) and
8. Make reports and recommendations to the County Assembly as often as possible, including recommendation of proposed legislation.

In conduct of its mandate, the Sectoral Committee on Health Services at its meeting held on 21st June 2016 resolved to conduct a benchmarking visit to the Republic of Rwanda. The objective of the visit was to enable the Committee learn from the management of Health services in the Ministry of Health, Rwanda. To achieve this, the Committee conducted the visit from 4th September to 10th September 2016.

Rwanda is a landlocked country situated in Central Africa with a unitary form of government. Also known as 'the land of a thousand hills', Rwanda has five volcanoes, twenty-three lakes and numerous rivers, some forming the source of the River Nile. The

country lies 75 miles south of the equator in the Tropic of Capricorn, 880 miles 'as the crow flies' west of the Indian Ocean and 1,250 miles east of the Atlantic Ocean - literally in the heart of Africa. Rwanda is bordered by Uganda to the north, Tanzania to the east, Burundi to the south and the democratic republic of Congo to the west. The Country according to the 2012 Census has a population of approximately 12 Million and covers a land mass of 26,338 square kilometers and receive an average rainfall of between 110-200mm during the rainy months ranging from March to May and from October to November. The temperatures range from 24.6°C-27.6 °C with an altitude ranging from 1000-4500m above sea level.

The Capital City of Rwanda, Kigali city, serves as the gateway to the country. The Country is divided into 5 provinces, 30 districts, 416 Sectors, 2148 Cells and 14,837 Villages that form the main administrative units. Each province is led by a Governor on the Executive side and a Coordination Committee for oversight. The Districts are governed by a Mayor on the Executive side and a District Committee for the oversight. The Sectors, the Cells and the Villages are led by an Executive Committees whose operations are checked by a Sector Council, Cell Council and Village Council respectively. The population of Rwanda 10,537,222 people. (Demographic and Health Survey 2010)

Committee Membership

The Committee on Health services comprises the following members:

1. **Hon. Manoah Karega Mboku** - **Chairman**
2. **Hon. Martin Mugo Kanyi, MCA** - **Deputy Chairperson**
3. Hon. Peter Imwatok, MCA
4. Hon. George Ochieng Ochola, MCA
5. Hon. Samwel Nyaberi Nyangwara, MCA
6. Hon. Peter Owera Oluoch, MCA
7. Hon. Erastus Muiruri Mburu, MCA
8. Hon. Peter Wahinya Kimuhu, MCA
9. Hon. Charles Thuo Wakarindi, MCA
10. Hon. Leah Mumo Mate, MCA
11. Hon. Rose Nancy Luchiri, MCA
12. Hon. Karen Wanjiku Githaiga, MCA
13. Hon. Mohamed Abdi, MCA
14. Hon. Tabitha Akinyi Juma, MCA
15. Hon. Susan Karimi Njue, MCA
16. Hon. Florence Athembo, MCA
17. Hon. Catherine Okoth, MCA

The following is the list of Members who participated in the visit:

1. **Hon. Manoah Mboku**
2. **Hon. Abdi Mohamed**
3. **Hon. Catherine Okoth**
4. **Hon. Moses Ogeto**
5. **Hon. Samwel Njoroge**
6. **Hon. Pius Otieno**

The following Members of Staff participated in the visit:

1. Mr. Inyundele Austin
2. Mrs. Cammelyne Anguche

Acknowledgement

The Sectoral Committee on Health Service wishes to thank the offices of the Speaker and the Clerk of the Nairobi City County Assembly for the support extended to it in the execution of its mandate, particularly in the conduct of this visit.

The Committee further extends many thanks to the Ministry of Health (MINSANTE) of the Republic of Rwanda, The Rwanda School of Public Health and Kigali City Council for the acceptance to meet with the Committee, their warm welcome and their entire effort to ensure that the Committee successfully conducted its visits to various places. From these visits, the Committee was able to learn significantly and achieved the objectives of the visit.

The Committee also thanks the Secretariat for their input and valuable contributions during and after the visit and in the compilation of this report.

Finally, much thanks to the Members of the Sectoral Committee on Health Services. Your committed participation and contribution in decision making regarding the trip was invaluable to its success.

Hon. Members,

On behalf of the Sectoral committee on Health Services, it is my pleasant duty and privilege, to present the Committee's Report on benchmarking visit to the Republic of Rwanda.

SIGN..... DATE 25/10/16

HON. MANOAH KAREGA MBOKU,

CHAIRMAN, HEALTH SERVICES COMMITTEE

CHAPTER ONE: PRESENTATIONS

1.1 Overview of Rwanda Health Systems

1.1.1 Introduction

The delegation arrived in Kigali City on 4th September 2016.The programme included a series of presentation meetings and site visits. The delegation met the Health Coordinator from the Rwanda Centre of Excellence on 5th September 2016 who gave an overview of Rwanda Health Systems.

1.1.2 The legal framework, policies and guidelines

The delegation was informed that the population of Rwanda stands at 10,537,222 with 51.8% female and 48.2% male. The Country's life expectancy is 64.5 years and their under 5 mortality rate is 50 out of 1000 births. The infant mortality rate is 32 per 1000 births while the maternal mortality rate stands at 210 per 100, 000.

The delegation was further informed that the HIV/AIDS prevalence for the whole country is 3% and the Country's health worker density being 0.84 per 1000 people. The fertility rate is 4.2 children per woman. 85% of the population access and seek the services of health facilities.

On average, 15.5% percent of the Government of Rwanda's budget is allocated to Health Services.

The Gross Domestic Product per capita stood at 718 USD in 2014 and poverty, through the efforts of the Government, has reduced from 2000: 60.40% to 2015: 30.20%).

The delegation was additionally informed that the Government of Rwanda strived and achieved all the MDGs at the level of goals, except the ones on poverty, stunting; and waged women employment. Extreme poverty and some health targets have been exceeded as summarized below:

These categories have been broken down as follows:

	Goals	Status
1	Eradicate Extreme Poverty and Hunger	Partially met
2	Achieve Universal Primary Education	Met
3	Promote Gender Equality and Empower Women	Met
4	Reduce Child Mortality	Met
5	Improve Maternal Health	Met
6	Combat HIV/AIDS. Malaria and Other Diseases	Met
7	Ensure Environmental Sustainability	Met

1.1.3 The long term vision

The delegation was informed that Rwanda has a long term vision which is to transform the country into a middle-income one in which Rwandans are healthier, educated and generally more prosperous.

This vision will be actualized through the following government policies

- Vision 2020 health pillar
- Economic Development and Poverty Reduction Strategies (EDPRS)
- Heath Sector Strategic Plan (HSSP 1, 2 & 3)
- Joint implementation mechanisms

Specifically, in the Vision 2020, Rwanda envisions to continually improve the health of the people of Rwanda, through coordinated interventions by all stakeholders at all levels, thereby enhancing the general well-being of the population and contributing to the reduction of poverty.

Rwanda's administrative arrangement starts with the village up to the central government level which corresponds with specific standard of health facilities for specific administrative

units. In each of the 5 provinces, there is a tertiary hospital which are specialized hospitals serving the entire country and which offer medical training.

Each of the 30 Districts has a district hospital which provide government defined "Complementary package of activities (CPA) e.g C-section, treatment of complicated cases, care to patients referred by the primary health centers and carry out planning activities for the health district and supervise district health personnel

At the Sector level, there are Health Centres which fall under catchments of specific District Hospitals and they provide government defined "minimum package of activities at the peripheral level (MPA) which includes complete and integrated services such as curative, preventive, promotional, and rehabilitation services and they also supervise health posts and CHWs operating in their catchment areas.

The Cells whose distance from Health Centres is big, have health posts to offer a package of healthcare. This package includes curative out-patient care, certain diagnostic tests, child immunization, growth monitoring for children under five years, antenatal consultation, family planning, and health education.

Finally at the village level, there are Community Health Workers who provide complementary health care services in the areas of prevention, screening and treatment of malnutrition, integrated Management of Child Illness (CB-IMCI), provision of family planning, maternal Newborn Health (C-MNH), Direct Observation Treatment (DOT) for HIV, TB and other chronic illnesses and behavior change and communication.

1.1.4 Reforms in the Health Sector

The delegation was informed that the following aspects have been pursued to bring about well-coordinated and efficient working Sector;

i. Universal health insurance coverage which has been achieved up to approximately 92% for the whole country.
ii. Performance Based Funding(PBF) which is a system of motivation based on the performance of health personnel in all health facilities to the community
iii. Community based health system that involve the Community Health Workers at the village level. There are about 45,000 volunteers managing promotional, prevention and curative packages at the village level
iv. Quality assurance culture towards accreditation of Health Services especially in referral hospitals, district hospitals, health centres
v. Specific programs to tackle hygiene and malnutrition issues
vi. Human Resource in Health strategic plan to streamline the quality of health services
vii. Decentralization of health services to the various administrative units

1.1.5 Private Health System

The delegation was informed that the private sector in health is not quite vibrant but the available ones occur at three levels: dispensaries, clinics and Hospitals. There are 380 private dispensaries, 100 clinics and 5 hospitals. The services offered at these facilities are also under close surveillance by the Government to ensure they are in line with the standards under which the public facilities operate or even higher.

1.1.6 The Rwanda Health Insurance

The delegation was informed that it is now a Government policy that every citizen should be under some kind of health insurance cover and the community-based Health Insurance that is subsidized by the Government to the very poor category of the population covers up 92% of the population mostly in the informal sector.

La Rwandaise d'Assurance Maladie (RAMA) and Military Medical Insurance (MMI) are medical insurance companies that cover the formal sector and their plan is contributory where the employee contributes 7.5% and the employer 7.5 % for RAMA and 5% employee, 17.5 % employer and 15% co-payment for MMI.

The delegation was informed that this policy has contributed immensely in ensuring that the population accesses health services at most health facilities.

1.1.7 Regulation in the Health Sector

The presenter informed the delegation that both the private and public health Sectors are regulated by the following bodies:

- The National Bank of Rwanda (BNR) and the Ministry of Finance and economic planning (MINECOFIN).
- A vision to have Rwanda National health Insurance Council towards which the government is working.

1.1.8 Personnel hierarchy in Rwanda Health System

The delegation was informed that specific cadre of health personnel are deployed to specific level of health facilities that correspond with the administrative system of the country. In this system, referral hospitals have 150 physician specialists, 475 physician generalists at the district hospitals, 8273 nurse generalists at the health centre level and 45011 Community Health Workers at the village level.

The delegation further learnt that Rwanda has achieved 0.84 per 1000 health worker density compared to 2.3 per 1000 health worker density recommended by the World Health Organization (WHO).

The presenter also demonstrated to the delegation that the fertility rate trends has been reducing from 6.1 in 2005 to 4.2 in 2015 with many women taking up the modern methods of family planning. Maternal health statistics indicate an improvement where

99% women sought antenatal care, 91% deliveries assisted by skilled persons and 91% delivery at health facilities in 2015.

In vaccination, full package was administered to 93% of children between 12-23 years in 2015. The country also achieved 87% exclusive breast feeding rate the same year as per Rwanda Demographic Health Survey (RDHS, 2015).

1.1.9 Key aspects behind the milestones

The following aspects were identified to have contributed to the milestones achieved by the government in the health sector.

- Performance-based financing (PBF); to increase quality & quantity of health care. A tool to motivate and ensure service delivery is quick and effective;
- Community-based health insurance (CBHI): 92% of total population mostly in informal sector. Premium based on community wealth ranking done in Ubudehe program;
- Community Health Workers Program;
- Rapid SMS: Quick communication by SMS, CHWs have phones and send the message to the central desk. Copying high level officials; a daily report on the cases handled is submitted to the Hon. Minister office every evening;
- SISCOM which refers to a central Community Health Worker Information System
- Performance contracts with the President (Imihigo) as a means of enforcing social duties and obligations.

    - *Presentation of achievements by the Mayors and open public questions (TVR, radios, phones).*
    - *Annual Accountability day*
    - *Annual dialogue day*

    (These Contracts cover all sectors)

- Gender considerations in all life of the country development process ensures all are part of the resolve towards quality health care;

- Partnership Coordination Mechanism, Joint Action Development Forum (JADF) at all administrative levels aligned with country needs
- Effective Health indicator monitoring system;
    - *District Health System Strengthening Tool*
    - *National Health Management Information System (HMIS)database*
    - *Health centre data collection tool (Community Health Information System –SISCom)*
- Umuganda (Community work) to address identified community problems (sanitation, safe shelter to poor, road repairing);
- Umurenge SACCO (saving and credit cooperatives). There are 416 SACCOs which ensure that every Rwandan has a bank account, to allow savings. 2.5 million people have opened accounts and deposits are over 45Billion;
- One cow per family program; started as a presidential program, adopted by communities;
- Zero Tolerance to corruption;
- Medical Procurement and Production;
    - *Warehouse and Distribution unit*
    - *Quantification and Stock Monitoring Unit*
    - *Sales and Marketing Unit*
    - *Health commodities procurement unit*
    - *Medical Production Unit*
- Equitable access of quality cost effective drugs and medical equipment to the entire population of Rwanda; and
- Ministerial clusters which are coalitions among relevant ministries towards common goals. For instance, Social Cluster composed of Ministry of Health (MINSANTE) and Ministry of Finance (MINCOFIN) e.t.c.

1.1.10 Areas of strength

The following were identified as the drivers of the milestones achieved so far:

i. Strong political leadership and commitment from the central government and Ministry of Health;
ii. Better planning, management and monitoring and evaluation at all levels of the health sector;
iii. Introduction of sustainable and equitable financing mechanisms;
iv. Improved geographical access for the entire population;
v. Availability and rational use of appropriate medication;
vi. Community participation in health activities;
vii. Continued and enhanced partnerships between government and Development Partners; and
viii. IMIHIGO (Performance contracts with the President) related to Health.

1.2 The Community Health Workers System (CHWs)

1.2.1 Introduction

This presentation to the delegation was made by the coordinator from the Centre of Excellence on the operations of the CHWs in the health system.

1.2.2 Composition

The three (3) CHWs, one male and two females are mainly based at the villages. One of the two females specifically deals in maternal and infant health.

1.2.3 Selection criteria

The delegation was informed that selection to be a CHW is based on the following criteria:

- Accept volunteer status and live in the village;
- Easily accessible person;
- Perceived as honest by community peers;

- Able to read and write;
- Age range: 20 – 50 years (Mature Person)
- Ability to maintain confidentiality; and
- Be elected by the community

1.2.4 Scope of the role of CHWs

- **Preventive services** mainly through community mobilization / sensitization towards healthy lifestyles; malaria prevention, etc.
- **Promotive services** e.g through nutritional surveillance and education, growth monitoring, routine home visits, sensitization on hygiene and sanitation, sensitization against Gender Based Violence.
- **Curative services e.g** Integrated Community Case Management (iCCM), Community Maternal-New-born Health (MNH), Community TB-DOTs, Community based provision of family planning services and other commodities.

1.2.5 Specific interventions

The delegation was informed that the CHW programme provides complementary health services to the people and they make specific interventions that include:

1. Community-based prevention, screening and treatment of malnutrition;

- Monthly growth monitoring & promotion,
- Screening children for malnutrition cases using Mid Upper Arm Circumference (MUAC) tape and refer severe case to health center and treat moderate cases,
- Community demonstration kitchen gardens to prevent malnutrition and reoccurrence,
- Community level follow-up for treatment effectiveness.

2. Integrated Community Case Management (ICCM);
   Targets children under 5 years for Malaria, Diarrhea, acute respiratory infections like pneumonia, malnutrition
3. Community-based Maternal &Neonatal Care (CBMNC;

- Identify and register women of reproductive age and encouraging family planning
- Identify pregnant women and encourage Ante Natal Care, birth preparedness and facility based deliveries
- Identify women and newborns with danger signs and refer them to health facility for care
- Accompany women in labor to health facilities
- Encourage early postnatal facility checks for both newborns and the mothers

4. Community Based Provision of Family Planning (CBP);

Community health workers (CHW) provide:

- Condoms,
- Oral contraceptive pills,
- Injectable family planning methods,
- Standard Days Method/Cycle beads

1.2.6 How the Rapid SMS for CHWs operates

The delegation was informed that the Rapid SMS is a free and open-source framework for dynamic data collection, and alerts used by CHWs to report using SMS and give real-time data to ease tracking in 1,000 days of life i.e pregnancy cycle up to 2 years.

Government of Rwanda gave all CHWs mobile phone handsets, phone lines equipment to undertake their role.

Health Management Information System is a free and open-source framework for reporting. It is used by CHWs to collect aggregated data from all villages from CHWs on monthly basis.

1.2.7 Incentives for CHWs

To ensure that the CHW programme operates without interruptions and that it is sustainable, the following are the incentives for the CHWs

- Trust and respect from community members, leaders e.t.c gives the CHWs esteem to work with the Ministry for the people;
- Support from Supervisors and implementation partners help improve work;
- Regular trainings, coordination meetings supervision;
- In-country study tours to learn from peers in other districts;
- Distribution of mobile phone handsets, umbrellas, bicycles,
- Community performance-based financing (PBF) CHWs share part of the quarterly PBF and invest the rest as they wait for profit proceeds.
- Membership in cooperatives for income generation to CHWs. There are 475 CHWs cooperatives currently. All CHWs are organized in cooperatives to ensure income generation and accountability of expected results and sign the MOU with the MOH. Cooperative income generating projects including: poultry, cattle/goat/pig rearing, crop farming, basket making as well as other off-farm activities like transport, real estate e.t.c

1.3 Developing policies and laws

The process of developing the policy or law presentation was done by the coordinator from the Centre of Excellence to champion training e-health, biomedical engineering, health vaccines and immunization logistics in East African.

The presenter informed the delegation that any proposal which a Ministry wishes Cabinet to consider must be submitted formally to the Prime Minister with a request to place it on the Cabinet agenda.

The Minister who wishes to submit a proposal for Cabinet decision prepares a detailed document presenting the issue he or she wants the Cabinet to consider and take decisions on, as well as a Cabinet paper summarizing the content of the detailed document and clearly stating the decisions he/she wants the cabinet to take. Then, the Minister writes to the Prime Minister asking him to put the issue on the Cabinet agenda

For the policy development in the Health Sector, a proposal is made by the Ministry, then forwarded to the Social Cluster (MINSANTE, MINCOFIN e.t.c) for approval then it goes

to the Inter-Medical Cooperation Committee (IMCC) after which it goes for Cabinet approval and finally publication and approval by Parliament.

The process is guided by consensus building inclusiveness or power sharing, responsibility and respect for opinions of everyone.

1.4 HIV/AIDS programme

The delegation was informed that the overall HIV/AIDS prevalence across the country is 3%. When rated along sexuality, the HIV/AIDS is more prevalent among the females at 3.5% and 2.4% among the males from the Demographic and Health Survey (DHS) of 2013. Further, the disease is more prevalent in the age brackets above 35 years from the 2010 DHS.

The presenter informed the delegation that by 2013, HIV/AIDS was more prevalent in the urban areas followed by rural and then sub-urban.

53.6% females and 52.6 males in the Rwandan population has comprehensive knowledge of HIV whereas 34.8 females and28.2 males have knowledge about Prevention of Mother to Child Transmission (PMTCT) and 46.3 females and 47.1 males have knowledge about Anti-Retroviral drugs.

1.4.1Programmes in place to minimize impact

The following programmes have been put in place to mitigate the impact of HIV to the population:

i. Behaviour change
ii. Male circumcision
iii. Condoms
iv. Treatment and care
v. Focus on key populations

The above programmes are focused at stopping new infections, equal opportunity and keeping people alive.

HIV awareness to the general population is done through live radio talks, Production of Information, Education and Communication (IEC) materials, Public institution training on HIV and provision of minimum package e.g condoms.

1.4.2 The Rwanda National Strategic Plan (NSP) for HIV

The delegation was informed that this plan 2013-2018 was developed in line with Vision 2020 and DPRS2 to provide proper guide in the detection, management and treatment of HIV.

The over-arching principles of the plan include: national mobilization; leadership and ownership; equity and human rights (including Gender), HIV Integration in health sector, in national development strategy and in regional framework; cost effective and evidence-based planning and capacity building (Individual and institutional).

1.4.3 Targets of the plan

i. New HIV infections have been reduced by 2/3 - from 6000 to 2000 by June 2018;
ii. HIV related deaths have been reduced by ½ from 5000 to 2500 by June 2018, and HIV morbidity is decreased; and
iii. People infected and/or affected by HIV have the same opportunities as the general population

The delegation was informed that the above targets inform the basis of developing the programmes towards prevention, care and treatment and impact mitigation that bring on board the health support systems, players in coordination and strategic information.

1.4.4 Rwanda Monitoring and evaluation (M&E) plan for HIV

The delegation was informed that the plan is built on 12 components namely:

- Organizational structures with HIV M&E functions

- Human capacity for HIV M&E
- Partnerships to plan, coordinate, and manage the HIV M&E system
- National multi sectorial HIV M&E plan
- Annual costed national HIV M&E work plan
- Advocacy, communications and culture for HIV M&E
- Routine HIV program monitoring
- Surveys and surveillance
- National and sub-HIV databases
- Supportive supervision and data auditing
- HIV evaluation and research
- Data dissemination and use

1.4.5 Data collection

In the plan, there is one reporting system called the Health Management Information System, the indicators and reporting tools to be aligned to the partner's requirement, 100% of Health Facilities are monthly reporting in HMIS and indicators definition and reporting tools user manual defined

1.4.6 Quality assurance

- Existing of M&E and supervisor for HIV at District Level
- Data quality Assurance
- Integrated supporting supervision
- Help Desk for monthly reporting to ensure completeness and timeliness
- Data quality linked with Performance Based Financing
- Implementation of the new funding model for Rwanda : Result Based Financing with Government Funding

1.5 Epidemic Surveillance and Response Division

The delegation was informed that this division mainly deals in integrated Disease Surveillance and Response in Rwanda (IDSR).

The mission of the Division is to prevent and control epidemic diseases and other public health emergencies in Rwanda through the implementation of an effective and efficient national epidemiological surveillance system.

Its rationale lies in the Rwanda's adoption of the WHO-AFRO integrated Disease Surveillance and Response in Rwanda (IDSR) whose objective are:

- Detect trends signaling changes in the occurrence of disease
- Detect epidemics
- Provide appropriate response
- Providing information for planning

The Diseases under surveillance in Rwanda are Cholera, bloody diarrhea, Epidemic typhus, Meningococcal Meningitis, Plague, Typhoid fever, Rabies, Viral hemorrhagic fever, Yellow fever, Influenza-like illness, Pertussis and Diphtheria.

1.5.1 Diseases targeted for Eradication and Elimination

Acute Flaccid Paralysis, (AFP/Polio), Measles and Neo-natal tetanus

Other diseases of public health importance under the division include: Diarrhea for under 5 years, severe pneumonia in children below 5 years of age, Malaria, Food poisoning, viral conjunctivitis, Chicken pox (varicella), Mumps and Rubella.

1.5.2 Criteria for prioritizing diseases for Rwanda Surveillance System

The delegation was informed that prioritization of diseases under the surveillance system include: Impact (morbidity, disability, and mortality), significant epidemic potential, specific target of a national or international control programme, information to be collected lead to significant public health action e.g. immunization campaign.

1.5.3 Surveillance functions at different levels

National level

At this level, the team performs the following functions:

- Supporting function of the Surveillance &Response through training and tools, supervision, fund mobilization,
- Data quality and analysis of data reported through e---IDSR
- Collaborate and share information with the NRL and Outbreak Preparedness and Response Unit for a rapid response
- Provide feedback

Referral, provincial hospitals and district hospitals level

- Reporting on priority diseases
- Hospital oversight on priority diseases reported through e-IDSR regarding timeliness, completeness & data quality
- Inform the central level SMS and e-mail in case of probable outbreak within the catchment area
- Analysis of data within the catchment area
- Outbreak preparedness and response
- Provide feedback to Health Centres

Health centers and Private clinics

- Detect and record events involving disease or death,
- Report all available essential information immediately or weekly to DH
- Analysis of data/Facility level

1.5.4 The National Rapid Response Team

The delegation was informed that a proactive special emergency team at the central government level is always ready to be deployed to support the Disease Rapid Response Team (DRRT) in outbreak management. This is team is composed of Epidemiologists,

clinicians, laboratory technologists, environmental health scientists, health educators and communication experts, veterinarians and wild life experts, Emergency medical assistance service (SAMU)and other depending on the nature of the outbreak.

Further, the delegation was informed that at the District level, there is a District Epidemic rapid response team (DRRT) that comprise of director of the district hospital, medical director, the head of the District Health laboratory, M&E officer, IDSR focal point, data manager or statistician, environmental health officer (or in charge of Public Hygiene) and In charge of community health activities.

The delegation was further informed that during the beginning the IDSR strategy, challenges were experienced in terms of timely data reporting, analysis and response. However, efforts have been made to minimize the challenge through integration of ICT that would transform it to e- IDSR

1.5.5 Main achievements of e- IDSR

- Improved timeliness and completeness of disease reporting in Rwanda;
- Detected potential outbreaks and facilitating rapid investigation and response to limit outbreaks spread and fatality; and
- Automated data analysis and reports, an opportunity for quick decision making.

1.5.6 The key outputs of the e- IDSR

- Immediate and weekly reports are submitted
- Reminders for due report submission and late submission are sent to IDSR FP
- Notifications for probable outbreak and reminder concerned person on close outbreak

1.5.7 Current Global Public Health Threats

The delegation learnt that the following are the current global public health:

i. Emergence and spread of new pathogens including those with pandemic potential;
ii. Globalization of travel and food supply;
iii. The rise of drug resistant pathogens (AMR);
iv. Acceleration of science capabilities (accidental or intentional spread of pathogens);

v. Increase of bioterrorism;

vi. Climate change;

vii. Global increase of frequency and magnitude of disasters

1.5.8 Challenges faced in the health sector

i. Integrated Health Regulations(IHR) core capacities not yet fully implemented;

ii. Laboratory confirmation capacities in term of Infrastructures and equipment's for instance ;

iii. Turnover of the trained personnel at all levels;

iv. Sustainability of e-reporting system;

v. Decentralized capacity building; and

vi. Regional cross border collaboration

1.5.9 Way forward in addressing the challenges

The delegation was informed of the following as way forward to address the challenges faced by the Health Sector:

1. Sustaining and strengthening disease surveillance system by implementing the International Health Regulation and One Health approach;

2. Strengthening the national laboratory capacity for diseases confirmation at all level, the biosafety standards and the coordination of the national laboratory system;

3. Strengthening the emergency response capacity in term of human resources and infrastructure (equipment's and materials) to respond to huge demands;

4. Strengthening or adapt the risk communication strategy vis a` vis the technology advance for effective, coherent and credible communications during emergencies;

5. Engage the community, the media, private sector and civil society to be part of the awareness before and during health emergency; and

6. Advocate for sustained funding to support IDSR.

The delegation conducted visits to CHUK Referral Hospital and Masaka District Hospital the Directors who briefed the delegation and guided them around their facilities. The delegation confirmed that indeed the deliberations during the presentations sessions were indeed happening on the ground.

Further, the delegation paid a courtesy call on the Minister for Health who briefed them about the mandate and operations at the Ministry. The delegation was also able to visit the Kigali City Council where they met the Director in the Office of the Vice-Mayor in charge of Social Services and briefed the delegation about their mandate as far as health care is concerned.

The delegation was informed that the City has two types of health care facilities that include public and private health facilities.

The City has 3 levels of public healthcare facilities that include: referral, provincial and district health facilities.

In light of the foregoing, the City of Kigali has 4 district hospitals, 36 health centres, 33 health posts, 3 district pharmacies and 380 private health facilities.

The delegation was informed that management of District health System is vested in the District Health Management Team (DHMT) that comprise of the Vice Mayor in charge of Social Affairs as the Chairperson, District Director of health unit, District hospital Director, District Pharmacy Director and the District health monitoring and evaluation officer.

The City of Kigali through the DHMT is responsible of coordination, supervision and support district health units which in turn coordinate and supervise District Public and private health facilities health facilities.

CHAPTER TWO: LESSON LEARNT FROM RWANDAN EXPERIENCE

Following the visit to the Republic of Rwanda, the delegation was able to pick the following lessons for prudent practice within the Health Sector:

1. **Decentralization** of public health to local government
2. **Accountability and information flow for quick and timely decision and action-** the responsibility of oversight on service delivery is undertaken by both the recipients of the services and the leadership.
3. **High level of discipline among the people and law enforcement-**there is a high regard for the laws and policies in place to a level that it has become part of the people's personalities in the conduct of daily business.
4. **Stakeholder participation-** the success of mobilization, sensitization and implementation of policies is owed to the willingness of the relevant stakeholders to be part of the processes that are going to affect their lives.
5. **Public-private partnerships-** this is an integral function of cost-sharing and reduction in the implementation of policies and programmes by government and non-governmental entities.
6. **Capacity building for health sector personnel and liaison with think tanks-**the outcome is definitely better policies and maximum output by the staff. Further, through collaboration with think-tanks research informs decision making for better service delivery.
7. **Transparency-**the high sense of openness and integrity in the process of service delivery enhances development prudence through financial and human resources allocated for specific functions are used for the same without fraud or short changing.

CHAPTER THREE: CONCLUSION AND RECOMMENDATIONS

3.1 Conclusion

The seven-day visit by the Members of the delegation of the Nairobi City County Assembly to the Republic of Rwanda was a resounding success.

The delegation witnessed firsthand workings of various institutions and concerted effort towards quality health care. The rise of the Republic of Rwanda from the damages of the genocide to the current development status is manifest of a common resolve of both the leadership and the citizens to rebuild the country into a model to be emulated.

Indeed, Nairobi City County and Kenya can certainly draw from the Rwandan experience for best practices in the field of Health Services. Rwanda is a good example that through sound planning, policy implementation and follow-up mechanisms, a country can alter its fortunes dramatically.

Nairobi City County needs to adopt sound laws and enforcement mechanism in line with formulated policies in the Health care sector for the sector is key to the development of other sectors among others, tourism, economy and industrial development.

3.2 Recommendations

Following the visit, the Committee urges this Assembly to resolve as follows:-That,

1. Nairobi City County Government to enact sound and comprehensive law and policy on health care with proper enforcement mechanisms;
2. Nairobi City County to conduct a Ward-based mapping of the County Health Volunteers with a view of establishing the number for proper training intervention, motivation and equipping (comprehensive kit and communication means) for proper case management, reporting and monitoring;
3. The Nairobi City County to integrate Information Communication and Technology (ICT) through establishment of the County Health Information Management System database that will enable identification, monitoring and report on health related information. This is important also for proper resource allocation and management for specific programmes;
4. The Nairobi City County to ensure sufficient staffing in the County Health facilities so that the County can achieve the WHO recommended Health Worker density of 2.3 per 1000 persons and proper motivation for quality output;
5. Nairobi City County to establish mechanisms for efficient, effective and timely disease surveillance and response to reduce mortality due to delayed response to manageable cases in the County;
6. The Nairobi City County to ensure comprehensive stakeholder engagement including the Community, NGOs and media on programmes such as nutrition, sanitation, family planning and disease prevention targeting the communities. This will lead to effective information flow for desired results;
7. The Nairobi City County to establish Non-Communicable Disease (NCDs) sections in each of its main hospitals for diagnosis, management and treatment of growing number of NCDs such as cancer due to changes in lifestyle;
8. The Nairobi City County to ensure periodical inspection of all food selling outlets and hotels to ensure compliance with City Public Health standards. Further, the County to

implement ban on road side, open food preparation and dispensing for unlicensed operators;

9. The Nairobi City to formulate and enforce law and policy on transport and emissions in order to contribute to the fight against diseases due to lifestyle, especially emissions from vehicles;
10. The Nairobi City County to put in place mechanisms for reduction in maternal death, infant mortality and morbidity and raise the number/percentage of mothers delivering with help of qualified personnel and increase the number of persons seeking health related services at health facilities; and
11. The Nairobi City County to ensure transparency and accountability in the health sector through legislation to manage doctor-patient engagement, proper utilization of medical supplies and commodities in health facilities and prudent resource management for the benefit of all. This approach is intended to cub on negligence and misappropriation of government medical supplies (e.g drugs e.t.c) and take for sale in private health facilities.

APPENDIX

Appendix Presentations of Rwanda

MINUTES 58 OF NAIROBI CITY COUNTY ASSEMBLY HEALTH SERVICES COMMITTEE HELD ON TUESDAY 21ST JUNE, 2016 AT 11.00AM AT CHARTER HALL, CITY HALL BUILDINGS AT 11.00 A.M.

PRESENT

1. Hon. Manoah Karega Mboku, - Chairman
2. Hon. Martin Mugo Kanyi, MCA - Deputy Chairperson
3. Hon. Abdi Mohammed, MCA
4. Hon. Leah Mumo Mate, MCA
5. Hon. George Ochieng Ochola, MCA
6. Hon. Karen Wanjiku Githaiga, MCA
7. Hon. Peter Wahinya Kimuhu, MCA
8. Hon. Charles Thuo Wakarindi, MCA
9. Hon. Samwel Nyaberi Nyangwara, MCA

ABSENT WITH APOLOGIES

1. Hon. Peter Imwatok, MCA
2. Hon. Tabitha Akinyi Juma, MCA
3. Hon. Peter Owera Oluoch, MCA
4. Hon. Susan Karimi Njue, MCA
5. Hon. Erastus Muiruri Mburu, MCA
6. Hon. Catherine Okoth, MCA
7. Hon. Florence Athiembo, MCA
8. Hon. Rose Nancy Luchiri, MCA

SECRETARIAT

Mr. Inyundele Austin - Committee Clerk

Min. No. 306/hsc/June/2016: Preliminary

The meeting was called to order at 11.00 a.m after a prayer was said by the Nancy Luchiri. The Chair welcomed all the Members to the meeting.

Min. No. 307/hsc/June/2016: Adoption of the agenda

The agenda of the meeting was read and adopted by the Committee after being proposed by Hon. Nancy Luchiri and seconded by Hon. Martin Mugo.

1. *Prayer*
2. *Adoption of the agenda*
3. *Confirmation of previous minutes*
4. *Matters arising*

5. *Preparation for the meeting with the CECM on 22nd June 2016*
6. *Any Other Business*
7. *Adjournment and date of next meeting.*

Min. No.308/hsc/June/2016 *Confirmation of previous minutes*

The minutes 37 of the meeting of the Committee that was held on 13th April 2016 were read and confirmed as a true record of the deliberations and proposed by Hon. Abdi Muhammed and seconded by Hon. Nancy Luchiri.

Min. No.309/hsc/June/2016*: Matters arising*

There were no matters arising from the previous minutes

Min. No. 310/hsc/June/2016 *Preparation for the Committee's meeting with the CECM*
The Chairman informed the Members that the Committee had resolved that the County Executive Committee Member and the Chief Officer responsible for Health Services be invited to the meeting of the Committee.

He stated that the objective of the meeting will be to deliberate on the progress of addressing the following issues as had been resolved during a meeting with the Governor:

i. Disbursement of free maternity funds to health facilities
ii. Insecurity in the health facilities
iii. Delay in the supply of drugs by KEMSA
iv. Disbursement of Health Sector Services Fund(HSSF) money
v. Acquisition and coordination of ambulances services
vi. Separate account to be operated by the health sector

The Chairman informed the Members that the said meeting will be held on 22nd June 2016 from 11.00 a.m at the new chamber boardroom.

The Chairman requested the Members to attend the meeting in time to dispense with the agenda.

Min. No. 311/hsc/June/2016: Any Other Business
The Members were informed that the Health Sector had written a letter to the Budget and Appropriations Committee requesting for the suspension of the purchase of 120 Ha of land for Cemetery as had been planned for execution in the FY 2016/2017.
The Committee resolved to raise the matter with the CECM in the next Committee meeting.

The Committee resolved that a request for study tour be made to the Republic of Rwanda from 11th to 16th July 2016.

Min. No. 312/hsc/June/2016: Adjournment

There being no other business to consider, the meeting was adjourned at ten minutes to noon. The next meeting was scheduled for 22nd June, 2016 at 11.00 a.m.

SIGNATURE .....

(Chairperson)

DATE..... 7/09/2016

MINUTES 98 OF THE NAIROBI COUNTY ASSEMBLY HEATH SERVICES COMMITTEE MEETING HELD TUESDAY 25TH OCTOBER 2016 AT 11.00 A.M AT THE COUNTY ASSEMBLY FOYER, CITY HALL BUILDINGS

PRESENT

1. Hon. Manoah Mboku, MCA **Chairman**
2. Hon. Karen Wanjiku, MCA
3. Hon. Catherine Okoth, MCA
4. Hon. Leah Mate, MCA
5. Hon. Peter Wahinya, MCA
6. Hon. Florence Athembo, MCA
7. Hon. Martin Kanyi, MCA
8. Hon. Nancy Luchiri, MCA
9. Hon. Tabitha Juma, MCA
10. Hon. Abdi Mohammed, MCA
11. Hon. George Ochola, MCA
12. Hon. Susan Karimu, MCA
13. Hon. Erastus Mburu, MCA

ABSENT

1. Hon. Samwel Nyangwara, MCA
2. Hon. Charles Thuo, MCA
3. Hon. Peter Owera, MCA
4. Hon. Peter Imwatok, MCA

SECRETARIAT

1. Inyundele Austin – Committee Clerk

Min. No. 526/hsc/October/2016: Preliminaries

The Chair called the meeting to order at eleven O' Clock in the morning. The opening prayers were read by the Chair.

Min. No. 527/hsc/October/2016: Adoption of the agenda

The following Agenda of the meeting was adopted after being proposed by the Hon. Nancy Luchiri and being seconded by the Hon. George Ochola.

1. *Prayer*
2. *Adoption of the agenda*
3. ***Adoption of the report of the study visit to Rwanda***
4. ***Consideration of responses to requests to Statements***
   - ***Hon. Leah Mumo on Jericho Health Centre***
   - ***Hon. G. Maina on Umoja 1 Health Centre***
5. *Any other business*
6. *Adjournment*

Min. No. 528/hsc/October/2016: Adoption of the report of the study visit to Rwanda

The Committee was informed that pursuant to the resolution of the Committee in a previous meeting requesting the Clerk of the Committee to prepare a final copy of the report to of the study visit to Rwanda, the Chairman informed the Committee that a final report was before the Committee for verification and adoption.

The Chairman requested that copies of the report be circulated to all Members for perusal. The Chairman led the Members in reading through the report and the report was adopted having been proposed by Hon. Susan Karimi and seconded by Hon. Catherine Okoth.

Min. No. 529/hsc/October/2016: consideration of responses to requests to Statements

Statement requested by Hon. Leah Mumo regarding the lack of water and drugs and poor management of Jericho Health Centre.

The Committee was informed that the Executive had responded to the request as follows:

1. **Reasons for lack of water and drugs at Jericho Health Centre and when the County will supply drugs to the facility**

Jericho health Centre and its environs are currently facing an acute water shortage. The water rarely flows in the pipes leading to the facility to entirely depend on provision of water through water tankers from Nairobi City water and Sewerage Company. The sector

sometimes facilitates fuel for these tankers. However, this matter has been communicated to Nairobi City Water and Sewerage Company but nothing has been done to date

Further, the County procures drugs centrally from KEMSA who distributes to the health facilities according to the quantities ordered. However rarely are the facilities supplied optimally. This results in stock outs in the facilities. Due to delayed payment of debt, the supply has been irregular hence the frequent stock outs in the facilities.

Jericho Health Centre received its last drug supply from KEMSA in December 2015. It offers 24hour services resulting into high work load and consumption of drugs.
The County facilities will be able to be supplied with drugs once it has cleared the current debt with KEMSA.

2. Why the facility was closed on 2nd October 2016 yet it is supposed to operate 24 hours

The health facility operated normally on the said date. However, it encountered a challenge during the night shift. At about 11.15 p.m., about seven people came to the facility and started shouting and banging the facility door seeking forceful entry. The group proceeded to pelt rocks, blunt objects and kicks at the doors and windows. One of the people was cut by the glass of the door. The officers on duty panicked and called the area police to intervene. However, upon hearing staff calling the police, the group left but later came back with a nominated MCA that happens to live within the locality.

The staff opened the door when they recognized the MCA who scolded and threatened them for failure to offer services. The MCA called the County Executive Committee Member responsible for Health Services who requested to talk to the officer in-charge of the night shift.
The police form Jogoo Road Police Station arrived and assessed the damage caused by the group. They disappeared upon the arrival of the police and left the behind the MCA arguing with the police and later left together.

The staff on duty were asked to record a statement at the police station which they did under OB No. 02/03/16

3. Measures that the County has put in place to supply the facility with adequate drugs for patients

The County has continued to pay the current debt incurred at KEMSA from the last supply of drugs. The debt has drastically reduced and once cleared, KEMSA will be able to supply the County Health facilities with drugs. The orders for drugs for each health facility have been prepared and submitted to KEMSA.

4. Measures being taken by the County to ensure residents get better and timely services at the facility.

The County Health Management Team (CHMT) has organized itself into clusters to ease the supervision of Sub-County Health Management Teams (SCHMT) that supervises the health centres. This is done on a quarterly basis. The CHMT is always ready to accompany the SCHMT to any facility that may have challenges beyond their capability. Though this supervision, efficient service delivery to the citizens is ensured.

Statement requested by Hon. G. Maina regarding the status of drug supply in Umoja 1 Ward Health Centre

The Committee was informed that the Executive had responded to the request as follows:

1. The status of drug supply in Umoja 1 Health Centre

Umoja 1 Health centre received its last drug supply from KEMSA on 9th December 2015. The facility has a high work load as it serves the whole of Umoja I, II, Inner Core and the surrounding areas. Currently, the facility has stock outs of most of the major drugs. Therefore, the patients are given prescriptions.

2. Evidence of when drugs were supplied to the said Health Centre

There are delivery notes from KEMSA that indicate the date and amount of drugs that were supplied to the facility.

3. **Measures that the County Executive has put in place to ensure that the City residents receive proper care and medication in various health centres in the County**

The County Health Management Team (CHMT) has organized itself into clusters to ease the supervision of Sub-County Health Management Teams (SCHMT) that supervises the health centres. This is done on a quarterly basis. The CHMT is always ready to accompany the SCHMT to any facility that may have challenges beyond their capability. Though this supervision, efficient service delivery to the citizens is ensured.

The Committee resolved that the responses be tabled in the Assembly in their form.

Min. No. 530/hsc/October/2016: Any other business

The Members were informed that the Committee will be conducting a site visit to Makongeni Health Centre on Wednesday 26th October 2016 at 10.00 a.m and Member to convene at the Assembly for departure by 9.30 a.m.

Min. No. 531/hsc/October/2016: Adjournment

There being no other business to consider, the meeting was adjourned at seventeen minutes past noon. The next meeting was scheduled for Monday 24th October, 2016 at 11.00 a.m.

CHAIRMAN ..... DATE 26/10/16

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