DRAFT REPORT

USAID/KEA Regional Partners & Stakeholders Forum

Dates: November 19 - 20, 2019

Location: Windsor Hotel, Nairobi, Kenya.

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Summary

USAID Kenya and East Africa (USAID/KEA) Regional Health Partners & Stakeholders assembled in Nairobi, Kenya for a two-day forum to discuss the state of cross-border health activities and outcomes and to forge a way forward on improving health outcomes while increasing sustainability of existing and future programs. The discussions held in each of the days were guided by specific objectives. The specific forum objectives were:

Day 1: Review lessons learned from cross-border health activities to inform current and future activities.

Day 2: Define the critical problems and barriers to achieving positive health outcomes among beneficiaries in the cross-border areas.

Day 1: Review lessons learned from cross-border health activities to inform current and future activities.

On day one, the consultative forum was opened at 8:25AM, by facilitator Kimberly Hickok Smith followed by an official welcome by Wairimu Gakuo, Health, Population, and Nutrition Office (HPN) Deputy Office Director/Regional. Introductory speeches were delivered by Patrick Wilson, USAID/KEA Deputy Mission Director and Randolph Augustin, HPN Office Director, USAID/KEA.

Setting the stage/ highlights of meeting outcomes

Moderator: Wairimu Gakuo, HPN Deputy Office Director/Regional

Randolph Augustin, HPN Office Director, USAID/KEA

In his opening remarks, the director referred to the forum as a working session which required the participants to roll up their sleeves and figure out what is working and what is not working in regards to cross border health activities. Key highlights of his address were:

- Acknowledge the reality that the East Africa borders are opening up, bringing in great opportunities, and therefore the need to create systems that take advantage of the opportunities.
- Understand that though mobility brings great opportunities, but it also comes with great risks, calling for the urgent need to mitigate these risks in order to take advantage of the opportunities.
- Need for stakeholders to be open and honest when looking at the data and the evidence of cross border health issues and activities.
- Maximize opportunities at regional level to meet challenges/issues.
- Accept that there is a need for collective force and effort to address the identified challenges/issues.

Overview of USAID priorities, J2SR and Regional Pivot

Patrick Wilson, USAID/KEA Deputy Mission Director

In his opening remarks, the Deputy Mission Director expressed his excitement and reiterated that as per USAID policy, the purpose of foreign assistance is to end the need for foreign assistance. Key highlights of his statement included;

- The regional journey to self-reliance (J2SR) is the idea that East Africa should collectively be able to take care of its own development needs.
- East Africa is the fastest growing region in Africa, and this growth and dynamism holds a great deal of promise for the population that live in East Africa.
- The mobility of people and animals moving across borders creates health risks as diseases can also move across borders. Therefore, we must give these mobile populations the tools they need to allow them to defend themselves against these health risks.
- With more than 600,000 annual tuberculosis (TB) deaths in East Africa, women (15-24 years) at risk of contracting HIV, and children in conflict areas at risk of contracting infectious diseases, there is an urgent need to mitigate issues by ensuring that national and regional health actors are providing uninterrupted health services.
- USAID is working with regional intergovernmental organizations (RIGOs), nongovernmental organizations (NGOs), bilateral and multinational partners, and seeking new partnerships with the private sector to maximize innovation, strengthen health systems, and better align our efforts to achieve better health outcomes for the men and women of East Africa.
- Stakeholders need to be frank and have open conversations on the true state of health and the obstacles that are standing in the way to achieve better health. “We cannot solve problems if we cannot talk about them.”

- The main challenges are in financing health services, reliance on donors, lack of standardized accreditations.
- There is need to focus more on data and analytics so we know what the problem is and how we can fix it.
- USAID is investing millions of dollars in health but still not able to see results, hence the need to take a hard look at USAID and find out what it is we are not doing right.
- USAID is committed to supporting the Journey to Self-Reliance and supporting leaders who are committed to ensuring this happens.

Figure 1:Panel discussion on cross border health

Cross Border Health

Panel Presentations - cross-border health **Moderator**: Kelly Wolfe

Dorothy Muroki, Chief of Party CB-HIPP (Cross Border Health Integrated Partnership Project)
Project Goal Catalyze and support sustainable and African-led regional health development partnerships to improve health outcomes. **Objectives** • Increased access to and uptake of integrated health and HIV/AIDS services. • Alternative health care financing models identified, implemented and tested. • Strengthened leadership and governance by intergovernmental institutions. **Successes** • Contributed to broader recognition of cross-border health situation, risks and vulnerabilities, health care financing, opportunities at local, national and regional levels. • Defined key components (standard package) for EAC regional health service delivery in border areas. • Multi-sectoral stakeholder-designed innovative cross-border health unit (CBHU) model (replicable and scalable) for implementing cross-border health services and referral. • Developed manual cross-border health data management system, which informs need for digital health solutions. • Developed approaches/standard operating procedures, tools, curricula for cross-border health programming. • Strengthened capacity of border HRH (facility and community) on migration health. **Challenges** • All the HSS building blocks within cross-border health system have a policy dimension; encumbrances have implications on operationalizing a functional cross-border health system • When data is not collected, there is a limits viability of use for decision making (patient care, resource allocation etc.,) by the health system. • Partner states have unique coordination structures/mechanisms/protocols which have to work in tandem for efficient cross-border service delivery within the EAC region. **Lessons Learned** • A robust coordination process between bilateral and regional design and implementation of programming can enhance the efficiency of a functional and sustainable cross-border health system. • Coordination and collaboration; interoperable digital cross-border HMIS and national HIS; and a policy/regulatory framework are game changers in health package. • Portability of national health insurance/social protection is important for mobile and cross-border EAC nationals to access continuum of care across borders. • Utilization of local evidence is key in supporting policy, action and advocacy at all levels for sustainable cross-border health service delivery.

Dr. Jean de Dieu Ngirabega, Deputy Executive Secretary/Research

East African Health Research Commission (EAHRC)

Project Goal

Strengthening cross-border health systems in EAC by improving the quality of health services for mobile populations, and communities residing along strategic borders of EAC through the East Africa Cross-Border Health Services Program (EA-CBHS).

Objectives

- Pilot and approve a Cross-Border Health System that supports the continuum of care for priority diseases and services.
- Employ digital technology to strengthen the cross-border health system and enable continuous and real-time generation of health-related information associated with mobile populations and cross-border communities.
- Use implementation science approach as a basis to inform decision making and to strengthen cross border health systems.

Successes

Although EAHRC is yet to record any direct success as the project is yet to be implemented, key progress has been made as follows:

- EAHRC analyzed CBHIPP data on building blocks in cross border health services and identified gaps that are cross cutting.
- The 18th Sectoral Council) recognized the report of country consultations on EA-CBHS Pilot programme.
- Created 10-year strategic plan (2019-2028) - approved by EAC council and funded for the first 5 years.
- Received approval for EA-CBHS Pilot programme (EAC/SCHealth/18/Decision 19).
- Authorization to implement the EA-CBHS pilot programme and share progressive reports every six months, starting with 19th sectoral council (EAC/SCHealth/18/Directive 42).

Challenges

- Data security, ownership, sharing, and hosting of server has proved a challenge.
- Choice of program study sites did not consider representativeness of partner states.
- The role of other EAC Stakeholders and National Ministries of Health yet to be aligned with direct stakeholders at EAC and Partner State level.

Lessons Learned

- There is need for further country consultations to develop regional data policy.

Fatuma Adan, Senior Regional Program Coordinator

Intergovernmental Authority for Development (IGAD)

Project Goal

Improved management of health risks that transcend borders through a resilient regional cross-border health system in the Horn of Africa.

Objectives

- Establish a system for Pharmacovigilance and quality monitoring of medical products at IGAD cross-borders.
- Strengthen regional cross-border tuberculosis (TB) diagnosis and management capacity.
- Strengthen regional policies and strategies for vulnerable cross-border mobile populations.
- Strengthen regional cross-border knowledge management for health.
- Strengthen IGAD technical and coordination capacity to implement cross-border health interventions.

Successes

- Cross border TB- 6 cross border districts sensitized; 26 districts assessed.
- At least 203 health facility staff trained.
- Regional cross border learning event on TB.
- Reduced transmission of MDR-TB and HIV in region through inter-country sharing of medications.
- Joint work plan developed and supportive supervision.
- IGAD health division document archival and retrieval system.
- Key informant interview on knowledge management for health.
- Health assessment report with recommendations endorsed by the member states for action.
- Established a specific knowledge management for health department.

Challenges

- Health interventions for cross border populations is not captured by national states.
- Political sensitivities between Somalia and Kenya.
- Slow uptake, adoption and implementation of technical guidelines/documents in some countries than others.
- Disparities in member states health systems capacity.
- Insecurity in some cross-border areas.
- Complexity in designing and implementation of activities due to massive porous and unmanned borders that facilitates mobility of diseases and substandard and falsified health commodities.

Lessons Learned

- The health system is generally oriented towards the static populations leaving out mobile populations.
- There in need to have framework and standardized approach for health to address these mobile populations.
- Better coordination of health service delivery across borders plays a major role in improving cross border health services.

Dr. Doreen Othero, Regional Program Coordinator, Public Health and Environment.

Lake Victoria Basin Commission (LVBC)

Project Goal

To institutionalize the integrated PHE approach into national and regional policies and frameworks.

Objectives

- Promote generation of PHE information and Knowledge Management in the region.
- Contribute to reduction in environmental degradation while simultaneously increasing access to and utilization of FP/MNCH services.
- Establish and operationalize national PHE networks.
- Increase the participation of women, men and youth in sustainable livelihood improvement initiatives.
- Mainstream PHE into regional and national level policies and Institutions of higher learning.

Successes

- PHE Statutory structures established; Regional Policy Steering Committee (RPSC) - providing policy guidance and Regional Technical Working Group (TWG)
- Policy- buy-in from communities to heads of states for example, some governments have adopted PHE as a sustainable approach to achieve their SDG (Uganda).
- Guiding documents developed and used by state and non state actors.
- National PHE networks established and taken up by Community Based Organizations.
- Capacity building (training, conservation and resource mobilization).
- Media engagement and mainstreaming PHE into universities.
- Increased uptake of MCH services, FP, credit access and labor participation, malaria prevention, use of clean energy.
- Developed a knowledge management strategy to guide knowledge and information sharing.
- Digital monitoring and evaluations leading to timely information release and integrated approach in the regions.

Challenges

- Shortage of staff in the project.
- Attribution of success due to multisectoral approach- population, health and environment. sectors are working together but specific sectors want to own successes without realizing that it is the success of all the sectors.
- Lack of policy harmonization, policies must be reviewed in the integrated policy.
- Changing the sector quo – there is always fear of interference from other sectors.
- Uncertainty of funds and silos within the donor organizations.

Lessons Learned

- Establishing, strengthening and working with Community Based Organizations (CBOs) provides an opportunity for enhanced ownership and sustainability.
- Capacity building of the beneficiary populations and stakeholders is key to achieving self-reliance.

- Evidence-based advocacy can trigger governments to appropriate funds to supplement donor funding.
- Meaningful involvement of Local Government structures is a major sustainability strategy.
- Partnerships between Governments and Civil Society Organizations is key in building synergies and sharing of resources.

Panel Discussions – cross border health

Moderator: What do you think should be the priorities to strengthen cross-border health systems?

Dorothy Muroki, *COP, (CB-HIPP)*	Cross border health has to be imbedded within national systems and cannot be a standalone. Regional and bilateral processes must work together for a functional cross border health system. We need a regional policy framework and systems that will allow data sharing across borders.
Dr. Jean Ngirabega, *ES, EAHRC*	Each country has a system. What we are missing is the understanding of what cross border systems really entails**.** Priority should be in identifying and addressing gaps in cross border health systems and especially working on coordination, collaboration, information sharing, and interoperability.
Fatuma Aden, *Senior Regional Program Coordinator* IGAD	The principle in health and community health is that if it has not made a change in the community or in the household, then it has not happened. If we do not see lives improved, morbidity reduced, and life expectancy increase within the household, then it has not happened. Member governments have what it takes, but we are not seeing change in the community. We have to speak to each other and digital health and policies have to speak to each other as well.
Dr. Doreen Othero, Regional Program Coordinator, PHE *LVBC.*	Evidence generation is needed in cross border areas to understand the benefits to beneficiaries then plan for how this evidence will be used. We need to determine how evidence will be used to influence policy before programs can be anchored.

Plenary Discussions, Question & Answer

Participants were asked to respond (in writing) to the six questions below. The participants were then asked to read one answer of their choice as they introduced themselves. Below is a summary of key responses shared by the participants.

Question 1: What are the three most important lessons you have learned over the course of your work?

- I have seen value for regional work and also highlighting the leadership and strong leadership by the stakeholder in the country.
- The instruments that are been implemented at county level helps us avoid duplication and wastage of resources.
- I have seen increased opportunities. We no longer see health as a government only task. Private sector partners must also engage with civil societies and join this journey to improve cross border health services.
- It is important to have evidence informed policies so that we can seal the gaps .
- We have seen the existence of the pharmaceutical regulation policies that help to fight counterfeited products that are crippling our health care provision.
- We have seen opportunities everywhere with decisions that no longer have borders and making cross border control very easy.
- There is fantastic work been done in both countries and regions in East Africa. There is a great increase in interest of the region in terms of implementing programs.
- Facilities and the governments are willing to coordinate and leverage with the enabling countries.
- Regional approaches can be a shortcut to success in cross border health activities. This reduces the buy in process and saving time in project implementation. Once you have stakeholder involvement then you can be able to steer further growth.

Question 2: What do you think are the top two priorities to strengthen cross-border health systems?

- What we need to happen at the national level is implement the policies so they do not remain only as theories.
- Standardize the multiple systems within our countries, and then integrate them across the border to increase access to cross border health services.
- Ensure we are measuring the same units, and have a harmonized way to calculate and harmonize any of these results.
- Strengthen the structures of the regional institutions so that they have the capacity to give guidance at a regional scale. Respective governments can be able to integrate with their own national systems and ensure integration into cross border issues.
- What should be highlighted most is information sharing so people know what has worked and what has not worked so that we improve the efforts and align them with the objectives.
- We need to strengthen the M&E function and have a fully-fledged M&E working with the region to enhance regional information monitoring and sharing.

Question 3: From your experience, what challenges and opportunities exist for collaboration/coordination to improve cross-border health outcomes?

- When it comes to certain cross border issues, it is not clear who will pay for what. There is a place where it gets a little bit blurred. The Journey to Self-Reliance is a slippery one and

must be walked very strictly.

- East Africa region is spending less on health and the challenge going forward is how do we ensure we entice the government to fund domestic health and resources.
- Product registration is not cross border leading to limited access to medicine across borders.
- We must focus on the three C's- collaboration, communication, commitment and increase advocacy.
- We need to look keenly into community programs and come up with interventions that are based on evidence. The data from the field should inform tailor made projects.
- The challenges faced working in cross border leads to inefficiency even in tracking cross border clients.

Question 4: What are the opportunities for using digital technologies?

- Introduce digital health in the university curriculum and train medics on digital systems.
- Process the laws on data privacy creates a very fertile crowd for data exchange and gathering.
- There are challenges on data sharing and data security and data management. We need to harmonize this information and be able to use it within our work.
- Make interaction between ICT specialists, and health providers so that they work together for a sustainable and easy adoption of digitized technologies.
- Take advantage of the mobile systems and leverage data sharing between the regions.
- Harness digital health in the health systems and build leadership to improve regional investment in digitization.

Question 5: What are some experiences in using digital tools that would support cross-border health?

- Sharing medicines through digital systems to avoid wastage and scarcity of pharmacology products.
- Cooperating and sharing data is encouraged, however the question remains, what data are we sharing? Is the data correct? Is it aggregated?
- Digital technology can ease data mining, and our major challenge is that either the data is not there or data cannot be shared.

Question 6: What are the opportunities and challenges for private sector engagement?

- There is a platform for us to engage the private sector. We have come together as a region, and that gives a platform for a cross border /regional perspective. However, the biggest challenge for us is to break the silos and engage in these issues together.
- We need to build /nurture commitment from the government and use the private sector beyond corporate social responsibility. We need more efficient ways to utilize the private sector.
- The role is not competitive but a complimentary role. It is inevitable that government and private sector must work together.
- There are many opportunities, and the private sector is already investing in health

especially in the hard to reach areas and in pharmaceuticals and human resources management.
- The private sector has stood out firmly and if we focus on these opportunities then we can strategically position ourselves.

Measure Evaluation Studies

Moderator: Wairimu Gakuo

Panel presentation - Measure Evaluation Studies
Studies presented by: Stephanie Watson-Grant

Title: Mobility and Treatment, a study of priority populations with HIV &/or TB on East African borders
Aim of Study To improve care and treatment for people living with TB and/or HIV in East Africa cross-border areas along the shores and on the islands of Lake Victoria by providing information about the relationship between mobility and health in this population. **Methodology** • Abstraction of data from TB and pre-ART registers and TB and HIV treatment cards to create three cohorts. • Quantitative surveys to examine mobility patterns, access to health services while mobile and at home, and other health outcomes. • Qualitative interviews to further examine mobility and feasibility/acceptance of using a unique identifier. • Male and female community focus groups to examine mobility and health in the community and challenges of seeking care while mobile. • Six months after initial data collection, return to shore facilities for abstraction of TB treatment outcomes for the TB cohort. • Tracing of clients without recorded TB outcomes who participated in quantitative interviews and provided contact information. **Preliminary Findings** • Initial data collection complete • Currently conducting follow up data collection to collect TB outcomes—expected completion by November 30, 2019 • Draft report expected January 31, 2020 • Final report expected March 31, 2010

Title: CB-HIPP, Performance Evaluation and Costing Analysis

Aim of the Study

Performance evaluation to determine what worked well and that which did not work so well, determine stakeholder satisfaction, and examine contextual factors that facilitated or hindered the success of each component.

Methodology

Performance evaluation

Key informant interviews- over 100 stakeholders interviewed in October 2019

Preliminary analysis included identification of common themes and patterns of responses

Costing study

Costing questionnaire – collection of cost data, such as budgets, work plans, expenditure summaries and accounting/financial accounts

Preliminary Findings

Functional coordination and collaboration system

- CB-HIPP was able to engage high-level regional and national stakeholders.
- Stakeholders were part of decision-making process which increases buy-in and ownership.
- Created linkages with colleagues from across the border and a system for cross-border communication where previously there was none.
- Stakeholders embraced collaboration to address cross-border health issues.

2. *Functional service delivery and referral system*

- Increased new HIV and TB case identification.
- Improved linkage to care.
- Improved retention in care for both HIV and TB.
- Inter-facility referrals greatly improved.
- Tools developed by CB-HIPP help document number of nonnational clients for budgeting and planning (mostly related to drugs and commodities).

Conclusions

1. The seven components are interrelated and difficult to separate.
2. CBHUs have been shown to be a viable service-delivery model to support 90-90-90 and other service delivery goals.
3. Coordination and collaboration are critical to cross-border health programming and underly all other components of the standard package.
4. Stakeholders at Kenya/Uganda sites are the most satisfied with the project.
5. National and regional policy are the key to sustainability.

6. An interoperable HMIS and a portable healthcare option are key components of the package but will likely take years to be realized.

Recommendations

- Coordination needs to be multi-sectoral and include immigration, security, administration.
- Increase opportunities for in-person cross-border meetings/forums.
-

Title: HIS Interoperability, Assessment of Interoperability readiness of East African HIS

Methodology

- Assessment of oversight team and key stakeholders from Ministry of Health (MOH) and other ministries, departments, and agencies (MDAs) of ICT.
- Review key documents guiding digital health, and interview key stakeholders from government, implementing partners, and donors.
- Systematically assess foundational elements needed for interoperability and digital health.

Findings

- Disparities in technical capacity for digital health and interoperability.
- Lack of common laws/policies/ regulations/standards/policies for cross-border data sharing.
- Weak human resources capacity in skills and numbers.
- Lack of coordination around shared vision for interoperability.
- Varying understanding of the meaning of "interoperability" affects buy-in to a vision and resource allocation.
- Positioning of digital health in MOH is less conspicuous.
- A wide chasm between MOH and ICT.
- Many homegrown digital health information systems to learn from.
- There is momentum and goodwill to build on e.g., digital REACH, Global Partnership on Sustainable Development Data, E-Government initiatives.
- Timing is ripe: Countries are generally in the nascent stage, so it's easier to build on a shared framework.

Recommendations

- Collaborate and learn from country best use cases. Tanzania has a strong process for health information management. Rwanda is working on defining and adopting standards across the health sector. Kenya has an interoperability lab.
- Deeper understanding by leadership on the value of interoperability and specific use cases that highlight its value.
- Strengthen local institutions to produce appropriately qualified people in the right numbers to meet the needs of digital health.
- Regional technical working group on digital health or interoperability (example of Health Informatics Association).
- Socialize adherence to the principles for digital development and principles for donor alignment.

Plenary discussion and Q&A Session
Participants were given an opportunity to ask questions and seek clarifications from the Measure IV team.

Questions	Panel Responses
1. The findings are very informative but what were the limitations of the study? For example, how did you choose the facilities in the study? *Dr. Doreen Othero,*	We selected facilities that were already implementing the package. Although USAID was also interested in information from those who had not implemented the package, but the assumption was that we would going to facilities where there has been longer exposure to the package. The essence was to assess and learn from implementation. *Stephanie Watson-Grant (Measure IV)*
2. You seem to have had very many assumptions or held things constant- did you consider other factors especially those on access, and physical infrastructure? We have building blocks – human resources, finance, service delivery, essential medicines. Did you hold these things constant and assumed that the facilities were all the same? *Dr. Doreen Othero,*	The national government has invested a lot and the reality is that cross border issues will present differently in different regions. Yes, I agree that it cannot be one track. It is not only a regional conversation but a conversation for both. Accessibility of resources and facilities that are available on one side of the border and can be used on the other side of the border is a policy issue. In terms of the principles, they do mirror the HSS building blocks, and they have to be speaking to each other. There must be leveraging. *Dorothy Muroki, COP, (CB-HIPP)*

Digital Health

Panel Discussion - digital health
Moderators Ishrat Husain and Dessalegn Tasfaye

Opening Remarks: *Ishrat Husain (USAID/Washington AFR/SD*

Artificial intelligence and digital technology are revolutionizing health care provision. Africa is making significant progress in the adoption of digital technology, especially in the use of phones and internet and penetrating to the rural communities. The two inventions unique to Africa are:

- Mobile money – enabling people even in secluded areas to pay for health care and also

solving the problem of health insurance.
- The local production and use of drugs (e.g. Malawi) is improving accessibility to health products.

Despite slow progress, the future is promising, and high costs are the biggest huddle in quality healthcare for all. Low cost solutions can be found even for diseases. Digital technology can reduce the cost of outreach, improve diagnosis and precision of health care. The main questions to ask are:

1. Why are donors and countries not showing interest in financing digital technology in healthcare in East African countries?
2. Why is the response from the private sector still low? What would make it attractive for the private sector?
3. What can we do as donors and the private sector in improving digital technologies and engaging all the stakeholders?

Digital REACH/EAHRC - *(Dr. Jean Ndirabega, ES, EAHRC)*

Objectives

- Digital initiative to forecast and bring ICT within health systems in East Africa.
- Maximize the enabling environment for digitization.
- Ensure leadership, information sharing, and infrastructure go together with programmes.

Successes

- A health cloud – stores real time data from the regions.
- Medicine and link to the region.
- We have nine programs that will be implemented regionally but will start with the following four:
    - East Africa health cloud
    - Telemedicine
    - Surveillance
    - Capacity building of workforce

Challenges

- Need for further mobilization.
- How to align this digital reach to benefit the region.

CB-HIPP/Intelsoft - *(Stephen Wanyee, Program Manager, Intelsoft)*

Project Objectives & Activities

- Improved patient tracking and improved care
- Global goods- bringing together solutions
- Open health information exchange- global community on interoperability

Digital health should stand alongside other building blocks in health. Digital Health is not ICT for health. It has a bigger component of sustainability, and when you start to think of digital health you think more about open sources and open standards.

Some of the key things to achieve

- Improve patient tracking and continuous service to patients across borders through unique health IDs.
- Technology and environment are key in terms of trying to build a national health ID and be able to track down patients.
- CBE – global routes to make countries interact and bring together digital health solutions.
- Interoperability- OPEN information exchange. If a country doesn't have a model when it comes to the information then they can pick it and discuss how interoperability works.
- Consumer and healthcare service - so that we have common terminologies and content.

Challenges

- Lack of widely adapted health care service.
- Capacity of service providers.
- Weak competence on digital health leadership and management – curriculum to be developed.
- Unique identifiers pose challenges around privacy and confidentiality.

Lessons Learned

- Digital health is not ICT in health.
- Digital health interventions linked to health outcomes.
- Government is committed and are willing to support the implementation and the findings that are going to be used in this technology. Implementing regional programs.
- For digital health to work then we must have it as an important component in policy and also in investment.
- EMR are designed by evidence in science. If done correctly and implemented correctly and used meaningfully can result in better health outcomes.

Dr Ahmed Bashir

IGAD/Regional Action through Data (RAD)

Purpose

To enhance the current models of healthcare across sub-Saharan Africa by changing how and why information is collected, analyzed, shared, and used.

Objectives

Aimed at developing innovative solutions through data and technology to:

- Direct the right information to the right person.
- Inform action to improve health outcomes for all.

- Emphasis on supporting cross-border, mobile populations.

Successes

- Evidence of continuity of care: Early reports from *Journey card* indicate that caregivers are often visiting multiple, cross-border facilities to maintain vaccination schedules.
- Member states buy-in and capacity strengthened:
  - Ownership of the tool, with in-house capacity for training and support in place.
  - Uganda national m-Health Committee has approved the use of RAD's CBCm.
  - Survey results indicate that health facility personnel recommend usage of the *Journey card* in more facilities.
- IGAD draft Data Sharing Policy Framework being reviewed by member states through in-country consultations.
- IGAD-Owned Server Set for Configuration in PY4. A July 2019 visit to Djibouti completed the necessary assessments to design and install an IGAD-owned data server.

Challenges

- In order to fully capture the continuity of care and impact, *Journey Card* must scale to additional sites and hard to reach populations.
- Servers at facility level not communicating with main servers.
- Health facility staff overwhelmed by the daily tasks by replicating an already-active paper-based system to the *Journey Card* solution creating a burden to facility staff.
- Limited resources for post-training supervision affects data quality, monitoring, and reporting timeliness.

Plenary discussions Q & A digital health

Questions	Answers
What are the regional and bilateral roles in facilitating digital health? What is the role of the stakeholders?	Their main role is to facilitate regional health by establishing a cohesive policy framework. The national governments must have strong leadership to make policy decisions, and the private sector can come in through investing.

Dessalegn Tasfaye *(USAID/Rwanda Mission Representative)*	*Dr Ahmed Bashir* *(IGAD)* Policy is about communication, and if anyone can move from one country to another and get access to health care then that is a win. We must be clear on what data we are sharing. Is it aggregated of personal data? *Stephen Wanyee* *CB-HIPP-Intesoft* The role of stakeholders should be in collaborating and documenting the evidence from research and then using this evidence to inspire the message to integrate the health care system across borders. *Dr Jean de Dieu Ngirabega* *(EAHRC)*
It was mentioned that there is a need to have unique identification, and now we are told there is a possibility of sharing these unique IDs across borders. What are you proposing? What about the immigration processes? *Evans Sago, MTAPs*	The challenge we have is in the policy framework and the legal frameworks to roll this out and release patient data across borders. *Stephen Wanyee* *CB-HIPP-Intesoft*
How can we use mobile technology in health insurance? This is a policy issue and an issue of political will because the systems are there. We just need to sit and agree on how to push towards having common health insurance. *Dr Sam Ogillo* *(Tanzania Healthcare Federation)*	It is really important to bridge the disconnect between private and public in order to achieve health benefits. The building on of personal record and health data on its own has no value if the value of health data is yet to be understood. People are yet to see the value of health data. *Stephen Wanyee*

	CB-HIPP-Intesoft
My question is on supply chain. What are we doing about facility tracking and patient tracking? RAD is doing a good job on patient tracking but is there a way we can have an integrated system that also tracks stock visibility? *Tedious Owiti* *(International Organization for Migration)*	We are looking at it as logistics and we do regularly send back the data to the KEPI and UNEPI to show them how many tabs we have given over that period. So they can use it in logistics. It is immense and we therefore use it to track and identify in treating an MDR TB on a daily basis. How can they get their medication in their local activity in their village? With such technology then the information goes back to the home hospital that the treatment has been received. *Dr Ahmed Bashir* *(IGAD)*
Shouldn't we empower our EAC hospitals through training and then link our EAC hospitals for referrals to happen across borders? How can we use the capacity of our youth who are highly innovative in the area of ICT? *Moses Ndhiro* *(EASTECO)*	The role of service delivery is on providing services and not training. For now, we can only look into the capacity of our hospitals to equip them enough to handle cases. Therefore, during phase one we will link the learning and capacity building, then increase and link all health services. *Dr Jean de Dieu Ngirabega* *(EAHRC)*

Closing Remarks: *Dessalegn Tasfaye (USAID/Rwanda Mission Representative)*

There is a lot to be done in standardization, and all countries can use the same standards to implement in their home countries. In Rwanda we have been using EMR since 2014, and the use can be adopted in other countries. To give an example, EMR data quality is 80 percent and Rwanda is moving EMR to improve patient identifiers. We need to work hard on that. We have foundation systems that need to be the same and be able to identify interoperability for purposes of improving cross border health services.

Medicines Regulation and Harmonization/Pharmacovigilance

Panel Presentation - medicines regulation and harmonization/pharmacovigilance
Moderator : Wairimu Gakuo

John Patrick Mwesigye, Senior Health Officer, EAC **PHARMACOVIGILANCE SYSTEM STRENGTHENING IN EAC**
Purpose: To support the establishment of a regional system to track safety and quality of medicinal products and address health risks that transcend borders. **Overall Objective:** To establish a Pharmacovigilance (PV) system that facilitates detection and data sharing on safety and quality of medicinal products and any change to their risk-benefit balance with a focus on the therapeutic category of ART, anti-TB, maternal child health, and reproductive products: • Putting in place a system for monitoring safety and quality of medicinal products to improve the management of risks of substandard and falsified products that transcends borders, • Integrated information management system and databases for pharmacovigilance to facilitate information and work sharing, • Building regional capacity to implement EAC pharmacovigilance program for vulnerable and cross border population, **Successes** • Project supported EAC Secretariat to present in two international fora. • Reinstated the Regional Experts Working on Pharmacovigilance and Post Market Surveillance. • Piloted medicines safety and poor quality tools at of Namanga cross border area in Feb. 2019. • Approval of the EAC Harmonized Compendium on Safety and Vigilance of Medical Products & Health Technologies by the 18th Sectoral of Ministers of Health on 26th March 2019 (EAC/SCHealth/18/Decision 17). • Establishment of partnership and synergies with private sector, industry, institutions of higher learning, patient associations, CSOs, donor partners, and IGAD. **Challenges** • There is no current data on the status of medicines or levels of substandard and or falsified medical products for the region (regional operational research required). • Porous borders still an issue for the countries to address some of the issues on substandard and falsified products. • Maturity of partner states, technical and financial capacities is at different levels. • Limited or no support availed to some of the partner states comes as one of the limiting factors to the success of the project. • Preparation and finalization of an implementation letter seems to be lengthy (two to three years framework plan might work better).

Lessons learned

- All medical products should meet quality, efficacy, and safety requirements.
- There is a high level of commitment across partner states (from experts to policy makers).
- Regional approach to regional challenges can achieve faster than going it alone.
- Development partners financial and technical support can be a key catalyst in fast tracking and fostering regional integration through regional projects and programs.

Anthony Torotich, Medicines Regulatory Harmonization Specialist, IGAD

Medicines Regulatory and Harmonization

Purpose: Monitoring the quality of medicine across borders, registration, supply, and pharmacovigilance.

Achievements

- Mapped Registered Medicines in selected IGAD member states (ET, KE and UG) to those that were WHO-prequalified as at April 2016.

Challenges

- Focus on few regulatory areas: PMS.
- Lack of private sector engagement.

Lessons learned

- Regional dynamics in post-market surveillance slightly different from national issues and need to be considered.
- Partnership and ownership by the member states and the private sector remain a cornerstone to successful implementation of regional regulatory interventions.
- Sharing information amongst member states NMRAs is key to enhancing access to safe, quality medicines and control of SF medicines.
- Collective selection of products based on the public health importance will enhance impact of MRH activities.
- Expansion to new regulatory areas: registration, clinical trials, pharmacovigilance.
- Storage and medicine handling is critical in maintaining quality of medicines.

Stephen Kimatu, Project Director, PQM

Promoting the Quality of Medicines (PQM) Program

Purpose: To implement a system for monitoring safety and quality of medicines used in MCH, FP, TB, HIV/AIDS at selected cross border points.

Activities:

- Establish a Regional Expert Working Group (EWG) on Pharmacovigilance (PV) and Post-Market Surveillance (PMS).

- Implement a survey to determine the prevalence of Substandard and Falsified (SF) MCH-FP/TB/HIV-AIDs medical products in select IGAD cross-border areas.
- Provide technical input on PMS survey manuscript.

Successes

- In collaboration with IGAD MRH, successfully established the IGAD Regional EWG for PV/PMS that led and implemented regional PMS.
- Member states conducted first-of-its-kind regional cross-border PMS with focus on oxytocin and amoxicillin dispersible tablets (DT) and amoxicillin suspension.
    - Piloted risk-based PMS training with Uganda NDA as TOT.
    - Trained IGAD EWG on risk-based PMS and facilitated protocol development.
        - *Results: Assay: Amox (DT & Suspension) -100% Pass; 21% oxytocin - Fail. Not Registered: 72% oxytocin, 30% Amox DT, and 26% Amox suspension*
- Facilitated baseline self-assessment of national PV systems.
- Provided technical review of draft PMS manuscript.

Challenges

- PMS capacity varies among member state MRAs (e.g., countries with less developed PMS systems need additional support).
- Utilizing data from member states to take national regulatory actions requires regional mutual recognition and/or policy convergence.
- Security concerns in select border areas barred sampling thus preventing MRAs from gaining medicine quality information in these areas.
- Sustainability of PMS activities (e.g., participation of some member states was impacted when USAID funding was not available).

Lessons learned

- Having an EWG comprising the heads of PMS and PV units facilitates decision making and regional reliance (e.g., MRAs agreed to accept test results from member state ISO accredited lab).
- Regional expertise is available (e.g., Uganda NDA led TOT for PMS protocol development) and networks (e.g. IGAD and EAC) can benefit and become self-reliant.
- Contextual realities (e.g., access to remote areas) must also be considered when developing PMS survey protocols.

Plenary discussions Q & A - medicines regulation

Questions	Panel Responses
This goes beyond access and assessing quality medicines. From what we have heard, regional harmonization works but how do regional strategies apply to the country levels? With the harmonized pharmacovigilance policies and guidelines this would eliminate the need for individual guidelines for each country. The Journey to Self-Reliance can be made easier if we acknowledge our capacities and utilize these to sustain programs. We challenge the programs to do documentation and dissemination of evidence and regulations so that they can be read and adopted. *Dr Ndinda Kusu,* *MTaPs*	Currently, we have an effort to ensure the pharmacovigilance efforts are shared with others in the regional so that we can move together. It is not easy to assume that one work done in a regional sector can be accepted and hosted by individual countries. There is still a high level of scrutiny that it still needs to undergo at country level. *John Patrick Mwesigye,* *Senior Health Officer, EAC*
It is important to start working and to walk the journey together. Involve us so that we can be able to put in our efforts and understand and walk a common journey. Whatever we are doing is for the good of the patients. Harmonization of the implementation is valuable. We like the idea of harmonization of regulations but the important thing is to ensure the information is disseminated. *Dr Anastacia Nyalita* *Kenya Welfare Federation*	The main challenge with dissemination has always been the quoting of figures that are not scientific and also the fact that many of these studies are done in silos. We should want to encourage all the stakeholders to synchronize and even conduct these studies together within a common agenda so that we have harmonized results. We also accept that most of the work has been done within our agenda and calendars and that in future we could communicate our schedules with the private sectors. *Anthony Torotich,* *Medicines Regulatory Harmonization Specialist, IGAD* You must ensure a regional integration so we do not lose the progress made so far. The environment of the private sector is to work hard to ensure that the capacities of manufacturing capacities in the region is assessed. There is a need for everyone to get on board so that we can

	be able to move together. We would like to continue to engage the sector especially in cases where you find that public insurance schemes don't work with the private sector community. We must understand what the needs of both sectors are and harmonize. *John Patrick Mwesigye,* *Senior Health Officer, EAC*
You have mentioned the issue of drug failure and the facts that it could be an issue of storage. Yes, it may be storage or maybe not. It may be difficult to know especially because this is a supply chain and it may be difficult to be 100 percent sure what went wrong. It could be quality, handling, or storage. How are you sure it was just storage issues? How can we make registration simpler and reasonable? The countries may not have the capacity to evaluate dozes but they ask for the dozes. Quality assurance is important what matters for me is, is the medicine of quality or is it not. But in government, registration is seen as a mark of quality and safety. We need to balance the issues of registration and avoid too much bureaucracy which affects accessibility and affordability. *Dessalegn Tasfaye* *USAID/Rwanda Mission Representative*	Majority of failures were due to storage and all oxytocin's must be stored in the fridge. We found the same oxytocin with the same batch numbers were failing in the regions where poor storage was practiced (i.e. there was no refrigeration). Registration is one of the core regulatory aspects that cannot be compromised. We must strengthen the regulatory systems and harmonize the technical guidelines. Once we harmonize the regulation processes, cross border restrictions will be minimized. We also do not want to simplify it so much and compromise the regulation system. If a product has been regularized at EAC then it should just be adopted within the member countries without having to be scrutinized again. *Anthony Torotich, Medicines Regulatory Harmonization Specialist, IGAD*

The issue of storage affecting quality is a big issue especially for medicine stored under the cold chain. The lack of storage supervision highlights what is happening out there. What guidelines are we coming up with and how can regulators implement these guidelines? There seems to be no quality supervision and control and especially for the vaccines. This gives an indication of what is out there. My call is really to have guidelines. What guidelines are we coming out with? *Ivan Onyutta,* *Uganda Healthcare Federation*	Strengthen the quality and safety through training on storage regulations and ensuring that drug safety is adhered to especially during handling and storage. *John Patrick Mwesigye,* *Senior Health Officer, EAC* Storage is a very big problem across the countries. There is limited awareness of the need to have these in good distribution and storage practices. How can we monitor the supply changes, and the quality of what has been approved? Most of the people who work as wholesalers and distribution do not know much about quality assurance. *Stephen Kimatu,* *Project Director, PQM*
What efforts are there on using the same terminologies given that each country has different drug names? What standards are each of the countries using and which mapping is used in broader digital health? *Stephen Wanyee* *CB-HIPP-Intesoft*	I am happy to say the terminologies in medicine are the same. What can change is the description but the terminologies have been harmonized *John Patrick Mwesigye,* *Senior Health Officer, EAC*
What model of support works best in this relationship? From beyond the technical assistance? I hope there is documentation of the different models used by the various RIGOs so that others can also learn from the models that are working since there can never be a one fit for all. *Dorothy Muroki, Chief of Party* *CB-HIPP (Cross Border Health Integrated Partnership Project)*	The agenda at the moment are pharmacovigilance, training of staff, and looking at what has worked well in which country so that we are not reinventing the wheel but adopting what is working so that we can move faster. We want to encourage the RIGOs to synchronize and even have programs together to increase buy ins. We want for example to leverage efforts within each country to cascade these to other regions, for

	example, the pharmacovigilance monitoring and reporting in Kenya is working very well and can be adopted by other countries. *Anthony Torotich, Medicines Regulatory Harmonization Specialist, IGAD*

Concluding Remarks

We are doing good work, and the call is for us to be able to share this information across borders and across organization so that we can leverage and scale up instead of doing the same things by ourselves.

Day 2: Define the critical problems and barriers to achieving positive health outcomes among beneficiaries on the cross-border areas

Highlights from Day 1:

Our sessions yesterday made it clear that there is so much for us to gain when we work together. Traditionally, health has been an area for government, yet the private sector is giving over 60 percent of health services in the country. Hearing from our partners who have been engaged in this region and the diversity of comments and questions from the audience/participants ensured that the discussions on cross border matters were practical and portrayed the true picture. We are at a point in the development space where we must think beyond funding and support. What can we do as a region to ensure that the projects we have at the moment are sustainable and resilient to go beyond us and beyond the donor? This is the journey to self -reliance; regional conversations have to be implemented at the national level.

The thing is to synergize and not to duplicate efforts so that the populations understand the needs. The main issues are the capacity gaps that we have as a region. What are our assumptions when we are looking at these cross-border efforts? What are we actually saying about the facilities themselves and how do they overlay when it comes to providing services and accessing services across borders? On digital health we need to understand and evaluate the cross-border partnership projects and leverage of what is already working. The question to ask now is, what is the readiness for countries to adopt these digital technologies? Finally, on medicines regulation and harmonization, the movement of drugs, the quality and storage of the drug, and the need for registration is critical if we are to improve access to quality drugs.

Wairimu Gakuo, HPN Deputy Office Director/Regional.

The sessions were good. We need to tap into our resources to figure out how we can move the regional conversations into the national levels and transform these conversations into actual work/implementation. How can we tap into these regional, continental, and in-country resources and information, learn, and harmonize these efforts?

Dr Ndinda Kusu, MTaPs

We need to build into existing systems, and we have very substantive resources. And therefore countries need to speak to each other. The systems and the projects need to collaborate and speak to each other and have this as a multisectoral agenda and not work as individual institutions,

Fatuma Adan, Senior Regional Program Coordinator, (IGAD)

There is need to link cross border programs and the national program. The need for communication and integration will make it easier to have linkages between the national and cross border efforts and successes.

Ishrat Husain (USAID/Washington AFR/SD

To give ideas and assignments to regional organizations on how these inter regional teams are becoming more and more important and these are the things that we need to consider and be able to tap into. There are county level standardizations that we need to coordinate and we need to work in collaborations until regional agendas become collaborative and help the agenda to be realized.

Dessalegn Tasfaye USAID/Rwanda Mission Representative

Role of Private Sector

Moderator: Sheila Macharia, USAID/KEA -Health Population & Nutrition

Panel Presentations - Private Sector

<table>
<tr><td>Samuel Ogillo, Chief Executive Officer at the Association of Private Health Facilities in Tanzania, APHFTA)</td></tr>
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Objectives

- APHFTA implements a wide range of programs in the private health sector through the support of development partners, members contributions and APHFTA's investment profits.
- Improving and sustaining the quality of health care in healthcare facilities.
- Strengthening and sustaining private health sector's influence in the district, regional and national levels.
- Imbedding use of ICT in the private health sector.

Successes

- Collaboration with national disease control programs at local and central government levels.
- An innovative specialized microfinance facility, owned 99 percent by APHFTA.
- AMiF is a social investment designed to provide loans that will deliver positive social impact which includes:
  - Ensuring availability of medicines and other essential medical supplies at all time- no stock-out.
  - Affordability of medicines and other healthcare services to the target populations.
  - Ensure facilities access quality medicines from registered suppliers (reduced counterfeit drugs).
  - FP, improved maternal health, reduced child mortality and combated HIV/AIDS, malaria and other diseases.
  - Aims to empower women and poor communities (80 percent of ADDO owners/sellers are women)- with positive economic impact.

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<tr><td>Danny Mutembe, Founder and CEO of MD Conseil Medical Supply

Rwanda Health Care Federation</td></tr>
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Objectives

- To ensure, maintain and safeguard the interests, privileges, and welfare of its members and of the private healthcare sector in general.
- To provide advocacy for the private health sector to the government, development partners, other related stakeholders and the general public.
- To promote the exchange of ideas among those involved in private health care provision.

Successes

- Advocacy for seven associations among others.
- Approached by the Ministry of Health to bring together governments and nonstate actors,

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and we made deals. Government started treating us seriously.

- Training for members of federation for the first two years
- Geographic Information System (GIS) data on health facilities.
- Pharmaceutical regulatory monitoring systems – we have a local invention on this and it is slowly been adopted by pharmacists RIMS.
- Babyl- digital healthcare provider, with doctors on call and can send online prescriptions .

Challenges

- Self-sustainability.
- RHIA prices.
- Access to financing.
- Counterproductive policies.
- Initially had a problem with prioritizing what needed to be done first.

Dawit Moges; Owner and CEO of Sr Aklesia Memorial General Hospital and Hema Advanced Diagnostic Laboratory. Ethiopia Health Care Federation

It is the youngest federation compared to the other federations. Received seed money from USAID.

Activities

- Giving trainings on health management and finance.
- Monitoring and conducting mobile VCT programmes.
- To help the cross-border collaboration to work with other countries. It is hoped that the launch of the cross - border coordination and collaboration system will improve coordination among the federations.

Challenges

- Resistance by professionals to participate in the federation as members, yet they all benefit regardless of whether they are members or not.
- The secretariat is not capable of doing so many things at the same time.
- Lack of right/adequate facilities.

Successes

The government is very positive in the involvement of the private sector and have accepted the calling.

Ivan Onyutta, Advocacy and Programs

Uganda HealthCare Federation

Objectives

- Address issue of quality of care and services
- Improve human resources for health for Uganda

- Training health institutions

Successes

- Inclusion on key policy taskforce and committees
- Dedicated PPP Technical Working Group
- Health Policy Advisory Committee
- UHC Inter-Ministerial Committee
- Input on the National Development Plan
- Self-regulatory Quality Improvement System for private sector

Challenges

- Lack of specialist staff
- Out-of-date skills with few training opportunities
- Wide variation in quality of services with limited Ministry of Health supervision
- Client inability to pay for services
- Poor data reporting practice
- Weak business and finance management skills
- No deliberate alignment to overall health sector planning or focus areas
- Difficulty in retaining staff who prefer MoH working conditions and benefits

Lessons Learned

- Private sector is not just about the money. Inclusion of the private sector can improve service delivery and facilities.
- The infrastructure is already there, and the private sector can come in to deliver services in hard to reach areas.

Plenary Discussions, Q&A: Private Sector

Questions/Comments	Response
Do you have the bandwidth for a regional approach? If we are going to harness the private sector, and ensure the cross-border matters are attended to someone needs to be engaged, have you identified the platform where you have convening power and political power to put forth your ideas?	First, we are many federations, and yes, they have been working individually. However, we were promised to get a seat in the AU, and this would be critical in forming a platform for an Africa healthcare federation which will now have a regional perspective. This would make the private voice even louder than before. *Dawit Moges*
Countries are talking a lot about UHC. As the private sector what can you contribute towards this conversation?	The cooperation and collaboration have been seen and are doing well. Leveraging on the strengths of the private sector, especially in reporting and showing results, can be used to develop policies and regulations. There is also need for political

Finally, on the issue of equity, what are you doing collectively? *Sheila Macharia*	good will from the government side to help cascade some of the piloted activities we have at the moment. *Danny Mutembe* The private sector is recognized in the collaboration of the integrated health services across the borders, and there was a tie between policy and integrated health services. Having policy in collaboration is very important, and we now sit on the policy making bodies. The federations are already there, and the platforms are there. The global financing facility has a private sector platform with regional hubs, and these are things that work in terms of scalability. *Ivan Onyutta,*
How are you engaging with national information systems, and what are the barriers that you are facing in trying to feed your efforts into the national systems? *Stephanie Watson-Grant*	All countries in East Africa should have one health system. However, when the donors come in, they say they are only supporting the public and not for private. We should agree that healthcare is one thing and it should be done across by all actors. We are all willing to do it but we are doing it in different ways and we only need to link. We are working very well as one team in the private sector. *Samuel Ogillo*
This is a good time for the private sector to show their role in improving health care. However, I am disappointed that none of the panelists mentioned the role of the private sector in digitization and increasing digital technologies in the region. It has been shown that digital technologies increase access and affordability of health care services. There is need to share information amongst the countries so that the role of the private sector can be clear and uniform. *Ishrat Hussain*	The private sector is way ahead in developing digital technology medical assistance, but the government is still behind in adopting these policies. We need support so that we can transform this into bigger sustainable efforts. *Samuel Ogillo*

Comments from the participants
In Kenya, private sector is seen as a for profit organizations. We are growing stronger and many governments are not seeing us or considering the important role played by the private actors. *Dr Elizabeth Wala*   From the IGAD perspective I am happy that Ethiopia and Kenya are doing a lot. We need to extend this to the other countries to come on board to join the conversations, and if we go through the IGAD platform would be useful and the private sector can be supported. *Dr Fatuma Adan,*   We have a drive for new members to scale up our own capacity and collaboration and the new members that we are targeting, such as Djibouti and Sudan. Our vision is that we must take up the challenge and ensure we scale up what we do and that which we plan to do in the future and determine how widely we exist and how we add value to the world. *Dr Anastacia Nyalita*   I am happy that the federations are doing well. When I look at the private sector, I see it as a way for innovation, excellence, and access. I can imagine access has been there and has been used in terms of innovations and standardizations. We need these innovations to become the reality. We seem to have a conflict between private and public institutions, but the issue should be how we can provide services to the populations and how we can support one another. If we provide services within the effective policies then that will be good, and can be ground for further partnership between the private sector and other stakeholders. *Dessalegn Tasfaye*

Closing Remarks: There is so much learning, but the question should be how do we do this. Must the learning be just within the region or can it be from other regions as well? We seem to have policy challenges, and there are opportunities for cross learning. There is so much work going on and so much opportunity, and the Kenya Housing Federation has shared what is going on. As the private sector you have a space at the table to have these discussions and put your ideas forward. As we develop the vision then donors can start to think about this and as a region we must also begin to look critically into this vision. (*Sheila Macharia*)

Group Activities

On the second day of the forum, participants brainstormed on three case studies which highlighted three key areas of intervention, TB, malnutrition, and family planning. The groups were to identify the obstacles presented on the case studies, propose main points of intervention, and suggest the roles of specific stakeholders who are/could provide these interventions. The participants were divided into three groups, each addressing a case study on TB, malnutrition, and family planning as follows:

Case Studies

Group 1: Case of Hope (Family Planning)

Moderator- Kelly Wolfe/Notetaker- Sam Mwangi/ Presenter - Dr Elizabeth Wala

Hope, is a 19 year Kenyan girl who *lives in Omeri estate in Busia town, Kenya with her 55 year old aunt Susan, who is a fish trader. Depending on the market, Susan often crosses the border to Uganda to buy or sell fish. Hope dropped out from Busia Township Mixed Secondary School after getting pregnant while in form one. Every day, she has to cross the border to Busia town on the Ugandan side to seek casual work which is hard to come by and is sometimes forced into commercial sex work to eke out a living. Hope is not planning to have another child soon so her friend advised her to visit the family planning clinic at the local health center where she gets her pills. Since she has been spending more time during the day on the Ugandan side, she visited a local clinic to get the pills but she was turned away since she doesn't have Uganda National ID. Hope has a Kenya National Health Insurance Fund (NHIF) card which she laments is not accepted across the border.*

Group 2: Case of Juma - Hope's husband(TB)

Moderator- Kimberly Smith/Notetaker- Maureen Onyango/Presenter Dr Ndindi Kusu

Hope's boyfriend, Juma is a truck driver *who operates his truck mostly from Mombasa to ferry cargo to destination in Uganda, Rwanda, Burundi and South Sudan. He was recently diagnosed with TB and put on treatment. The long trips are wearing him down, and sometimes he has had to skip treatments. Sometimes he is on the road across the border the day he is supposed to receive his next treatment and has to wait until he is back home to get his treatment. He has been warned about the potential consequences of not completing treatment but he does not know what else to do.*

Group 3: Case of James - Hope's son (Malnutrition)

Moderator - Fartun Yussuf/Notetaker - Lucy Mogeni/ Presenter John Patrick Mwesigye

***Hope's 4- year old son, James**, has recently begun kindergarten. Hope is concerned that James is not gaining as much weight as she expects for his age. He is often left in the care of his aunt, Susan but because she also has to travel across the border, James spends a lot of time with a neighbor who also has young kids. Hope recently took James to the nearest health center where they weighed James and although they were too busy to talk to Hope, they did refer her to the Busia County referral hospital, but she has not been able to make it there because of the distance.*

Using the problem tree model in which the roots of the tree represented the problems/obstacles, and the branches and trees presented possible solutions, the participants were able to come up with numerous intervention points to deal with the problems identified.

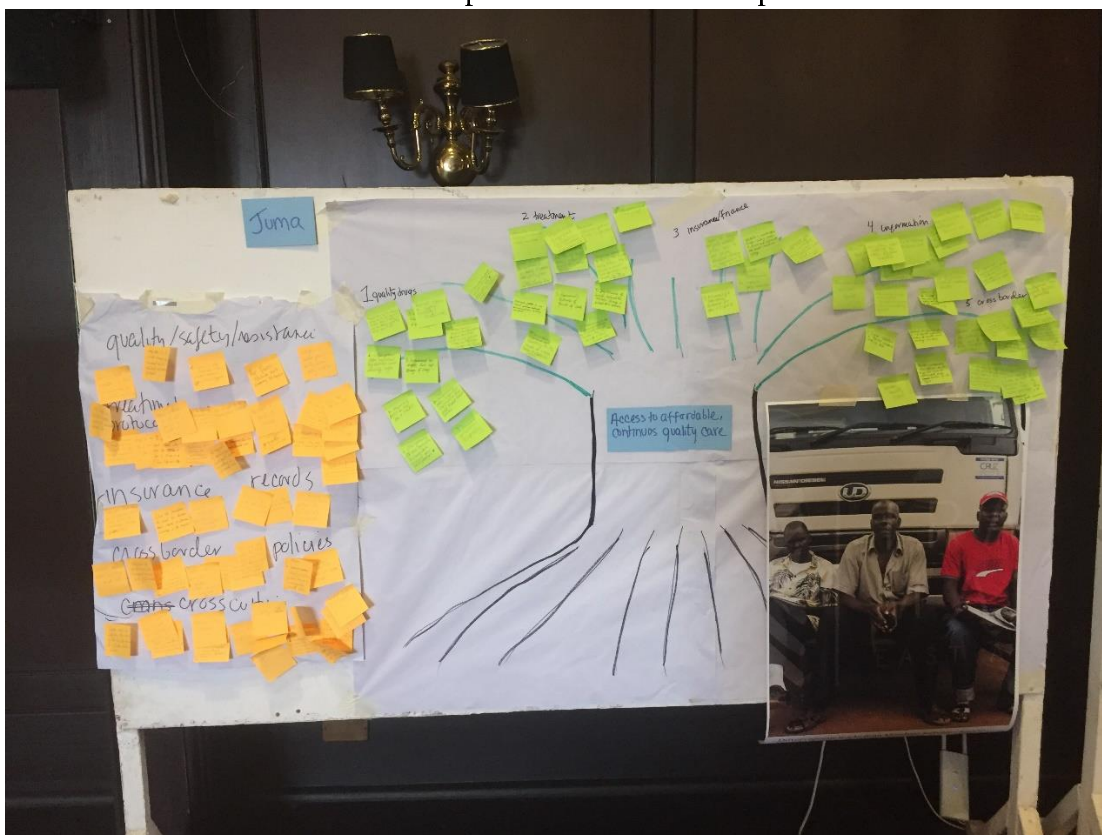

Figure 2: Problem tree- Case of Juma

Final problem analyses and intervention points

Each of the groups presented their findings based on main obstacles which was to build into a problem statement. After developing the problem statement, the group was to then suggest interventions. The following section summarizes the results from the groups.

Problem Statements presented by the participants.

1. Access to affordable continuous quality of care.
2. Inadequate capacity at all levels (regional, national, cross border, local).
3. Inadequate regional harmonization and implementation of national policies to address cross border health system gaps.
4. Weak cross border health information systems.
5. Access to health services.
6. Increased risk to diseases.
7. Lack of Regional policies to regulate regional health systems.

Main impact interventions identified

1. Regional network for the supply chain of quality drugs.
2. Harmonized medicine regulations and guidelines.
3. Digital platforms for treatment, monitoring, referral, and adherence.
4. Regional health financing policy that leads to regional comprehensive health insurance.
5. Establish interoperable health information systems.
6. Create and sensitize regional frameworks for adoption by partner states.
7. Improve knowledge management to inform and advocate for cross border policies.
8. Strengthen capacity and commitment of RIGOs to carry out their mandate.
9. Digitization and interoperability of cross border health information systems.
10. Standardization of national curricula and in-service training.

Summary of different stakeholders' input on their role in addressing the problem

Interventions	Who
• Alternative livelihood and income generation	Government, the Private Sector, CSO
• Training of private sector providers • Mobilize and strengthen regional private sector • Standardization national curricula and in-service training	Private Sector
• Availability of family planning products in private sector facilities	Private sector
• Establish interoperable health information systems	EAC
• Portability of health insurance • Regional health financing policy that leads to regional comprehensive health insurance	EAC, Member States & Private Sector
• Policy harmonization • Create and sensitize regional frameworks for adoption by partner states	EAC & IGAD
• Mapping of key actors and drivers of risk	Research Center
• Cross-border health minimum package	EAC & IGAD
• Dialogue between private and public sectors	EAHP
• Work through different associations (Beach Management Unit for fishing sector; truck drivers)	EAHF & LVFO
• Health education, counseling and distribution of free SRH products	CSOs
• Regional agency for the supply chain of quality drugs	EAC & IGAD
• Harmonized medicine regulations and guidelines	EAHP
• Digital platforms for treatment, monitoring, referral, and adherence • Strengthen capacity and commitment of RIGOs to carry out their mandate	EAHF & LVFO

Feedback from participants

Following the event participants were asked to complete a brief evaluation. Out of 11 total respondents, 100 percent agreed that they were satisfied with the event and that the presentations were effective. Nearly all respondents agreed that the objectives of the event were met and the event materials were satisfactory. Participants praised the insightful discussions, the opportunity to share and learn from colleagues, and the innovative structure and facilitation of the event – specifically the case study exercise which enabled participants to think outside the box. Feedback was overwhelmingly positive.

Closing Remarks and Vote of Thanks

You will all agree that these last two days have been intense. We had the chance to discuss and deliberate on pertinent issues on cross border health services and went ahead to brainstorm on possible solutions to the obstacles we identified. We are very grateful to all the participants and humbled to have had the chance to hear your thoughts and expertise on these key issues. As stakeholders, the work you have done in these two days is very important as it will inform decisions during deliberations to develop future interventions or project ideas that focus on sustainability and the Journey to Self-Reliance.