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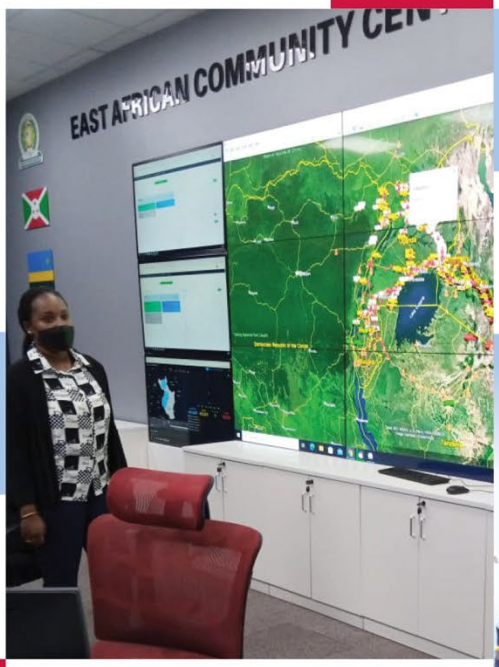

Landscape Analysis Report

LHSS East Africa Cross-Border Health Activity

LOCAL HEALTH SYSTEM SUSTAINABILITY PROJECT

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Local Health System Sustainability Project

The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support access to universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year project will build local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

Recommended Citation: The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ. *March 2022. Landscape Analysis Report: LHSS East Africa Cross-Border Health Activity.* Rockville, MD: Abt Associates.

Date: March 2022

Submitted to: Scott Stewart, Task Order Contracting Officer's Representative, USAID Bureau for Global Health, Office of Health Systems

USAID Contract No: 7200AA18D00023 / 7200AA19F00014

Cover photos: Photos courtesy of Francis Kangwana.

This report was made possible by the support of the American people through the United States Agency for International Development (USAID). The contents are the sole responsibility of the authors and do not necessarily reflect the views of USAID or the United States government.

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Acknowledgments

The authors gratefully acknowledge insights offered by stakeholders and partners included in Annex C. We are particularly grateful for the collaboration and guidance received from USAID Washington, USAID Kenya and East Africa, the East Africa Community, and the Intergovernmental Authority on Development. The activity team is also grateful to its local consultants and LHSS consortium partners for their contributions.

Acronyms

CB-HIPP	Cross-Border Health Integrated Partnership Project
CBHI	Community based health insurance
CSW	Commercial sex workers
DHIS2	District Health Information System 2
EAC	East African Community
EAHRC	East African Health Research Commission
EMR	Electronic medical records
FGD	Focus group discussions
GBV	Gender-based violence
GESI	Gender equality and social inclusion
HMIS	Health management information system
HMT	Health management team
ICT	Information and communication technology
IGAD	Intergovernmental Authority on Development
IOM	International Organization for Migration
KII	Key informant interviews
KM	Knowledge management
LGBTQI	Lesbian, gay, bisexual, transgender, queer, and intersex
LHSS	Local Health System Sustainability Project
MOH	Ministry of Health
MOU	Memorandum of understanding
NHIF	National Health Insurance Fund
OOP	Out-of-pocket
RAD	Regional Action through Data
REACH	Regional East African Community Health
RIGO	Regional intergovernmental organizations
RIGO SSA	RIGO System Strengthening Activity
SOP	Standard operating procedures
STI	Sexually transmitted infection
TWG	Technical working group
UHC	Universal health coverage
USAID	United States Agency for International Development

Executive Summary

Mobile and vulnerable populations in Eastern Africa crossing the national political boundaries of countries face heightened risk for numerous illnesses, including HIV infection, tuberculosis (TB), malaria, and other infectious diseases. These issues are compounded by high rates of maternal and child morbidity and mortality, and stunting due to food insecurity in the region. Various other shocks—whether related to economic, conflict, environmental, or disease factors—can push these vulnerable and underserved populations into a vicious cycle of poverty and ill health.

The Local Health System Sustainability (LHSS) East Africa Cross-Border Health Activity aims to increase access to and use of affordable, quality health care in cross-border areas, building upon the USAID-funded Cross-Border Health Integrated Partnership Project (CB-HIPP). During the Inception Period, a four-month phase from December 2021 to March 2022, the activity completed a qualitative landscape analysis related to health information systems, health financing, and service provision within five cross-border site locations, in order to generate evidence on work plan objectives and cross-cutting issues. The analysis served to establish a baseline understanding of current cross-border health challenges and opportunities, and determine organizational and technical capacity gaps to address within key stakeholders like regional intergovernmental organizations (RIGOs) charged with leading cross-border health initiatives. Specifically, this analysis report will be used in the following ways:

1. Identifying indicators to gauge areas of activity impact and success;
2. Soliciting buy-in and commitment from key stakeholders to ensure local ownership and impact beyond the life of the project;
3. Determining organizational and technical capacity gaps to address within RIGOs; and
4. Establishing a baseline understanding of current cross-border health challenges and opportunities, which serves as a knowledge base for implementation in phase two of the activity.

By interviewing over 90 regional, national, and cross-border health representatives in 42 interviews, the activity identified the following areas that were further reviewed, validated, and refined with stakeholders during the official activity launch/consultation meeting from March 23 through 24, 2022.

Objective 1—Improved and Digitized Cross-Border Health Information Systems in Cross-Border Areas: The activity seeks to improve policies and regulations for information sharing, and the interoperability and digitization of health information systems across borders. Landscape analysis findings revealed that all five cross-border sites have functional health management information systems (HMISs), guided by their respective country regulations, as well as dedicated HMIS staff responsible for data management and quality assurance, with varying technical capacity across sites. However, harmonized guidelines for health data sharing and protection do not exist, hindering effective referral and follow-up of patients in cross-border sites. Sites have parallel patient registration systems, both paper-based and electronic, and some established informal mechanisms of sharing patient data (e.g., WhatsApp, sync framework systems, and written patient records). However, such tools are inconsistent among border sites and are unregulated. Electricity is available at all cross-border sites, although with disruptions, but all sites have power backup systems. Internet connectivity remains sub-optimal, though if this is addressed, along with HMIS capacity among facility staff, all sites have the potential for enabling digitized and interoperable systems for health information sharing. Further, both RIGOs have developed data sharing and protection policies and guidelines, though the Intergovernmental Authority on Development (IGAD) representatives mentioned challenges with

inadequate staffing and funding resources to execute. Representatives from the East African Community (EAC) noted their data sharing policies were developed in anticipation of a regional data warehouse that will facilitate data sharing across their member states. Under this objective, the analysis brought forth the following areas for activity implementation:

- Coordinate data sharing and systems interoperability through establishing a cross-border HMIS task force comprising of focal persons from member state HMIS teams and cross-border sites.
- Leverage existing relevant health information system structures within both RIGOs, such as by providing technical assistance to the EAC regional warehouse intended to support health data sharing across member states.
- Support the establishment of digital patient registration systems within cross-border site facilities currently using paper-based patient registration systems, ensuring they are interoperable to payment systems and their national HMIS.
- Support the finalizing of guidelines for data interoperability and sharing among member states and RIGOs.
- Build cross-border site capacity to implement data interoperability or sharing guidelines established by EAC or IGAD.

Objective 2—Increased Capacity of RIGOs to Lead the Development and Implementation of Cross-Border Programs and Policies: RIGOs are critical players in the development agenda for East Africa, coordinating its member state governments in areas of trade, food security, peace and security, and health. The very nature of cross-border health work involves coordination between multiple countries sharing borders, placing RIGOs at a key position of authority to ensure adherence to standards and regulations that affect cross-border populations in the region. Analysis findings showed that the roles of EAC and IGAD clearly drew upon existing mandates to identify and address health-related policy gaps, despite no current policies or regulations existing that govern health information systems or health service provision within cross-border sites. Identified bottlenecks were conflicts between member states that strain dialogue and inhibit implementation, and inadequate communication between RIGOs and their member states in programmatic implementation. The analysis found that each of the organizations is capable of leading cross-border health initiatives, pulling from its strong member state commitment to health, core technical health competencies, and regional-level research capabilities—provided they receive targeted strengthening in areas like supporting member state "domestication" (i.e., national adherence) of regional policies and implementing locally-led and sustained cross-border health initiatives. The following are recommended areas of activity intervention:

- Support both RIGOs in revisiting or improving their organizational structure and staffing required for achievement of the vision (i.e., effective and efficient systems, and staff with appropriate capacities to carry out functions) that enable them to play a prominent role in cross-border health.
- Liaise with key cross-border health stakeholders (e.g., public and private facility teams) to map their needs, interests, and potential for contribution in cross-border health work, aligning their support with the RIGOs' vision where necessary.
- Strengthen meeting engagement with both RIGOs to respond to the needs of member states, strengthen intergovernmental decision-making processes with the goal of optimizing effectiveness and efficiency, and improve RIGO and member state communications.

- Strengthen cross-border health platforms at RIGO and cross-border site levels (e.g., technical working groups, taskforces, initiatives, projects) to enhance collaboration, coordination, and alignment of efforts for better synergy and to avoid duplication of efforts and wastage of health resources.
- Form an inventory of developed and executed regional policies, and review obstacles to cross-border policy implementation and consequences of non-implementation for lessons learned.
- Document processes and procedures to respond to staff turnover within RIGOs affecting the ability to implement cross-border health initiatives.

Objective 3—Strengthened Regional and National Financing, Resource Mobilization, and Accountability for Cross-Border Health: Universal health coverage (UHC) is front of mind in the East African region, potentially solidifying wide-ranging support in efforts to expand access to quality and affordable health care services for cross-border populations. Analysis findings revealed that while several national health financing strategies exist, there is no regional-level framework that coordinates strategic planning, mobilization, and allocation of resources for health financing among member states to their cross-border site locations. Though both Kenya and Tanzania offer national health financing arrangements, cross-border populations largely pay for services out-of-pocket (OOP), and are traditionally not covered under schemes largely linked to formal sector employment. The private sector plays a significant role as key provider of services in the region, particularly in providing services like HIV treatment, sexually transmitted infection (STI) testing, and gender-based violence (GBV) services to cross-border populations. Citizenship, along with factors like perceived confidentiality, was noted as a significant factor for cross-border populations accessing either public or private facilities on a particular side of the border. Recommendations for activity intervention are:

- Support RIGOs' ability to advocate for cross-border health financing arrangements, enabling the direct engagement of RIGOs with local cross-border health authorities, and identifying champions to advocate for their national governments to allocate resources for cross-border populations, regardless of their citizenship status.
- Develop a roadmap for success on cross-border health access, mapping the sequence and milestones required to successfully translate member state commitment to action at the point of service delivery.
- Support the design of financial protection options for cross-border populations in coordination with RIGOs, review expansion of existing schemes to incorporate portability functions, and identify opportunities for covering cross-border populations through use of private sector services.
- Formulate a corporate engagement toolkit to support cross-border health access, by reviewing current practices to leverage financing from the private health and non-health sectors at cross-border sites (e.g., provision of health care services for cross-border migrants in search of temporary or seasonal employment), and assist in sharing lessons learned for consideration and replication in other country borders.
- Support strengthening private health provider readiness and services through tailored capacity-development programs to improve their operations and offer better quality services catered to cross-border and mobile populations.

Cross-Cutting Considerations (GESI): Recognizing the LHSS project approach of integrating gender equity and social inclusion proactively into all interventions, the activity used this landscape analysis as an opportunity to review intersecting vulnerabilities and constraints of

women, men, boys, and girls living or moving across the five cross-border sites. Findings revealed that several gaps remain in cross-border populations' access to services across border, affected by sex, age, socioeconomic status, language, and citizenship. Such groups largely access services at private sector facilities, perceiving them to provide greater privacy and confidentiality, as well as to be more safe, less congested, and catering to their unique health needs. The following recommendations identify areas for the activity to embed gender-transformative approaches within its interventions, across the three work plan objective areas:

- Integrate gender equity and social inclusion (GESI) lens in RIGO-level policies, ensuring that the different categories of cross-border populations are outlined, along with their health needs, risks, and ways to improve their access to care.
- Include representatives of cross-border populations at the table with RIGOs and member states in planning and priority-setting for cross-border health, ensuring that changes and actions resonate with the people ultimately impacted.
- Ensure confidentiality in data sharing mechanisms, and communicate assurances to cross-border patients in order to build trust and encourage use of services.
- Support RIGOs in disaggregated data review and addressing any gaps identified in member states and cross-border sites, ultimately for use of data in informing resourcing and improving health worker competencies.
- Designate cross-border focal points for health equity to support implementation of existing GESI-related strategies at cross-border sites.
- Support RIGOs to advocate for key populations by ensuring balanced leadership and representation of women in management positions to safeguard resourcing for women's health issues.
- Use knowledge management (KM) functions for GESI, leveraging existing knowledge sharing platforms to hold joint learning and knowledge exchange workshops with RIGOs and cross-border health stakeholders, and to develop a GESI learning strategy informed by best practices among the various stakeholders.
- Include key population health considerations in portable financing options, ensuring a review of the diverse needs of key populations utilizing such services largely within the informal economy.

1. Introduction

The LHSS East Africa Cross-Border Health Activity aims to build upon the achievements of the former USAID-funded CB-HIPP, implemented from 2014-2020. The activity works in partnership with USAID Washington, the USAID Kenya and East Africa Mission, RIGOs, national and local governments in Kenya, Uganda, Rwanda, and Tanzania, and private sector stakeholders to support the following objectives:

1. Improved and digitized cross-border health information systems in cross-border areas;
2. Increased capacity of regional organizations to lead the development and implementation of cross-border programs and policies; and
3. Strengthened regional and national financing, resource mobilization, and accountability for cross-border health.

The LHSS East Africa Activity has two phases, with the first phase labeled as an Inception Period for evidence generation to gather information on the three activity objectives and cross-cutting issues, such as GESI. This report consists of a complete landscape analysis of cross-border health issues in the East African region—specifically within five cross-border site locations—that will be utilized in the following ways:

1. Identifying indicators to gauge areas of activity impact and success;
2. Soliciting buy-in and commitment from key stakeholders to ensure local ownership and impact beyond the life of the project;
3. Determining organizational and technical capacity gaps to address within RIGOs; and
4. Establishing a baseline understanding of current cross-border health challenges and opportunities, which serves as a knowledge base for implementation in phase two of the activity.

2. Methodology

The landscape analysis sought to develop a current and contextualized understanding of cross-border health issues affecting mobile and vulnerable groups related to the three objective areas and GESI within CB-HIPP's previous areas of implementation. Through a comprehensive desk review, key informant interviews (KIIs), and focus group discussions (FGDs), information was gathered from five[1] cross-border health sites bordering Kenya, Uganda, and Tanzania (see Annex B for a detailed map). Cross-border sites, as defined by CB-HIPP, are locations measuring a 50kms radius from both sides of a border that were identified by significant cross-border movement of people for trade and other purposes. The sites were also selected due to a significant presence of mobile and vulnerable populations, high disease burden, and gaps in health services.

Specific stakeholders that were interviewed within the sites include cross-border health authorities, beneficiary association representatives, port health authority members, peer counselor groups, and private health facility and private pharmacy actors. Other key stakeholders interviewed in the East African region were both RIGOs, EAC and IGAD, Ministry of Health (MOH) officials from focus countries, CB-HIPP and its former partners (e.g., Intellisoft), and relevant USAID-funded regional cross-border projects (e.g., USAID RIGO System Strengthening Activity (SSA)) (see Annex C for a list of all stakeholders interviewed).

This exercise was led by the activity Chief of Party (COP) and Monitoring, Evaluation, and Learning (MEL) Technical Lead, and supported by local consultants and LHSS consortium partners: the Health Information Systems Program (HiSP), Training Resources Group, Inc. (TRG), and Banyan Global (Banyan). Technical oversight and quality assurance were provided by Abt home office staff in Rockville, Maryland.

Defining the Target Population

The analysis's target population is composed of mobile and vulnerable groups crossing borders within East Africa, which consist of various actors with differing health needs. Such groups are differentiated by occupation, age, sex, and social behavior and practices. Communities residing among cross-border sites are seen as vulnerable due to neglect of border communities by national governments, and a lack of resources directed toward their socioeconomic and health circumstances. These groups represent the far-flung areas of the health system encountering multiple barriers to accessing quality health care. Key populations to consider for this activity are defined in Annex D and include men, women, men who have sex with men, transgender individuals, truck drivers, fisherfolk, female sex workers, children and adolescents, and persons living with disability.

Landscape Analysis Policy Questions

The landscape analysis desk review and data collection aimed to explore the following high-level, policy focused areas related to activity objectives and cross-cutting components:

[1] CB-HIPP primarily operated within three cross-border sites bordering Kenya and Uganda, and briefly expanded to three more sites bordering Kenya/Tanzania and Rwanda/Uganda. In conducting the landscape analysis, LHSS was made aware of the Gatuna/Katuna site (bordering Rwanda and Uganda) having been closed for three years due to ongoing geopolitical tensions. Further consultations with CB-HIPP identified similar difficulties faced by the project. Though the site reopened in January 2022, security around the border remains an ongoing concern, stalling the activity's data collection efforts there. LHSS intends to better understand the security situation and weigh engagement against other potential border sites, in consultation with USAID/Washington. Thus, this report focuses on the remaining cross-border sites bordering Kenya, Uganda, and Tanzania, and excluded Rwanda for the time being.

- Health information management policies, digitization, and interoperability systems in the RIGOs, focus countries (i.e., Kenya, Uganda, and Tanzania), and cross-border sites
- Extent to which health information technologies and digitization systems are introduced and practiced in the RIGOs and focus countries
- How health information data is disaggregated, compiled, analyzed, and interpreted
- RIGO-level cross-border health policies and regulations
- Existing RIGO-level health governance structures, platforms, and coordination mechanisms
- How health systems within each focus country respond to cross-border health issues
- Whether portable health insurance is being discussed among countries currently
- Role of government and private sector health facilities and programs in providing services for mobile and vulnerable populations crossing-borders

Please see Annex E for the complete list of policy-focused questions developed to inform final data collection tools.

Desk Review

Desk review was conducted concurrently with primary data collection between December 2021 and February 2022. Materials examined included final project documents from CB-HIPP, such as:

- A regulatory analysis of access to and financing of HIV/AIDS services in East Africa
- Facility capacity assessments at cross-border sites, identifying priority areas for technical assistance
- A multi-country comparison of health care service costs at cross-border locations
- A study on the ability and willingness to pay for health insurance and save for health expenses among cross-border populations in East Africa
- An actuarial analysis looking at the pricing of a portable benefit package
- A comparison of TB standards of diagnosis and treatment across EAC countries

Other CB-HIPP documents reviewed were a MEASURE Evaluation cross-sectional study on health status and behaviors of mobile and vulnerable populations within cross-border sites; MEASURE Evaluation's performance and costing evaluation of CB-HIPP; USAID Kenya and East Africa Mission 2019 stakeholder forum discussion notes; CB-HIPP handover notes; and the final CB-HIPP report.

Regional cross-border health studies and assessments were also reviewed, including, but not limited to:

- The USAID-funded Regional Action through Data (RAD) Digital Health Landscape Analysis
- EAC's Digital Reach Initiative Strategic Plan, 2019-2028
- IGAD's Cross-Border Health Policy, 2021-2030
- IGAD's Social Development Sector Strategy

- The International Organization for Migration (IOM) Framework on Health, Border, and Mobility Management
- Republic of Uganda's Health Financing Strategy, 2015/16-2024/25
- Republic of Kenya's Health Financing Strategy, 2020-2030
- USAID Kenya and East Africa Mission Regional Development Cooperation Strategy, 2020-2025

Moreover, documents uncovered from respondents during primary data collection pertaining to cross-border health issues, or objective areas and GESI, were reviewed simultaneously.

Primary Data Collection

Design

Data collection employed the following qualitative methods:

- KIIs with RIGOs' health team officials and MOH officials;
- FGDs with district, county, and sub-county health management team (HMT) officers, port health authority members, beneficiary association representatives (e.g., truck driver union members, transport and general workers' union members), and private health facility and pharmacy officials within the five cross-border sites.

Interviews consisted of both in-person and virtual settings, with in-person interviews conducted in an outdoor physical space or a large private setting with open windows, in order to minimize risk for exposure to COVID-19. Interviews were conducted by three teams to cover the many geographic areas, with each team consisting of a lead interviewer and note-taker. Lead interviewers were local consultants hired by Abt, and note-takers were either Abt field office staff or partner consultants. Interviews were conducted in English or Kiswahili and recorded with a digital audio recorder with consent.

Stakeholders who were engaged in cross-border health within the five cross-border sites were selected for both KII and FGD interviews. Based on stakeholder availability for interviews, the team then used purposive and stratified sampling methods to select a total of 42 interviews (29 KIIs and 13 FGDs).

For all interviews, lead interviewers read out a consent form along with an introductory summary explaining the purpose of the activity and landscape analysis, and requested consent to be interviewed and for the interview to be digitally recorded.

Data Collection Instruments

The team developed a comprehensive questionnaire based on the high-level, policy-focused research questions noted in Annex E. The questionnaire was subsequently tailored for each stakeholder classification, noted in the below six groups:

1. Cross-border health stakeholders (e.g., sub-county/district health management teams)
2. Beneficiary association representatives (e.g., truck drivers' associations, commercial sex worker (CSW) association members)
3. Private health facility and pharmacy members
4. RIGO and MOH officials
5. HMIS-affiliated entities (e.g., Intellisoft)
6. RIGO-affiliated entities (e.g., USAID RIGO SSA)

Tailored questionnaires per group were dependent upon their role and position relative to the activity objective and cross-cutting areas. Thus, interview lengths varied between 0.5 and 2 hours, depending on the tailored questionnaire used. Please see Annex F for the comprehensive questionnaire, with sections on cross-border health information systems; RIGO capacity; and regional and national financing, resource mobilization, and accountability for cross-border health.

Data Collection Management and Analysis

Lead interviewers transcribed interviews at the end of each data collection day, and uploaded transcriptions and voice recordings to MOVEiT, an automated and secure managed file transfer site for sensitive data. Recordings were deleted from digital audio recorders once lead interviewers had confirmed successful upload to the secure site.

Transcriptions were then uploaded to Abt's Analytic Computing Environment-3 (ACE3), allowing for the use of qualitative tools such as NVivo to analyze interviews across the five cross-border sites and various individual stakeholder interviews. Analysis entailed a thematic review of all transcriptions to pull out major topics and patterns referenced during interviews, providing insights into answers for the high-level policy research questions noted in Annex E.

Study Limitations

The following limitations should be noted for this landscape analysis:

- Purposive sampling, though common to qualitative research, could have introduced some bias in selecting stakeholders for interviews, resulting in nongeneralizable data across the cross-border sites and region. The limited sample size of respondents could have limited information saturation (i.e., the analysis did not capture all possible responses to a question), and also prevents the ability to conduct statistical tests for creating conclusive remarks or relationships. Rather, the analysis was designed to have breadth than depth in order to rapidly identify areas for further exploration.
- Interviews conducted in FGDs may have introduced a degree of group bias, as respondents could have influenced one another's responses. This was mitigated by the team attempting to actively engage all participants in the interview process.
- The spectrum of knowledge on health information systems, institutional capacity, and health financing among respondents was wide, resulting in varied levels of detail among interviews across the cross-border sites.
- Certain stakeholder groups presented biases in providing favorable impressions and perspectives of cross-border health activities. Other manifestations of this bias include respondents understating the actual situation or circumstances in anticipation of potentially receiving donor-funded support.
- Interview bias remains inherent to qualitative analyses, where the nature of semi-structured interviews, and the use of multiple interviewers, present varied levels of quality in data collected. The team mitigated these biases by limiting the number of interviewers in the study.
- Given the breadth of information requested from respondents, the length of time during interviews limited the ability for additional probing and follow-up questions by interviewees.

The following sections provide results of the landscape analysis per objective area—on cross-border health information systems; the capacity of RIGOs to lead cross-border programs; and regional and national financing, resource mobilization, and accountability for cross-border

health—including the major thematic areas under each objective as well as GESI-focused findings. The summaries and preliminary recommendations section provide exploratory action items based on the themes uncovered to review and validate during the planned March activity launch/consultation meeting with key stakeholders.[2]

[2] The LHSS East Africa Activity launch/consultation meeting is planned for March 23-24, 2022, in Nairobi, Kenya. Proposed attendees are cross-border health authorities from both sides of the border within the five cross-border sites; representatives from EAC and IGAD; representatives from MOH focus countries; USAID Kenya and East Africa Mission and bilateral Missions; and the LHSS East Africa Activity team.

3. Objective 1 Findings: Improved and Digitized Cross-Border Health Information Systems in Cross-Border Areas

Context

Sharing health data across countries is paramount in promoting continuity of services and improving surveillance systems for illnesses, with digital technologies offering potential solutions to collecting, managing, using, and communicating priority health data. In the East African region, however, there has been a lack of collaboration on ensuring interoperable health data in facilities across border countries. Main barriers are reportedly the lack of standard indicators and standard operating procedures (SOPs) for cross-border health, endangering patient privacy and confidentiality when health data is shared—particularly for mobile and vulnerable populations. Other barriers include the absence of communication mechanisms across neighboring border sides that limit effective patient referral, defaulter tracing, and continuity of care.

Furthermore, most cross-border health facilities within the East African region rely on paper-based systems, with very few (largely bordering Kenya and Uganda) using a digital HMIS to track service delivery indicators. Alternatively, health facilities along major regional transport corridors (spanning areas within Kenya, Uganda, Tanzania, Rwanda, and Burundi) report through their national HMIS, albeit with varying reporting rates.

To lay the foundation for digitization within the region, both EAC and IGAD have made recent progress in developing strategies for member state adoption. In 2019, EAC launched the Digital Regional East African Community Health (REACH) Initiative, a set of regional programs to apply information and communication technology (ICT) across country health sectors. The initiative's 2019-2028 strategic plan included a workstream component on identifying and developing common guidelines, standards, and protocols for an effective regional digital health ecosystem. Similarly, IGAD with the support of USAID through the RAD project developed a data sharing and protection policy and implementation guidelines, and noted the need to build member state capacity to implement the policy.[3] The following sections detail landscape analysis findings on the readiness of activity cross-border sites to facilitate data interoperability and a digitized HMIS, which will enable LHSS to better liaise with both RIGOs in implementing strategies on continuous information sharing across border sites.

[3] The LHSS East Africa Activity is awaiting access to both EAC and IGAD's digital health strategic plan and policies. Information on whether member states contributed to the development of both documents, and support cross-border level data sharing and use, is to be determined.

Intervention 1.1: Improved Policies and Regulations for Information Sharing and Interoperability of Health Information Systems Across Borders

Summary of Findings

From the activity work plan, Intervention 1.1 entails a review of current health information management policies, guidelines, regulations, and practices that would facilitate data interoperability across systems, allowing for continuous information sharing across cross-border sites. The landscape analysis thus appraised the HMIS capacity, data collection practices, reporting and analysis practices, data feedback mechanisms, HMIS regulations and guidelines, and data interoperability policies of cross-border public facilities. Findings (noted below through "sub-themes" pulled out from the thematic analysis of data gathered from desk review and interview transcripts) uncovered that no formal system or guidelines currently exist for data sharing across cross-border sites, though representatives from both MOH Kenya and Uganda indicated future plans to develop those within their countries. CB-HIPP engagement primarily utilized "informal" arrangements for sharing data between cross-border health stakeholders during periodic cross-border meetings.

Data flow processes are similar across all the sites, moving from the health facility level to the national reporting system. There is clarity within each site on their own data collection practices, all utilizing standard tools that provide for data disaggregation, and on data management guidelines specific to each country. There is an absence of harmonized guidelines and SOPs across the five sites for data collection, verification, management, analysis, and quality, given that those available are country-specific.

Sub-Theme 1: Patient Information Sharing and Confidentiality

Analysis findings uncovered that no formal mechanism for patient information sharing exists among the cross-border sites. Formal mechanisms for disease surveillance, however, were mentioned, with MOH Kenya respondents noting to follow the 2006 WHO Guidelines on Communicable Disease Surveillance and Response Systems with other countries in the region.

Alternatively, informal patient information sharing occurs among cross-border health facilities, utilizing various tools like WhatsApp (e.g., Busia health workers reported sharing patient data on the app with other health workers operating at the other side of the border), Microsoft Sync Framework (e.g., North Star Alliance facilities reportedly uses this data synchronization platform that enables facility collaboration and offline usage), and paper-based referral cards (as reported in Sio Port). Holili/Taveta and Malaba were the only sites where health workers reported to not utilize informal processes or mechanisms for patient information sharing between facilities.

Regarding patient data confidentiality, representatives from MOH Kenya and Uganda stated being dependent upon the professional ethics of the individual health worker, and the adherence of facilities to use non-unique patient identifiers, protect patient records at facilities, and aggregate reporting that removes patient identifiers. Beneficiary representatives within Busia, Malaba, Muhuru Bay/Kirongwe, and Sio Port/Victoria/Majanji indicated that cross-border populations are reportedly comfortable with health workers sharing patient information when referring their cases to other facilities.

Sub-Theme 2: Data Collection, Reporting, and Analysis

The desk review examined tools used for cross-border site routine health data collection, analysis, and reporting, and the availability of guidelines for data management. HMTs and North Star Alliance facilities (hereon noted as "facility teams") across all sites stated having standardized, country-specific data collection tools with guidelines on how to fill in forms and capture patient data at various service delivery levels, whether by digital or paper modalities (Holili/Taveta and Malaba reported using paper-based systems, while the remaining sites used both paper-based and digital systems). MOH Kenya and Uganda representatives reported the same, noting that in-country standardized data collection tools exist, but are not consistent with other EAC and IGAD member states.

Facility teams across all sites capture routine health data and use standard indicators to monitor priority health problems. Table 1 summarizes the frequency of data collection and reporting at the sites, with routine data collection occurring daily, certain sites reporting data weekly for the Integrated Disease Surveillance and Response (IDSR), all sites reporting monthly for all other service data, and few sites reporting quarterly on TB data. All data is reported to the sub-county/district level[4] within the same country, which is reviewed for quality and then shared at the national level (Sub-Theme 3 provides more information on data reporting and feedback processes).

Health workers reported experiencing challenges in collecting, documenting, and sharing data such as high workload and different partner priorities (e.g., from donors, private sector, service delivery organizations). Required data disaggregation is noted within the in-country standardized data collection tools. The Government of Uganda instituted a Presidential Directive on digitizing health information that supports data disaggregation, while MOH Kenya developed guidelines on capturing such data either digitally or through paper-based methods.

Facility teams in all sites reported using data mainly for accountability, planning, resource allocation, surveillance, and decision-making purposes. At the RIGOs-level, data can be used by member states for formulating policies, drafting a memorandum of understanding (MOU) and agreements, identifying gaps, supporting resource mobilization, and furthering knowledge management (KM) and research.

Table 1. Routine Data Collection & Reporting Across Sites

Site	Data Collection		HMIS Reporting	
	Daily	Weekly	Monthly	Quarterly
Busia	☑	☑	☑	
Malaba	☑	☑	☑	
Sio Port/Victoria/Majanji	☑	☑	☑	☑
Holili/Taveta	☑		☑	
Muhuru Bay/Kirongwe	☑	☑	☑	
North Star Alliance	☑		☑	☑

Sub-Theme 3: Data Quality and Feedback Mechanisms

In reviewing data quality and feedback mechanisms available at the national level, respondents from MOH Kenya and Uganda noted an inbuilt data validation application embedded within their national HMIS/DHIS2 platforms. MOH Uganda also reported the use of Microsoft Excel for further data verification. Intellisoft indicated other mechanisms used by the Kenyan national

[4] Sub-counties are located within Kenya, and districts are located within Uganda and Tanzania.

government to validate data, such as the Integrated Patient Registration Service (IPRS) and Data for Accountability, Transparency, and Impact (DATIM) system.

At the cross-border site level, facility teams in all sites reported to have mechanisms in place for checking data quality, specifically as data is being collected. A majority of sites reported the availability of guidelines for data quality assessment, and indicated to have staff specifically designated for data quality. Figure 1 summarizes the data flow and feedback processes reported across the sites.

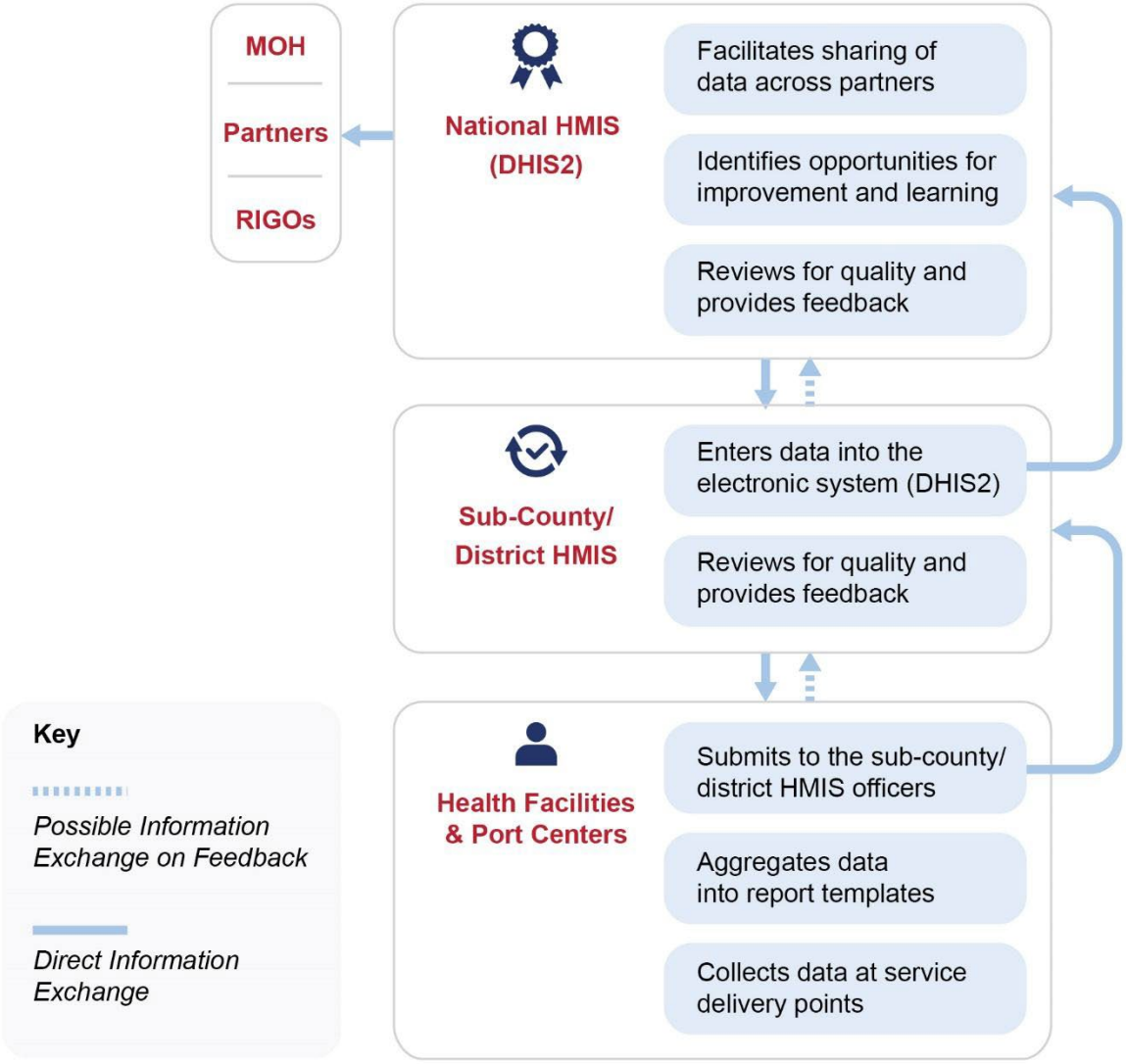

Figure 1. Data Flow and Feedback Processes

Facility teams in all sites indicated receiving written feedback from the sub-county/district health information teams (specifically, joint steering committees on these teams) within the last three months. Facility teams on the Kenya side of the border engage in a monthly sub-county forum, where sub-county teams share and track feedback within the inbuilt HMIS feedback mechanism or through WhatsApp. Cross-border data feedback seems to not exist among these sites; and if so, country-specific guidelines may pose a problem for harmonizing feedback.

Sub-Theme 4: HMIS Guidelines and Regulations

As noted in Sub-Theme 2, facility teams in all sites have standardized, country-specific HMIS guidelines, SOPs, regulations, and tools for data collection, management, verification, and analysis—signed and dated. While none were specific to the cross-border context, the following is a list of HMIS guidelines and regulations referenced during cross-border site interviews:

- Data Quality Assessment Guidelines (Busia and North Star Alliance)
- Disease Surveillance Guidelines at Borders and Ports of Entry (Busia)
- National Data Management Guidelines for Kenyan Health Facilities (Busia and Sio Port)
- User Manual for Data Collection (North Star Alliance)
- MOH Guidelines for Data Collection and Analysis (Malaba)
- Mfuma wa Taarifa za Uendeshaji Huduma za Afya (MTUHA) SOPs for Filling Patient Registers (Holili/Taveta)

Sub-Theme 5: Data Sharing and Interoperability Guidelines

As noted in Sub-Theme 1, no formal mechanisms for patient information sharing exist among the cross-border sites. The desk review and interviews also showed that data sharing and interoperability guidelines, SOPs, or policies do not exist at the national level for Kenya, Uganda, and Tanzania.

However, each country has a national data protection and privacy act created within the last five years, which apply across all service sectors. Representatives from both MOH Kenya and Uganda indicated there are plans to implement health data protection policies, but the timelines were not provided.

Respondents from IGAD noted that its recent data sharing and protection policy and guidelines, developed with the support of USAID through the RAD project, faces implementation challenges due to staff resource constraints. EAC respondents shared that, through the Digital REACH Initiative, plans are in place (though timelines are unsure) to develop common guidelines, standards, and protocols across their member states for an effective regional digital health ecosystem.

Cross-Cutting Considerations: GESI

For key populations (listed in Annex D) who face stigma and discrimination within their communities, the right to confidentiality is a fundamental determinant of when and where they seek care and which services they seek. Breaching confidentiality can reinforce stigma and discrimination, discourage patients from seeking care, delay care seeking, and disempower patients. Consultations with both public and private health facility workers in the cross-border sites indicated there are practices most facilities put in place to ensure patient confidentiality. These practices were confirmed for both digital and paper-based data at the collection, sharing, and utilization stages. During data collection, health workers noted ensuring confidentiality by asking for consent from patients before sharing patient information. In some facilities, there are select authorized staff who can access patient data. Other practices include ensuring that patient names are not disclosed when sharing data (e.g., when disclosing aggregated data from health facilities to the sub-county/district level through official channels such as the HMIS/DHIS2). Patient data is also shared for referral or follow-up care purposes through WhatsApp groups formed by health workers. This sharing is not a formal practice across all sites but occurs based on a facilities' initiative. To ensure confidentiality, patient data shared on WhatsApp does not include patient names, only their non-unique identifier numbers.

Health information systems rely on high-quality and accurate information to inform evidence-based health policy and practices. Beneficiary association representatives for key populations indicated that cross-border populations are to a large extent comfortable sharing their health records across borders, especially at facilities perceived as protecting confidentiality and with free services. Patients who have experienced stigma and discrimination at facilities are less comfortable with information being shared. Consultations with study participants further revealed that fear of losing employment due to disclosure of health status like COVID-19 positive results (for truck drivers in particular) is another limiting factor. Patients with dual identification documents (e.g., Uganda and Kenya) are reluctant to share their identification because it is illegal to have dual identifiers. Ugandans crossing over to Kenya fear being denied services if they disclose their nationality. Ugandans sometimes choose to identify as Kenyans for fear of incurring higher costs because they are not from Kenya, and some Ugandan communities reportedly feel stigmatized by Kenyan communities. Some patients also provide inaccurate location and contacts because they do not want to be followed up by health care providers for their treatment.

Based on the study findings, in spite of the confidentiality measures mentioned above by health workers, two peer volunteer female sex workers mentioned that actual or perceived breach of confidentiality within health facilities is one of their current concerns, especially within government facilities. This leads them to prefer seeking care in private facilities or stand-alone (non-integrated targeted) facilities that only serve key populations. Consequently, interviews revealed that men who have sex with men (MSM) and female sex workers prefer drop-in non-state prevention centers, which are often donor funded. These centers have outreach services and peer educators who identify health risks, share information, and provide referrals. Key populations expressed concerns that privacy, going hand in hand with confidentiality, was often breached in government facilities were providers unintentionally exposed patients' health status.

Intervention 1.2: Digitized and Interoperable Health Information Systems Established in Cross-Border Area

Summary of Findings

Intervention 1.2 in the activity work plan entails a review of HMIS systems and platforms utilized at the cross-border site level that could support more efficient data collection and management of health issues. The landscape analysis sought to assess the availability of existing HMIS systems, technology infrastructure, and equipment at cross-border sites to support interoperable and digitized systems.

Findings showed that cross-border sites have varying and inconsistent HMIS resource capacity and technical staff. Facilities use parallel systems—either paper-based or electronic medical records (EMR)—for patient registration, with only some interoperable with their billing system. HMIS reporting systems are digitized at the national level across countries, utilizing DHIS2. Not all indicators captured through paper-based records or EMR are reflected in the national HMIS.

Electricity is available at all cross-border sites, although with disruptions, but all sites have power backup systems. Internet connectivity is sub-optimal, with some sites reporting unavailability for some days of the month. ICT equipment is available across sites with a majority being tablets and desktops. All equipment uses standard operating systems—Windows, Linux, or Android.

All sites with reporting and billing systems have the potential for interoperable systems, if HMIS capacity is strengthened and internet connectivity issues are addressed. However, interoperability across sites is also dependent upon the existence of an interoperability

architecture including data sharing and protection policy for cross-border sites across the countries.

Sub-Theme 1: HMIS Resource Capacity

Although findings revealed that facility teams at all cross-border sites consist of HMIS staff, roles and quantities vary. HMIS staff members include health records officers, health information officers, data quality analysts, data officers, monitoring and evaluation officers, and biostatisticians. Facility teams at all sites reported there being a functional technical team responsible for data collection and data quality within health facilities at each border side, validating data as it is collected. These technical teams do not collect data from facilities at the other side of the border.

Findings from EAC and IGAD indicated that both RIGOs had team members with HMIS skills cutting across data capture, verification analysis, and visualization; however, respondents from both organizations noted that team members required further training to enhance their current skills set (although the specific areas were not articulated). Data management processes within RIGOs as it relates to utilizing cross-border health site data was unclear.

Sub-Theme 2: HMIS Information System and Updates

Facilities across the five sites used varying methods of patient registration—either through a paper-based system or EMR. All facilities, however, report routine health data through the DHIS2, with dedicated system management personnel responsible for regular maintenance and system updates. Facilities on both the Kenya and Uganda sides of the border noted receiving a system maintenance update in the last three months.

Although patients pay to access health services, only facility teams at Busia, Holili/Taveta, and Sio Port/Victoria/Majanji reported having a billing system interoperable with their patient registration system.

One EAC respondent noted that the organization is working to develop a regional data warehouse, which will host all member state data from DHIS2 and be managed by nominated data specialists. This entity is envisaged to improve cross-border data sharing, though the implementation modalities by which this occurs at the cross-border site level is unclear.[5]

Sub-Theme 3: HMIS Technology Infrastructure and Equipment

Facility teams within Busia, Malaba, and Holili/Taveta reported experiencing intermittent power disruptions for an average of 10 days each month, while Sio Port/Victoria/Majanji reported experiencing disruptions of fewer than 10 days each month. All sites use either generators or solar for power backup.

All facility teams reported that ICT personnel maintains internet network, with connectivity at the sites available for an average of 20 or more working days in a month (except for in Sio Port/Victoria/Majanji, whose teams reported internet availability for an average of less than 10 days in a month). Regarding the type of internet connection, all sites except for Malaba use broadband connectivity, all sites have mobile data connectivity, and none of the sites use dial-up connection.

Facility teams in all sites had the required ICT equipment, which included laptops, computers, printers, and tablets that facilitate digitalized systems; however, the number of equipment, and whether they were functional, varied significantly by site. Tablets were the majority of equipment

[5] EAC's data sharing protocol detailing specifics of this regional data warehouse was not yet made available for review.

reported across the sites, possibly due to their portability and ease of access in remote locations. The operating systems largely used were Windows, Linux, and Android. Figure 2 summarizes the breakdown of functional equipment as reported by site.

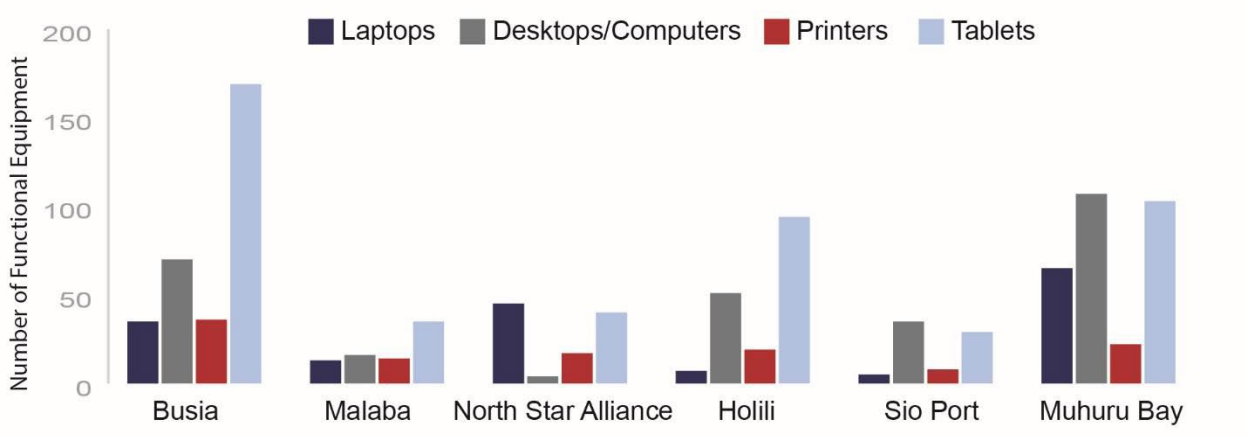

Figure 2. Functional Infrastructure Equipment Per Site

Cross-Cutting Considerations: GESI

Health care providers face constraints when collecting, documenting, and sharing data related to sex, age, and social and economic status from cross-border populations. Many people accessing services at borders do not have any form of identification, which makes it difficult to confirm the actual age of the patient. There is also stigma associated with revealing age; for example, some female sex workers will jointly access HIV testing services with clients, but do not want to reveal their age because it can influence pricing of services. Data collection tools also limit effective data collection; for example, in Busia, health facility respondents mentioned a barrier in not having an option to record intersex populations, and many respondents mentioned concerns over misidentifying transgender individuals. Likewise, MSM and transgender populations fear being criminalized for disclosing their sexuality. Government facilities, more than private facilities, may be perceived as connected to other government structures and hence some cross-border patients who access these services may be unwilling to disclose their identities for fear of follow-up or identification, particularly if they have committed crimes in their countries. The process of digitization has potential to increase existing distrust, particularly if individuals feel the data could be used in a dangerous way and shared more easily.

Despite high prevalence of gender-based violence (GBV) among cross-border populations, consultations indicate that GBV data is not captured within the main data collection tools, and is often collected for internal purposes. GBV is already underreported due to stigma, and without official data capturing, resources are further limited for essential health services related to GBV responses. As a result, GBV remains underfunded or dependent on donor funding.

4. Objective 2 Findings: Increased Capacity of RIGOs to Lead the Development and Implementation of Cross-Border Programs and Policies

Context

Over the last decade, the East African region's rapid growth has stimulated economic integration with the world, leveraging advances in the banking, health, and business sectors to access regional and international markets. EAC and IGAD both effectively contributed to these changing dynamics, utilizing government partnerships through their member state network to benefit political, security, and social agendas. Both RIGOs have taken the lead in driving the development agenda for the region as well, making strides in areas of food security, trade, peace and security, and health. However, many challenges exist in efforts to standardize regional policies and regulations, influenced by insufficient member state financial contributions, fragile national leadership, and inadequate monitoring and evaluation capabilities.

In particular, the inherent nature of addressing cross-border health issues involves liaising with multiple national governments—placing RIGOs in a key position of authority to ensure adherence to standards and regulations that affect cross-border populations across their member states. The CB-HIPP Final Evaluation Report highlighted member state and cross-border stakeholders' beliefs that cross-border health work must be codified in policy through RIGOs to ensure sustainability, and that continued national and regional engagement is essential for success in addressing ongoing border health crises. Stakeholders shared that the process of implementing cross-border health activities is complicated by the presence of member state specific structures, systems, and processes, and indicated that duplication of efforts between cross-border health initiatives (often donor-led) and work internal to the EAC related to cross-border health (i.e., led by HIV/AIDS units or the East African Health Research Commission, or EAHRC) is a potential roadblock to progress.

CB-HIPP sought to include national and regional stakeholders at all levels of decision-making when developing its "Standard Package" of project activities—from assessment through implementation, which was reported to increase stakeholder satisfaction, buy-in, and ownership. At the cross-border level, project coordination and collaboration relied on existing structures (i.e., health management teams) and stakeholders (i.e., MOH officials) to facilitate quarterly cross-border consultations that formed linkages with colleagues from across the border, and served as a new platform for cross-border communications. What is not clear is the extent to which these activities continued in the absence of CB-HIPP's efforts and funding.

The following sections detail landscape analysis findings on the capacity of both RIGOs to independently lead cross-border health initiatives and knowledge sharing and evidence generation for cross-border health learnings across the region. Findings will support LHSS in crafting activity interventions that build identified capacities for RIGOs to leverage existing

coordination and collaboration mechanisms for strengthening partnerships on cross-border health.

Intervention 2.1: Strengthened Partnerships between Regional Organizations and National Governments for Cross-Border Health Activities

Summary of Findings

From the activity work plan, Intervention 2.1 entails a review of existing roles, relationships, frameworks, responsibilities, partnerships, and institutional capacity among EAC and IGAD that relate to cross-border health issues. The landscape analysis sought to examine such questions under four major components (noted as sub-themes below): organizational mandates, legal frameworks, implementation capacity, and coordination and stakeholder engagement. Findings showed that overall mandates for both EAC and IGAD were clear among member states and actors like IOM, with several cross-border health policies existing with IGAD, but not for EAC. The roles of RIGOs among implementers of cross-border health services (e.g., HMTs, private facilities and pharmacies) were less clear, citing no defined communication channels between the two actors.

Health-related treaties and frameworks exist within both RIGOs, ratified by member states and intended for "domestication" within their respective countries, such as on free movement of citizens critical in allowing for accessing services across borders, and disease surveillance of communicable and non-communicable diseases. No treaties or frameworks are directly specific to cross-border health services.

The success of both RIGOs in implementing cross-border health programs depends on several factors. Largely, commitment from member states to the RIGOs' organizational vision, consistent engagement and collaboration among member states, and RIGOs' research expertise and technical competencies in health were reported as factors for successful implementation. Alternatively, implementation can be hindered by the lack of data collection mechanisms and policies for RIGOs and their member states, inconsistent budgets for coordination, bureaucratic decision-making approaches, misconceptions about the workload of cross-border health initiatives among member states, and gaps in RIGO-level governance structures for cross-border health.

Findings revealed that there are internal discussions on cross-border health among RIGOs and member states during quarterly meetings. Member states are expected to raise any new cross-border health initiatives at such forums to create linkages with relevant countries, though the extent to which that is successful is unknown. On a quarterly basis, technical working groups (TWGs) and various expert groups within both RIGOs meet on various health issues (though none are specific to cross-border health). Other cross-border health stakeholders, such as the private sector, non-governmental organizations, community-based organizations, and faith-based organizations, are presently not engaged during such meetings, but coordinating their work with RIGOs' cross-border health efforts offers a future area for improvement.

Sub-Theme 1: Organizational Mandate

Organizational mandate focuses on the presence or absence of clearly defined and well understood roles, authorities, responsibilities, and functions of an organization. Findings from interviews revealed that EAC and IGAD, along with their member states, have clearly defined roles, responsibilities, procedures, and accountability in the realm of cross-border health: both are tasked with identifying policy gaps and formulating appropriate policies to address them.

The IGAD Cross-Border Health Policy (2021-2030) delineates the RIGO's mandate as follows: "the Health and Social Development Department will coordinate overall implementation and monitoring on behalf of the Ministers of Health, as well as coordinate resource mobilization."

From this policy, IGAD is charged with improving cross-border coordination and collaboration by facilitating the development of guidelines and directives; building member state capacity where needed; liaising information sharing and research; supporting monitoring and evaluation; and establishing a health repository. Other statements from this policy speak to IGAD's responsibility in developing and implementing a long-term, comprehensive, and equitable health financing and social health protection strategy to improve access and quality of services to all populations and ensure portability across member states.

The East Africa Treaty establishing EAC mandated its role in health activities by taking action toward the prevention and control of communicable and non-communicable diseases; promoting the management of health delivery systems and better planning mechanisms to enhance efficiency of health services; harmonizing national health policies and regulations; and promoting the exchange of information on health issues to achieve quality health. The treaty established five standing TWGs responsible for managing all health-related matters on the following topics:

- Medicines and Food Safety
- Control and Prevention of STIs, HIV, and AIDS
- Control and Prevention of Communicable and Non-Communicable Diseases
- Health Research, Policy, and Health Systems Development
- Reproductive, Child, and Adolescent Health and Nutrition

While the work of each TWG may have cross-border health implications, there is no working group specifically focused on cross-border health provision. Sub-Theme 4 provides further information on existing platforms among both RIGOs.

An MOU[6] exists between the member states of both EAC and IGAD, establishing a joint obligation to address disease surveillance within the East African region. However, no written and ratified policies or regulations governing cross-border health information systems exist, which are essential to effective disease surveillance. No mandates or agreements exist between RIGOs and their member states on improving health service provision at cross-border sites, despite related ground activities and collaborations (typically donor-funded) occurring along borders.

Findings from the analysis also revealed that the roles and responsibilities of member states, as it relates to working with both RIGOs on areas like cross-border health, are to provide technical support during meetings and approve, adopt, and implement policies. Representatives from USAID RIGO SSA shared that member states also often contribute by providing contextual in-country experiences, and promoting domestication of agreements or adoption of lessons shared at RIGO platforms. Specific to cross-border health, representatives from IOM indicated that various EAC member states have worked with them on areas like strengthening collaboration on health service delivery to mobile and vulnerable populations.

An understanding of the mandates and roles of both RIGOs varied among representatives of MOH Kenya, MOH Uganda, IOM, and USAID RIGO SSA. All but those from MOH Uganda indicated that the roles of RIGOs in matters of cross-border health were clear and well understood, stating their function in determining policy gaps and creating appropriate regional policies, agreements, and roadmaps to address such gaps. MOH Uganda representatives

[6] The LHSS East Africa Activity is currently awaiting access to this MOU.

shared that the roles of both RIGOs were not well understood by cross-border health actors, and noted that the Government of Uganda directly oversees development of policies and MOUs for use within their borders to ensure services to cross-border populations.[7]

Sub-Theme 2: Legal Frameworks

Legal frameworks are the system of rules and laws that regulate decision-making and agreements. In this case, considering that RIGOs' authority lies within their member states, and they have no supranational legal mandate or jurisdiction superseding that of national governments, the analysis reviewed the specific treaty articles[8] and governing policies giving regional authority—as agreed upon by member states—to lead and implement cross-border health programs and activities.

Respondents from EAC referenced the East Africa Treaty Article 118 as a formative framework for cross-border health, where member states commit through EAC to taking actions in preventing communicable and non-communicable diseases and pandemics that easily transverse borders. Respondents also referenced EAC protocols on free movement, which are vital to ensuring that citizens can freely move and seek health care services at either sides of the border.

Respondents from IGAD noted a range of policies that govern cross-border activities, including the Cross-Border Health Policy (2021-2030), cross-border strategic frameworks, and a knowledge management strategy. Most of these policies are available in the public domain.[9]

Sub-Theme 3: Implementation Capacity

The analysis also reviewed the RIGOs' implementation capacity, or the ability to plan, manage, monitor, and improve the quality of cross-border health activities implemented. From interviews with EAC, IGAD, MOH Kenya, MOH Uganda, and USAID RIGO SSA, several factors were found to both support and hinder the RIGOs' abilities to implement regional cross-border health policies and programs.

Factors that support cross-border health policy implementation were: strong member state commitment to the RIGOs' vision; member state contributions (when continuous and consistent) for funding cross-border health activities; and regular engagement and collaboration among member states to provide clear and decisive direction. Respondents noted that both EAC and IGAD are also known for specific core technical health competencies (e.g., service provision, health information systems, and financing) that could complement member state experiences in areas of cross-border health, and support the effective implementation of those activities. One respondent from EAC indicated a strong interest in pursuing resource mobilization to address cross-border health challenges, and noted that the RIGO has recently engaged in more resource mobilization advocacy efforts alongside their traditional roles.

Notably, respondents from EAC also highlighted the EAHRC's expertise in regional-level research and its development of evidence-based reports and policy briefs shaping decision-making at the EAC-level with their member states. They indicated interest in future collaboration between the commission and LHSS to conduct rigorous studies on cross-border health issues and best practices for program implementation.

[7] The role of the Government of Uganda in developing cross-border health policies and MOUs was not validated or addressed by other cross-border health actors.
[8] Treaties are ratified by all member states and are binding, though the interview did not pursue whether or not treaties and its articles were adhered to.
[9] IGAD team members offered to share their latest internal assessments and research papers on cross-border health.

Factors found to inhibit effective implementation of cross-border health policies include circuitous decision-making approaches; an absence of RIGO-level data collection mechanisms, data sharing, and data protection agreements; lack of implementation policies or guidelines for collaboration; limited resources for implementation; and slow “domestication” of regional policies in-country.

The analysis found that EAC's consensus-building approach for decision-making was assessed as being centralized and hierarchical, potentially delaying or derailing impactful decisions on topics such as cross-border health. Approvals require involvement, support, or clearance from top authorities, typically taking a longer period of time and potentially reducing support or momentum for cross-border health interventions. Alternatively, respondents from IGAD reported that the RIGO had a positive image and reputation in the region for tackling health challenges quickly, with fewer bureaucratic processes and “an effortless and efficient work manner.”

As noted by USAID RIGO SSA respondents, the capacity of RIGOs to implement cross-border health programs effectively also depends upon the involvement and commitment by their member states. Some member states were often reported to be non-committal when attending RIGO-level meetings. Inconsistent attendance by member states at such fora also adversely affects implementation of policies in border sites within the region.

Though respondents did not provide specific examples, they indicated that many member state laws only focus on broader aspects of health in-country, without a particular focus on cross-border health issues. Some cited member state reluctance to sharing data, and the different data protection and sharing policies within each country, as constraining factors to RIGOs’ cross-border health program implementation.

Lastly, an issue that was found to hinder implementation was member state attitudes towards regional and cross-border health activities, considering them as “extra work” on top of their existing responsibilities. Respondents noted that the sheer volume of stakeholders engaged in RIGOs through its member state representatives can make it difficult to develop shared understandings, resulting in potential misconceptions and slower or hindered implementation. There currently exists no plans within both RIGOs to address such challenges and obstacles.

Sub-Theme 4: Coordination and Stakeholder Engagement

Beyond the RIGOs’ capacity to implement cross-border health activities, the analysis reviewed its capacity to coordinate and effectively engage a variety of internal and external stakeholders for cross-border health initiatives. Findings reveal that presently, RIGOs and their member states internally discuss cross-border health during quarterly meetings. Member states through RIGO-level forums have collaborated with external stakeholders as well, such as IOM, on developing policies governing mobile and vulnerable populations’ access to health care services (though no such policy has been developed at present).

Representatives from USAID RIGO SSA shared that TWGs and various expert groups exist within both RIGOs (though not related to cross-border health) and meet on a quarterly basis. Technical areas that are discussed depend on the core purpose of the technical or expert group—offering potential leverage for integrating cross-border health issues and initiatives within existing health-focused platforms.

IGAD representatives indicated that a typical agenda for their quarterly meetings involved discussions on KM and sharing among member states; EAC representatives noted meetings largely discussing surveillance (e.g., disease, risk, conflict). Meetings for both RIGOs review individual member state progress in adopting and implementing regional commitments, and offer an avenue for exchanging best practices and learnings. Both EAC and IGAD

representatives suggested that further coaching was needed—on facilitating decision-making, implementing and advocating for adherence to cross-border health policies, and advocating for cross-border information sharing—in order for meetings to be more effective.

Figure 3 depicts a mapping of cross-border health roles at the local, national, and RIGOs-level, taken from analysis findings across the above sub-themes that noted various relationships existing within and among the following cross-border health stakeholders:

- **RIGOs and Member States:** The roles of RIGOs and their member states in the realm of health are well documented and understood by both actors (i.e., the East Africa Treaty and IGAD Cross-Border Health Policy (2021-2030)).
- **RIGOs and Implementers:** Without a common vision or modality by which RIGOs and implementers of cross-border health services can communicate, there appears to be no agreed basis for decision-making between the two actors. As a consequence, member states, facilities, pharmacists, and donors make choices that serve their own interests.
- **Member States and Implementers:** Roles are reportedly clear for both actors, but the uneven influence of national stakeholders on cross-border health decision-making results in limited communication and consultation with the implementers of cross-border health services. As a result, there may be a disconnect between decisions taken at the national-level, and the wishes of implementers and health users at the border, which could lead to ineffective implementation.

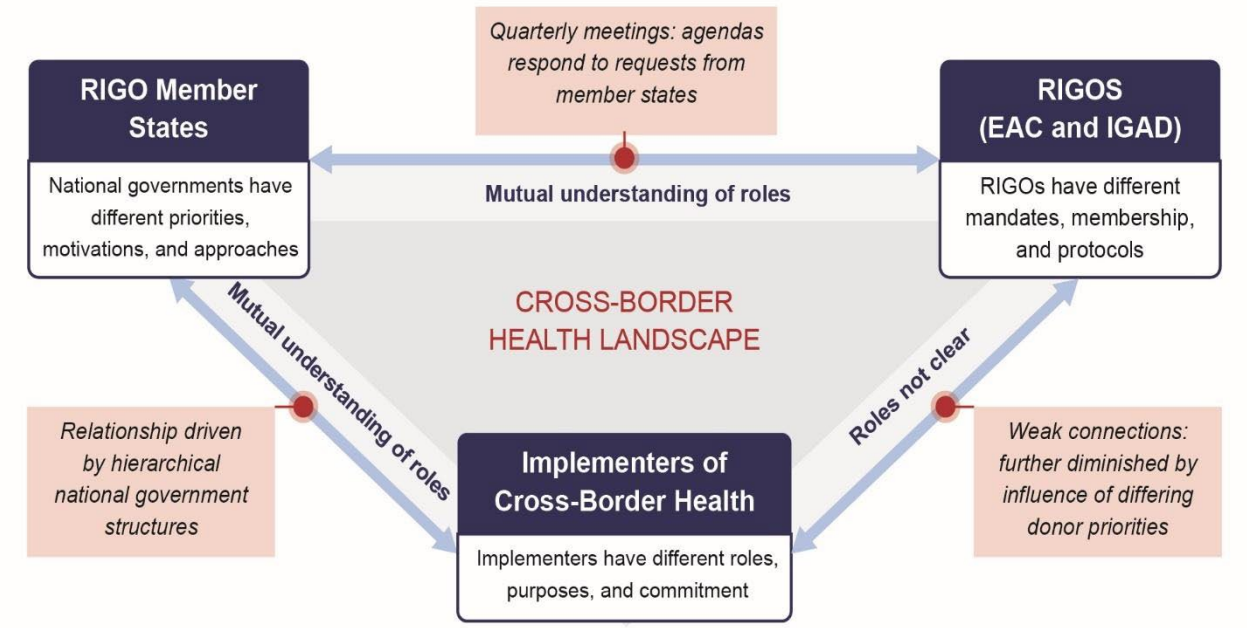

Figure 3. Mapping of Cross-Border Health Stakeholder Roles

Cross-Cutting Considerations: GESI

Key populations for this activity are often perceived as potential carriers and spreaders of diseases to other countries. They are most susceptible to diseases given their mobile livelihoods, yet they are marginalized and experience inequalities in accessing health care services. They are more vulnerable, economically unstable, and have different health-seeking behaviors. A current gap in targeting cross-border populations among RIGOs and their member states is their frequent framing of these populations as threats, rather than emphasizing their vulnerabilities and patient-centered needs for effective health outcomes.

There were a variety of perspectives among respondents concerning who relevant actors were to ensure that laws and policies for cross-border populations remain gender- and socially-inclusive. One MOH official said that they were unaware of any. Most gender and social integration efforts are limited to working with key populations and specific diseases (e.g., HIV), rather than integrating across health sectors and considering the diverse needs of multiple clients. Structures like the Ministry of Gender exist, whose roles include gender inclusion and mainstreaming, but the analysis found they presently are not engaged on cross-border health issues within activity focus countries. IOM indicated that specific actors like donors offer GBV services at cross-border sites, but sustainability of services once funded projects end remains questionable. MOH Kenya shared that each country has services that target these key populations, but there has not been enough training for government staff to run the facilities at borders offering such services.

Intervention 2.2: Strengthened Regional Partner Capacity to Generate Evidence and Knowledge Management Capacity for Advocacy

Summary of Findings

Knowledge is an essential resource to the success of any organization's activities. For health in particular, knowledge is most valuable when shared and used to inform policies and decisions that lead to better health outcomes. The plethora of health sector interventions within the EAC and IGAD regions necessitates continuous and rigorous collection, synthesis, and sharing of knowledge among member states and their stakeholders. Intervention 2.2 sought to review both RIGOs' capacity to lead in evidence generation and KM for the East African region, with the landscape analysis revealing their policies and strategies, existing platforms, and processes for KM.

Findings showed that both RIGOs have recently enacted strategies specific to knowledge sharing and evidence-generation, with designated departments, Secretariats, communities of practice, and expert working groups regularly pursuing KM objectives. While KM platforms are not specific to cross-border health, several health-focused ones exist within both EAC and IGAD, and offer an opportunity to leverage such mechanisms for improving cross-border health evidence generation and knowledge sharing.

Sub-Theme 1: Knowledge Management Strategies and Platforms

Representatives from both EAC and IGAD indicated a concerted commitment toward evidence generation and KM among member states. In EAC, the 2018-2023 Knowledge Management Strategy for Health directs its KM responsibilities, citing alignment with the EAC Treaty to "promote exchange of information on health issues in order to achieve quality health within the Community." The strategy includes objectives to create an enabling environment for planning, implementing, and coordinating KM at the regional and member state levels; build capacity of the EAC Secretariat and member states to generate, synthesize, and share KM products and services; enhance ICT and face-to-face knowledge sharing platforms; and promote access to KM products among targeted networks (e.g., best practices forums, share fairs). Directed by this strategy, the EAC Health Department, Planning Department, and EAHRC all engage in internal KM-related activities, though efforts are not harmonized across the organization, and none are specific to cross-border health.

In 2019, IGAD and the USAID-funded Knowledge for Health Project (K4Health) conducted a KM assessment of IGAD to serve as the basis for its KM for Health Strategy. The project engaged in

several trainings with the IGAD Secretariat and their member states on basic principles, processes, and tenets of KM to improve generation, collection, analysis, synthesis, and sharing of health data from the national to local levels.

Directed by the above strategies, both RIGOs host various knowledge-sharing platforms. Internal and external stakeholders can access EAC health-related research, tools, and publications from the EAC Health Department and EAHRC through its *Regional Knowledge Management Portal for Health*, available to the public. IGAD, through the USAID-funded Cross-Border Health Initiative Project established an internal document repository, archival, and sharing system for health, including research from border health programs within the IGAD member states. IGAD also hosts an external *Resilience Portal* managed by the Platform Coordination Unit of IGAD's Drought Disaster Resilience and Sustainability Initiative. Though not specific to cross-border health, this website enables access to KM tools that support programming, investment tracking, and project transparency—which could benefit cross-border health initiatives as well.

Sub-Theme 2: Knowledge Management Processes

Knowledge is shared and managed across RIGOs and their member states through regular meetings, conferences, and workshops. From the EAC Knowledge Management Strategy for Health, an expert working group on KM was developed, who reportedly meets on a quarterly basis with member states to review progress against strategic objectives (respondents were unaware if progress had been made or what limitations exist, if any). Currently, no cross-border health focused KM group exists within EAC.

"Communities of practice" within IGAD specific to health engage in periodic KM reviews of member state evidence generation on health, though respondents from USAID RIGO SSA were unclear of the frequency of meetings, and whether the communities also focus on cross-border health evidence generation. USAID RIGO SSA representatives also noted other various knowledge-sharing platforms by both RIGOs, such as biannual collaborating, learning, and adapting workshops and scientific conferences. For instance, respondents from MOH Uganda noted the biannual EAC Scientific Conference referencing EAC's regional portal for health, as well as recent publications from EAHRC.

Respondents within both RIGOs, MOH Kenya, MOH Uganda, and USAID RIGO SSA shared they were unaware of any formal knowledge sharing processes within specific member states to the RIGOs, or mechanisms between RIGOs and member states with cross-border sites.

Cross-Cutting Considerations: GESI

Multiple legislative, regulatory, institutional practices, and policies that address gender equality, social inclusion, and vulnerability exist within specific East Africa countries (i.e., Kenya, Uganda, Tanzania, and Rwanda). At the continental level (the African Union) and regional level (both RIGOs), policies that speak to gender equality are shown in Table 2.

Table 2. Gender Policies per Organization

Organization	Relevant Policy
African Union	Strategy for Gender Equality and Women's Empowerment
EAC	Gender Strategic Plan
	Gender Policy
	Framework for Gender and Social Development Outcome Indicators for EAS Development Strategy (2011-2016)

Organization	Relevant Policy
	Participatory Gender Audit Report for EAC Organs and Institutions (2013)
	Gender Mainstreaming Strategy for EAC Organs and Institutions (2013)
	Comprehensive Regional Integrated Sexual, Reproductive, Maternal, Newborn Health, HIV and TB Programme (2022-2027)
	Regional STI Study Report
	EAC Integrated Health Programme
IGAD	Cross-Border Health Policy (2021-2030)

However, implementation of some of these policies has been a challenge due to limited enforcement mechanisms and resources, and knowledge sharing platforms for disseminating these lessons learned do not exist. EAC recently launched the Comprehensive Regional Integrated Sexual, Reproductive, Maternal, Newborn Health, HIV, and TB Programme (2022-2027) to amplify work on sexual and reproductive health and HIV programs, which offers an opportunity to harmonize care for cross-border populations that require such services. However, GESI approaches within the programme to ensure holistic inclusion of women and men's health concerns are lacking. Other examples indicate that gender inclusion remains a persistent gap; for example, despite the myriad of social and economic impacts of COVID-19 on the lives of women within the EAC region, a recent working paper by the African Economic Research Consortium reported that the existing EAC Gender Policy Framework and ongoing regional and national COVID-19 policy and intervention activities remain "gender-blind," with no mechanisms in place to ensure that women are among the key beneficiaries.

Women tend to be underrepresented in regional, national, and local leadership and management positions, which can lead to ignoring women's concerns and under-resourcing gender-based health services. The same working paper found women were not represented in regional and local COVID-19 response committees, which led to reduced funding for women's concerns particularly in conflict and humanitarian contexts.

According to facility workers and beneficiary association representatives, policy or regulatory factors that must be considered for mobile and vulnerable populations to successfully access health services include free movement of people across borders; access to free health services; a common working language; standardization of quality of services; disease surveillance and information-sharing across border sites; patient-centered referral systems, and frequent knowledge exchanges between service providers in cross-border sites.

There is an ongoing 2020 initiative between several civil society forums and the EAC Secretariat to address GBV and mitigate the effects of COVID-19. The objective of this initiative is to strengthen monitoring, reporting, and accountability mechanisms of regional and sub-regional bodies on GBV and practices that promote the economic empowerment of women and girls. Proposed activities include establishing a regional GBV Sector Working Group that holds bi-weekly virtual meetings on prevention and response to GBV during the COVID-19 pandemic; developing a tool for the working group to fill in their GBV interventions during the COVID-19 pandemic; continuously assessing GBV hotspots and economically hard-hit areas for women in business around the region and cross-border areas; and partnering with stakeholders and media to report GBV cases and seek redress for the victims. Dependency on donor funding to finance and support GBV services is one of the sustainability concerns highlighted in the study.

While specific actors deliver GBV services across borders, limitations in technical training for government staff hinder meaningful and holistic delivery of care for key populations.

5. Objective 3 Findings: Strengthened Regional and National Financing, Resource Mobilization, and Accountability for Cross-Border Health

Context

Within the Africa Leadership Meeting Declaration in 2019, African Union member states noted their commitment to create regional platforms to support relevant ministries, including finance and health, to catalyze, capture, and scale innovations; disseminate best practices across countries; and reduce gaps in domestic financing for health.

In cross-border sites across East Africa, mobile populations do not have consistent access to quality and affordable health care services, often times frequenting neglected, resource-constrained areas without due attention by the health system on either side of the border. Both RIGOs have made concerted efforts to support health financing arrangements across member states, with EAC investigating social health protection systems for UHC for use of a portable health insurance package across countries, and issuing the following recommendations[10] for member states to enact:

- Establish ICT systems to access member information across countries;
- Create electronic universal health insurance member cards;
- Encourage the EAC summit to pass a resolution requiring residents to have health insurance at home and in their destination country when traveling regionally;
- Offer regional option(s) with additional fees for members of public schemes to extend coverage to other countries in the region; and
- Create an agreement among member states to recognize one another's public schemes.

The EAC also developed strategic guidelines on a minimum package of health and HIV/AIDS and STI services through a participatory, interactive process, involving several stakeholders from member states and led by the EAC Regional Task Force on Integrated Health and HIV and AIDS Programming along Transport Corridors in East Africa.

IGAD, through its comprehensive Cross-Border Health Policy (2021-2030), also developed proposed solutions and strategies for improving access to quality health services at border sites. One particular policy objective includes member states establishing or expanding upon their national health insurance or social protection schemes to support UHC, including financial risk protection. The policy also calls for member states to develop and implement a long-term, equitable health financing and social health protection strategy and ensure portability across member states for cross-border communities, particularly ensuring access to regionally-agreed minimum standards of services for communicable, non-communicable, and neglected tropical and zoonotic disease services.

[10] The status of implementation of recommendations is currently unknown.

CB-HIPP assessed the feasibility of developing a portable health insurance package across Kenya, Uganda, Rwanda, and Tanzania, reviewing the cost of a defined package of services (including HIV/AIDS, TB, and family planning) to compare costs and understand drivers of cost. Facility service readiness was examined at cross-border sites bordering those countries, with findings indicating that costs were highest in Kenya and lowest in Uganda. Distinct challenges noted by RIGOs and member states in enacting a portable health care option were the lack of an interoperable HMIS within border facilities or UHC in all participating countries.

Sections below detail landscape analysis findings on recent efforts by member states and RIGOs to increase access to and financing of health care services for mobile and vulnerable populations. Knowledge gathered from this section will inform activity discussions on health financing scheme designs, such as who should be covered, who should pay, where services should be offered, and how to align costs and service standards in both sides of cross-border sites.

Intervention 3.1: Support Evidence Generation and Policy Advocacy Efforts to Establish Regional Portable Health Insurance Basic Package for Mobile and Cross-Border Populations

Summary of Findings

The activity work plan details Intervention 3.1 as an opportunity to fill in gaps in evidence on the feasibility of portable health insurance schemes in East Africa, particularly since the gap in completion of CB-HIPP and the ongoing global COVID-19 pandemic. The analysis thus reviewed the existence of in-country and cross-border risk pooling and other financing schemes, if cross-border populations are more or less likely to be covered by such schemes, and what portable health insurance options are being discussed among countries in the region currently. Findings showed that despite various RIGO-level policies on health financing arrangements, implementation has not been successful, with no regional-level framework for health financing that exists among EAC or IGAD member states. Desk research and respondent feedback indicated that social health protection mechanisms exist in Kenya (covering 32% of the population), Tanzania (covering 15% of the population), and Uganda (covering less than 1% of the population through community based health insurance (CBHI)). In 2020, Uganda tabled a bill in parliament for a national health insurance fund, but this was returned back to the Ministries of Health and Finance to revise. All three countries have private health insurance schemes that target citizens in the formal sector, potentially excluding the majority of cross-border populations working in the informal sector. Regardless of financial protection coverage, OOP payments are how most cross-border populations pay for services, with various in-country fee exemption waivers found to not always extend to cross-border populations, potentially excluding them from free priority health services.

Sub-Theme 1: Cross-Border Health Financing Policies and Coordination

Despite RIGO-level efforts to support health financing arrangements across member states—including EAC's exploration of social health protection systems for UHC and its strategic guidelines on a minimum package of health and HIV/AIDS and STI, as well as proposed solutions under IGAD's Cross-Border Health Policy (2021-2030)—successful implementation of such policies is far from practice. From respondents in public and private facilities and MOH Kenya and Uganda, findings revealed that the policy environment within the region is not conducive to a portable health insurance package, for the following reasons:

- No regional-level framework for health financing exists that are either signed off on, or ratified by, member states;
- Poor coordination of the strategic planning, mobilization, and allocation of resources among member states to their cross-border site locations remains a challenge; and
- Member state government leaders and political priorities regarding social health protection systems is ever-changing.

Sub-Theme 2: Financing of Health for Cross-Border Populations

Financing for provision of health care for cross-border populations is not considered a mandate or responsibility of national and cross-border local governments, explaining the consistent underfunding of cross-border health programs by such stakeholders.

Cross-border populations were most commonly found to pay OOP for health services. Facility teams in the Kenya and Uganda sides of the border reported that OOP payments for services were similar among both citizens and cross-border patients. Facility teams in Tanzania reported differently, noting higher charges for cross-border populations (identified as largely Kenyan) who seek services on the Tanzania side of the border. These groups also experience challenges to access local currency in countries within which they're seeking services, particularly noted as an issue among Tanzanians whose local currency was not accepted among facilities on the Kenyan side of the border.

Facility team respondents in Kenya confirmed that fee waiver programs exist for citizens, though they shared that such programs do not always extend to cross-border populations, implying that even widely practiced fee exemptions for free priority health services are not accessible to cross-border populations.

Sub-Theme 3: Financial Protection Options and Arrangements

As noted above, each country has some level of financial protection schemes that targets its citizens. Kenya provides a National Health Insurance Fund (NHIF) that runs multiple schemes targeting different pools in both the formal and informal sectors, while private health insurance targets those in employment. CBHI is also present in Kenya. Tanzania provides NHIF for civil servants, a community health fund for the informal sector, and Social Health Insurance Benefit that is part of the National Social Security Fund and targets formal sector employees. Tanzania also has a presence of private health insurance. Uganda does not yet have a national health insurance scheme, but has a presence of CBHI and private health insurance.

Desk review and stakeholder interviews confirmed that there is currently no existing portable financial protection mechanism in the region to cover cross-border populations. EAC and IGAD stakeholders noted that country-to-country commitments have been made to ease access to health services across countries, specifically noted between Kenya and Rwanda who have an agreement in place to improve access for health services.

Facility team respondents disclosed that the discussion on financial protection for cross-border populations is quite fragmented and mainly pushed by donors through NGOs. Member countries have not taken lead in these discussions, hence no shared ownership exists across the region.

Cross-Cutting Considerations: GESI

Demographic health surveys from the various EAC countries show that women and men have different access to health insurance. With the exception of Rwanda, where women represent 71 percent of health insurance holders, coverage for both men and women is below 25 percent. In Uganda, only 1 percent of women and 2 percent of men have health insurance. There are

certain inequities in affordability of health services along borders that RIGOs and member states could address, including high charges to Kenyans accessing services in Tanzania (sometimes double the prices), lack of cross-cutting health coverage and financing in the region, and lack of national insurance within some EAC countries (e.g., Uganda).

Intervention 3.2: Increased Private Sector Engagement in Cross-Border Health Service Provision, Financing and Management

Summary of Findings

The private sector plays a significant role in the health sector, serving as a key provider of services varying by country in the region. From the work plan, Intervention 3.2 entails a review of the current and potential future role of the private sector in the provision of health care services to cross-border populations. Findings from the analysis showed that cross-border populations access a variety of services in both public and private facilities that are driven by factors such as facility proximity and affordability, though stigma and perceived or real discrimination were reasons for limited demand. Services most commonly used in private facilities in particular included HIV treatment, STI testing, and GBV services, among others. Private facility respondents noted receiving mostly OOP payments for services from cross-border health populations, though certain groups like truck drivers can access services on duty and claim reimbursement, further incentivizing their use of essential health care services.

Sub-Theme 1: Demand for Services

Findings indicated that across public, private, and North Star Alliance facilities within the five cross-border sites, cross-border populations accessed a range of services, which included antenatal care; maternity services; routine vaccinations; HIV, TB, non-communicable diseases, and primary health care services; and specialized services. Treatment-seeking behaviors are driven by facility proximity, affordability, perceived quality, and availability of services and drugs.

Factors such as confidentiality, attitude of health workers, and easy access to services without identification card requirements were reported by private health workers as some reasons for cross-border populations seeking services with private providers.

Stigma and discrimination concerns were particularly noted to limit demand for and use of health care services. Beneficiary association representatives shared that Ugandans crossing to the Kenya side of the border in particular note fearing being denied services if they disclosed their true sexual identity. Such concerns can cause delay or avoidance of accessing health care services by these groups.

Sub-Theme 2: Supply or Provision of Services

Health workers within public and private facilities across the cross-border sites reported providing health services in-line with country guidelines and practices. Findings from private facilities in the cross-border sites reported providing a wide range of services to cross-border populations (who can afford them), including HIV treatment, STI testing, lab services, family planning, GBV services, cervical cancer screening, and TB and hepatitis B testing and treatment. These services were identified by facility teams as being markedly different from the services that cross-border populations seek at public facilities: namely, more primary health care services like vaccinations, COVID-19 testing, and antenatal care. Findings did not uncover any specific mechanisms used by private facilities to target cross-border populations; alternatively, teams within public facilities reported using peer educators, community

sensitization, and WhatsApp groups to inform those populations about their programs or initiatives.

Private facility respondents noted receiving payment for services through direct OOP payments or through payers like private health insurers and social health insurance contracting private providers to offer services to their members. Respondents confirmed, however, that payments for services from cross-border clients largely come from OOP payments, as there are limited insurance schemes that typically cover them. Notably, one respondent from a beneficiary association representing truck drivers indicated that some can access services while on duty and claim reimbursement from their employers. Findings from other private sector initiatives have demonstrated that corporate entities can be engaged to strengthen health service provision in areas that they operate in, and could potentially be leveraged in cross-border locations.

Sub-Theme 3: Private Providers Readiness and Capacity for Service Provision

As noted above, cross-border populations seek a wide range of services. Private providers must be adequately prepared to cater their services for a range of cross-border populations as well. Respondents from private facilities across the five sites noted the varying services requested by different roles, such as men traders largely suffering from road traffic accidents and sex workers requesting GBV services. Respondents indicated private providers needing to be more ready to render to these services, having the required commodities, environment to ensure confidentiality and a safe space, STI care, HIV testing, and MSM treatment-specific commodities. Women requesting private facility services tend to seek reproductive health care, such as family planning and cancer screening, and were reported to seek services more often than men. Private facility respondents shared that men often seek care when critically ill, as opposed to seeking preventative care services, and typically request STI care from private facilities over public ones.

Private facility respondents also noted that services are occasionally not available to cross-border populations due to occasional stock-outs. They suggested that financial protection mechanisms be in place for cross-border populations, and to provide financial incentives and assurances for private providers offering services to populations frequently crossing borders.

Cross-Cutting Considerations: GESI

Private sector services are often preferred by cross-border populations, given a perception of greater confidentiality, less congestion, safe and private services, and catering to their specific different needs. Private facility respondents noted the importance of holistic services; for instance, one such facility (a prevention drop-in center) offers key populations with a place to rest and bathe if needed, and are supported by peer educations who identify, refer, and follow-up with patients requiring services like HIV prevention and treatment. Unfortunately, this “peer educator model” is not replicated among all private facilities, or public facilities, along the borders. Respondents identified peer educators as being particularly important for young female sex workers, who face specific barriers related to limited networks and negotiating power for safe sex.

Another key factor for cross-border populations accessing services from private facilities is time. Private facility respondents noted providing for key populations with occupations that are demanding or competitive, like truck drivers, traders, and female sex workers, prefer to access services where they spent the least amount of time.

However, the cost of health care in the private sector is often unaffordable for most cross-border populations. For example, cross-border patients who need inpatient services may be referred to other health facilities but struggle to pay for health care due to a lack of insurance and high dependency on OOP payment. Government facilities were found to be more affordable, and thereby preferred by some cross-border populations; however, barriers in terms of availability of public facilities, services, commodities, and professional health services may affect acceptability of these services and preference for private health facilities.

While GBV services are largely provided with public facilities, some of the private facilities provide more comprehensive services for cross-border populations, as well as the general population. GBV services that are offered by both public and private providers in the study include clinical care; psychosocial counselling; post exposure prophylaxis, emergency contraception, legal representation referral services for specialized care, laboratory investigations, and STI screening. Not all of these services are always accessible to cross-border populations, due to lack of information and fears of stigma, shame, and reprisal.

6. Preliminary Summaries and Recommendations

The following is a summary review of landscape analysis findings per objective area, along with preliminary recommendations and suggestions for activity interventions to discuss and collaboratively refine during the LHSS East Africa Activity launch/consultation meeting in March 2022.

Objective 1: Improved and Digitized Cross-Border Health Information Systems in Cross-Border Areas

All cross-border sites have functional HMIS systems guided by their respective country regulations. In addition, they have HMIS staff responsible for data management and quality assurance, although the capacity varies across sites. Though guidelines exist to inform data management, they are not harmonized across countries, but rather relate to the cross-border site locations. There are parallel patient registration systems, both paper-based and electronic, which is appropriate given power surges and intermittent internet coverage across the various cross-border sites. Few sites have patient registration systems linked to the payment systems. There is relatively good ICT equipment to support the digitalization of systems.

The absence of interoperable communication systems in cross-border sites compounded by lack of guidelines for health data sharing and protection hinder effective referral and follow-up of patients. Nevertheless, some sites have established informal mechanisms for sharing patient data across health facilities such as WhatsApp, sync framework systems, and patient health information records and books, which can only be accessed by health workers. In addition, both RIGOs are making efforts to enable data sharing across member states. For instance, IGAD recently enacted a data sharing and protection policy and guidelines, though representatives from IGAD mentioned implementation challenges due to inadequate staffing and funding resources. EAC has also developed protocols in anticipation of a regional data warehouse that will facilitate data sharing across member states.

Recommendations

1. **Coordination of data sharing**. The activity will discuss with both RIGOs the possibility of establishing a cross-border HMIS task force that is comprised of focal persons from member state HMIS teams and cross-border sites. The task force would lead in maintaining consensus on the need for interoperable systems and harmonized protocols, while providing mutual HMIS support through cross-country and cross-border site learning.
2. **Leverage existing structures**. The activity will discuss leveraging the existing structures within both RIGOs, such as providing technical assistance to the EAC regional warehouse intended to support health data sharing across member states.
3. **Support digital patient registration systems**. The activity will explore opportunities to support the establishment of digital patient registration systems within the cross-border site facilities currently using paper-based patient registration systems, ensuring they are interoperable to payment systems and the national HMIS.

4. **Harmonize data interoperability and sharing guidelines**. Given that neither MOH Kenya or Uganda have health data interoperability and sharing guidelines, though respondents from both indicated plans to develop them, another recommendation is to support the member states in developing and finalizing such guidelines, ensuring their harmonization across member states and RIGOs.
5. **Build cross-border site capacity**. Finally, the activity will review opportunities to support building the capacity of cross-border sites on implementing data interoperability and data sharing guidelines by EAC or IGAD.

Objective 2: Increased Capacity of RIGOs to Lead the Development and Implementation of Cross-Border Programs and Policies

In the context of cross-border health, both RIGOs have different mandates, memberships, and protocols. Member states and cross-border sites also have different priorities, contexts, motivations, and approaches. EAC and IGAD have formulated agreements and policies to collaboratively address some key issues in cross-border health with their member states; however, in the absence of a shared vision, policy, or procedural frames, these agreements have not been consistently translated into member state policies or statutes.

While a considerable amount of information has been collected through the analysis, the data is inconclusive and/or contradictory at various points, without a cross-section of respondents to ensure a conclusive understanding of a holistic picture. Recommendations below is based on activity understanding as represented from the interviews, which will be further discussed and refined with both RIGOs and member states during the launch/consultation meeting.

Recommendations:

1. **Forming a shared vision for cross-border health**. The activity will work with both RIGOs to revisit or improve cross-border health policies and strategies under their coordinated leadership, incorporating the participatory engagement of other key cross-border health stakeholders. From this, the activity can support the RIGOs and their member states to develop a strategy for implementing a shared vision for cross-border health, noting the organizational structure and staffing required for achievement of the vision (i.e., effective and efficient systems, and staff with appropriate capacities to carry out functions).
2. **Strengthen stakeholder engagement**. The activity will liaise with key cross-border health stakeholders (e.g., public and private facility teams) to map their needs, interests, and potential for contribution in cross-border health work, aligning their support with the RIGOs' vision where necessary.
3. **Strengthen meeting engagement and communication**. In response to interview feedback from RIGO respondents on limited meeting effectiveness, the activity will work with both organizations to review whether meeting agendas respond to the needs of member states and stakeholders, strengthen intergovernmental decision-making processes with the goal of optimizing effectiveness and efficiency, review meeting mechanics (i.e., agenda, notes), and improve RIGO and member state communications.
4. **Develop an inventory of regional policies**. The activity will work with relevant actors within both RIGOs to create an inventory of developed and executed regional policies, and determine the implementation stage of each. The activity will also review obstacles to implementation and consequences of non-implementation for lessons learned.

5. **Document processes and procedures to respond to staff turnover**. Resource constraints, such as with staffing, were noted as a challenge for RIGOs to implement cross-border health initiatives. The activity will support EAC and IGAD in documenting cross-border health processes for use in orientation of new staff and volunteers, and to support transfer of knowledge and experience during handover meetings.

Objective 3: Strengthened Regional and National Financing, Resource Mobilization, and Accountability for Cross-Border Health

Countries within the East African region are actively working towards UHC, making this objective area a relevant and timely one. Findings uncovered that both RIGOs and member states support the free movement of people across the region, as well as the continued access to health services regardless of location. Views on how to ensure access of health care for cross-border populations differ among RIGOs, member states, and cross-border sites, along with the ability of stakeholders to harmonize cross-border health financing arrangements. Considering the reality of most cross-border populations paying OOP for services in both public and private facilities, and the fragmented discussions within country on expanding financial protection to these groups, the below section identifies recommendations for activity interventions in conjunction with existing stakeholder efforts.

Recommendations:

1. **Support advocacy for cross-border health financing arrangements**. The activity will work with both EAC and IGAD to support their abilities to advocate for member states facilitating access to health care services for cross-border populations. The activity will also support the direct engagement of RIGOs with local cross-border health authorities (including both the public and private sector), identifying champions for health financing arrangements to regularly advocate for their national governments to commit resources for cross-border populations, regardless of their citizenship status.
2. **Develop a roadmap for success on cross-border health access**. Working through existing RIGO-level structures, the activity can develop a roadmap for cross-border health service access, mapping the sequence and milestones required to successfully translate member state commitment to action at the point of service delivery.
3. **Support the design of financial protection options.** In coordination with RIGOs, the activity can support the design of financial protection options for cross-border populations, including (but are not limited to): benefit package details, financing service provision, provider payment mechanisms, pricing, accreditation systems, and data sharing. This design could also expand upon existing schemes incorporating portability functions, and identify opportunities for covering cross-border populations utilizing private sector services. The activity will support the RIGOs' ability to corral member states around acknowledging the existing challenges and working to introduce an inclusive, portable health financing scheme for cross-border populations.
4. **Formulate a corporate engagement toolkit to support cross-border health access**. The activity can further support private sector engagement by developing a business case and toolkit for private sector employers to support public health service delivery. The toolkit would entail a review of current partnerships to leverage that exist within the private health and non-health sectors at cross-border locations, and assist in sharing lessons learned across cross-border sites for consideration and replication in other country borders in the region. This intervention would extend to public sector facilities as

well who also provide critical services to cross-border populations, ensuring equity and improved quality along the border site continuum.

5. **Support strengthening private health provider readiness and services.** Private providers are either preferred or the only choices for many cross-border populations. These providers can benefit from tailored capacity-building programs to improve their operations and offer better access to their services. Potential activities are inclusion in training updates, commodity linkages, support supervision and guidelines, and job aide provisions.

Cross-Cutting Considerations: GESI

Recognizing the LHSS project approach of integrating gender, women's and girls' empowerment, and social inclusion proactively into all interventions, the activity utilized this landscape analysis to review different and intersecting vulnerabilities and constraints of women, men, boys, and girls living or moving across the five cross-border sites. Analysis findings identified that cross-border populations within East Africa vary in terms of health risk, literacy, and language, potentially heightening their risks and vulnerabilities. Gaps remain in their successful accessing of services across borders, impeded by sex, age, social and economic status, language barriers, and citizenship. Findings revealed that such populations often seek services at private sector facilities, perceiving them to ensure greater confidentiality and as more safe, less congested, and catering to their unique health needs.

The following recommendations identify areas of opportunity for the activity to embed gender-transformative practices and policies within its technical approaches across the three objective areas.

Recommendations:

1. **Integrate GESI lens in RIGO-level policies**. The activity could support the integration of a GESI lens into EAC and IGAD cross-border health-related policies and strategies, ensuring that the different categories of cross-border populations are outlined, along with their health needs, risks, and ways to improve their access to care.
2. **Include key populations at the table**. The activity could work with RIGOs and member states to include cross-border populations in planning and priority-setting, ensuring that changes and actions resonate with the people ultimately impacted.
6. **Ensure confidentiality in data sharing mechanisms**. When coordinating RIGO stakeholders to support health data sharing across member states, the activity could ensure that confidentiality and privacy are paramount in new systems, and are communicated to cross-border patients in order to build trust and encourage use of services.
3. **Support RIGOs in disaggregated data review**. RIGOs could be supported in capturing GBV data and addressing any data disaggregation gaps identified in member states and cross-border sites, ultimately for using data in informing resourcing and improving health worker competencies.
4. **Designate cross-border focal points for health equity**. The activity could work with RIGOs to lead the process of supporting implementation of existing GESI-related strategies, including designating and training focal points at cross-border sites (e.g., public and private facility authorities) to increase accountability for equity issues.
5. **Support RIGOs to advocate for key populations**. RIGOs could be supported in advocating for balanced leadership and representation of women in management

positions to safeguard resourcing for women's health issues. Within official documentation and communications, RIGOs could also be supported in reframing services for cross-border populations as patient-centered with diverse needs, rather than perceived threats to public health.

6. **Utilize knowledge management functions for GESI**. The activity could leverage existing knowledge sharing platforms to hold joint learning and knowledge exchange workshops with RIGOs and cross-border health stakeholders (including beneficiary association representatives for key populations) to develop a GESI learning strategy informed by best practices among the various stakeholders. Example topics of discussion are on how to design services that embrace principles of safety, confidentiality, non-judgement, and respect for cross-border populations.
7. **Include key population health considerations in portable financing options**. In supporting the RIGOs and their member states to identify portable health financing options for cross-border populations, the activity could ensure options include comprehensive GBV and reproductive health services, and consider the diverse needs of key populations utilizing such services largely within the informal economy.

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Annex B: Cross-Border Site Locations

LHSS East Africa conducted the landscape analysis within the following five cross-border site locations:

Land Cross-Border Learning Sites

1. Busia, Kenya/Uganda
2. Malaba, Kenya/Uganda
3. Holili/Taveta, Kenya/Tanzania

Wet Cross-Border Learning Sites

4. Sio Port/Victoria/Majanji, Kenya/Uganda
5. Muhuru Bay/Kirongwe, Kenya/Tanzania

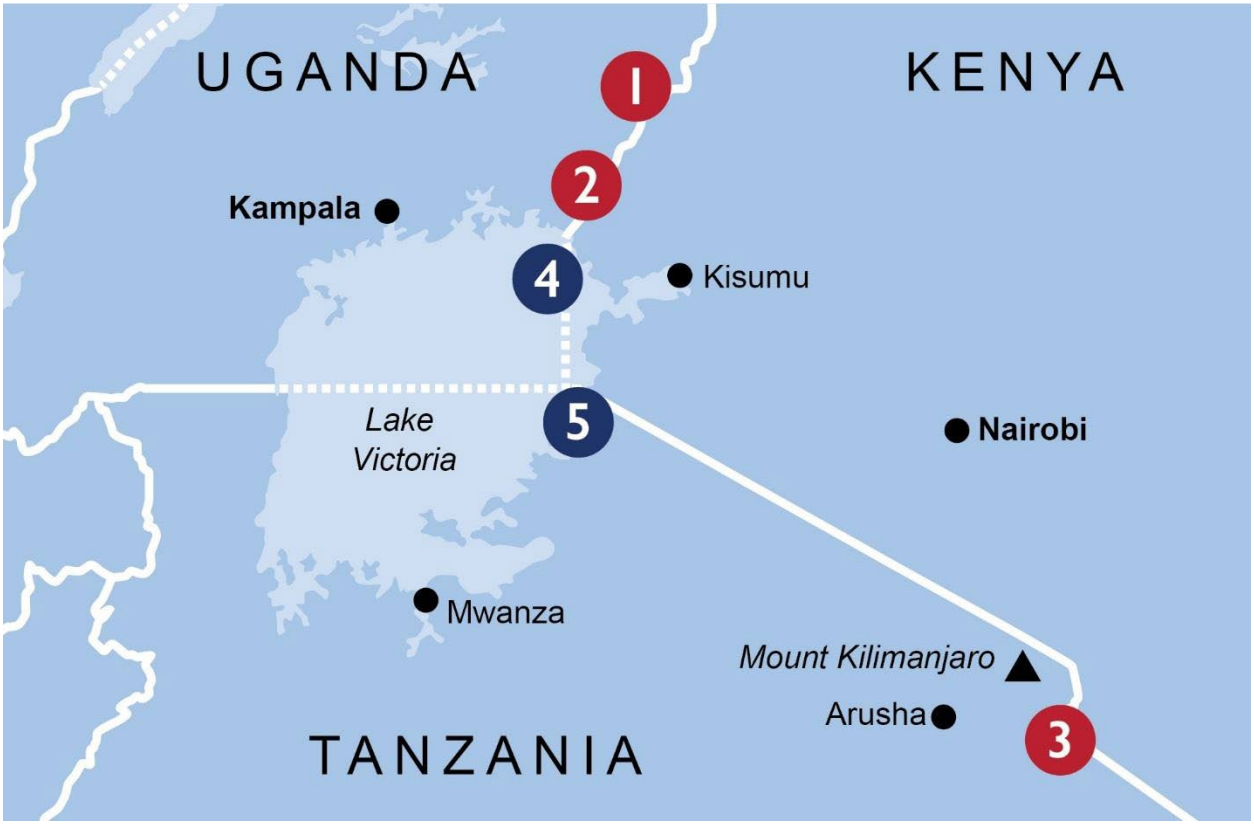

Figure B.1. LHSS East Africa Landscape Assessment Cross-Border Sites

Annex C: List of Stakeholders

The following table lists all stakeholders and their affiliations, per location, interviewed by the activity team for the landscape analysis.

Location		Stakeholder and Affiliation
Busia Cross-Border Site	Busia County	• **County Government of Busia**: Country Health Promotions Officer; County TB/Leprosy Coordinator; County Health Records and Information Officer; Deputy County Reproductive Health Coordinator; PMTCT/FP Coordinator; County Director of Health • **Port Health Authority**: Public Health Officers • **Busia Truck Driver Association**: Chairman
	Matayos Sub-County	• **Matayos Health Management Team (HMT):** Health Promotion Officer; Senior Medical Officer; Sub-County Public Health Nurse; HIV/AIDS/STI Coordinator • **Amalgamated Transport and General Workers Union (ATGWU):** GBV/TB Focal Person; HTS Focal Person; Condoms Focal Person; FP Focal Person; KPs Focal Person; Data Clerk • **Commercial Sex Workers (CSW) Association:** Director • **Private Nursing Facility:** Hospital Administrator
	Bunyala Sub-County	• **Sub-County Hospital**: Sub-County Medical Officer of Health; Sub-County AIDS Coordinator (SCASCO); Health Records and Information Management (HRIM); Program Officer • **Peer Counselor Group**: Peer Educators, FSW/ Fisherfolk Representatives
	Busia District	• **Busia District Health Team (DHT):** District Health Officer (DHO); Community Health Assistant DHO; District Surveillance Focal Person; District Biostatistician; District Cold Chain Technician • **Private Health Facility**: Records Officer; Deputy Facility In-Charge • **Port Health Authority**: Manager • **District Health Center:** Clinical Officer; Nurse
Malaba	Teso North Sub-County	• **Teso HMT**: AIDS Coordinator; Records and Information Management Officer; SCPHN • **Port Health Authority**: Port Health Officers
	Tororo District	• **Tororo DHT:** Assistant District Health Officer (DHO)/Maternal and Child Health; Assistant DHO/Environmental Health; Health Educator; TB and HIV Supervisor; Infection Prevention and Control Focal Person; Biostatistician; Assistant Inventory Management Office

Location		Stakeholder and Affiliation
	Malaba Municipal Council	• **Health Center**: Malaba Port Health In-Charge; Port Health Officer; Health Information Assistant; Health Center In-Charge; Midwife
Holili/Taveta	Taita Taveta County	• **Taita Taveta HMT:** County Director of Health/County Nutritionist; HRIO/Ag County HRIO; TB Coordinator/Ag CASCO; Health Department Project Coordinator; Public Health Officer; County Nurse • **Port Health Authority**: Port Health Officer
	Taveta Sub-County	• **Taveta Sub-County HMT**: AIDS Coordinator; Clinical Officer; Constituency Control AIDS Coordinator; Public Health Officer/Community Strategy; Ag SC HRIO • **Private Health Facility:** Clinical Officer
	Rombo District	• **Health Facility Management Team**: Facility I/C; Lab Technician; Records Officer
	Holili Ward	• **Health Facility Management Team**: Facility I/C; Lab Technician; Record Officer • **Private Health Facility**: Director; Clinical Officer I/C; Nurses • **Port Health Authority**: Port Health Officer
Sio Port/Victoria/Majanji	Samia Sub-County	• **Samia HMT:** ASCO; Sub-County MOH; Health Records and Information Officer; Reproductive Health Officer; Family Planning Officer • **Peer Counselor Group:** Peer Educators, Fisherfolk Representatives • **Private Health Facility:** HIV Clinic Coordinator; HIV Clinic Nurse; Health Records and Information Officer; CEO; Medical Officer
Muhuru Bay/Kirongwe	Migori County	• **County Health Department:** County Records and Information Management; Deputy Aids and STI Coordinator; Sexual and Gender Based Violence Coordinator; Deputy Public Health Director; Disease Surveillance Coordinator; WASH and Community Health Coordinator • **Private Medical Center:** Hospital Administrator; Pharmacy Technician • **Peer Counselor Group:** Field Officer; Peer Educators
	Muruhu Bay Ward	• **Sub-County Health Department:** Public Health Officer; Disease Surveillance Coordinator; Nurse; Sub-County Minister of Health; AIDS and STI Coordinator; Health Records and Information Officer • **Port Health Authority:** Public Health Officer

Location		Stakeholder and Affiliation
	Mwishoni (Kirongwe)	• **Center for International Health, Education, and Biosecurity (CIHEB) Kenya:** Nurse
Kampala City, Uganda		• **Ministry of Health Uganda**: HIV Prevention Coordinator
Nairobi, Kenya		• **North Star Alliance**[11]**:** Director; Finance/HR Manager; Communications Officer; M&E Manager; ICT Manager • **Intellisoft**[12]**:** Founder and CEO • **IOM:** Regional Migration Health Specialist; Regional Health Program Officer; National Migration Health Officer; National Health Programme Coordinator (Uganda) • **EAC:** Principal Information Technology Officer; Regional Malaria Coordinator • **IGAD:** USAID Partnership Lead; Head of Kenya Mission; Public Health/Nutrition Expert; Medicine Regulation/Harmonization Expert; Cross-Border Health Expert • **Ministry of Health Kenya:** Director of Health Records and Information • **USAID RIGO System Strengthening Activity:** Chief of Party

[11] North Star Alliance, a not-for-profit NGO, works to bring health services to mobile workers and the communities they interact with in East Africa (amid other locations). Alliance facilities are spread across the five activity sites.
[12] Intellisoft is a Kenyan software development and consultancy firm that specializes in the application and use of ICT in the health sector. Intellisoft was a project partner of CB-HIPP.

Annex D: Defining Vulnerable Populations

To effectively achieve health outcomes, it is important to explicitly define populations. Different types of individuals have different health needs and the system accommodates or does not accommodate their needs in key ways. Key groups that are important to consider for this analysis are defined below.

Men

Different types of men make up cross-border and mobile populations and their different intersectional identities create varying vulnerabilities. They include truck drivers, young men, men in business, and men who have sex with men. Men's health needs are often invisible and not considered when strengthening health care delivery (Beia, Kielmann and Karin 2021). For example, men are mainly viewed in health as majorly sexual risk takers and resistant to seeking care, leading to limited services designed for men. Dominant rigid masculinity norms in some contexts are passed on to young men and contribute to delayed or lack of timely health seeking behavior. A study of Rwanda by UNAIDS 2013 revealed that gender norms, values, and traditions construct men as powerful and strong, which deters men from seeking health care for fear of being perceived as weak. In Kenya, Rwanda, Tanzania and Uganda, there are considerably more female clients visiting facilities per month than men (59 percent of visits were by females compared to 41 percent of visits by males) (EAC 2015).

Further, traditional norms and expectations on masculinities promote risky behaviors among men; for instance, alcoholism, physical fights, other forms of violence, resistance to testing, and sexual activities that lead to HIV and STIs. Other forms of masculinities that increase male health vulnerabilities are categorized as burdened or overcompensating masculinities, whereby in trying to live up to breadwinning and provisioning roles, men overwork themselves and suffer poor physical health and mental health issues especially when they cannot provide for their families (Izugbara 2015). In the cross-border population context, men's occupations as truck drivers, young men crossing with livestock in search of pasture and water, fisherfolk, food vendors, men displaced by conflict, daily laborers, and traders can expose them to health risks such as COVID-19, HIV and sexually transmitted infections, urinary tract infections, diabetes, hypertension, eye and ear ailments, malaria, and road traffic accidents. It can also create tension at cross-border sites and conflicts. Men tend to seek health care later than women and when the illness is in advanced stages.

MSM and Transgender Individuals

The lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) communities in the East Africa context face stigmatization. Studies have shown some 32 countries across Africa criminalize the LGBTQI community and this affects access to services (Langat 2021). Following the passage of Uganda's Anti-Homosexuality Act in December 2013, hundreds of LGBTQI individuals fled to Kenya seeking safety, for example. LGBTQI members are susceptible lifestyle issues; for instance, abuse of alcohol, illicit drug use, and tobacco use. Experiences of discrimination and prejudice have led to HIV infection, STIs, and cancer. Low self-esteem and bullying lead to mental health disorders and physical violence. Men who have sex with men have high HIV prevalence rates in Kenya, estimated at 18.2 percent (PEPFAR/Kenya 2020). Men who have sex with men may organize into communities to be able to advocate for their

rights and improve access and utilization of health care services. For instance, Ishtar MSM was founded in 1997 in Kenya and is a welfare organization that advocates for health rights of men who have sex with men. In Kenya, medical insurance is an integral part of medical access through National Hospital Insurance fund that is available at a minimum rate of $5 per month. The requirement of a national identification number to access NHIF is often a challenge for transgender people.

Truck Drivers

Truck drivers cross borders frequently and do not always have access to consistent health services due to constant location change. Language is a common barrier for accessing health services for truck drivers. At the same time, truck drivers have increased vulnerability to certain diseases. The COVID-19 pandemic had complicated movement for these populations due to travel restrictions along transit routes and borders according to International Organization for Migration World Migration Report 2022 (IOM 2022). Further, these complications are likely to have heightened vulnerabilities for already marginalized populations and bring out important challenges related to cross- border health delivery. For instance, truck drivers at East Africa's borders reported delays in testing for COVID-19, due to low staffed testing and screening facilities (Jones and Schmidt-Sane 2020).

Fisherfolk

Female fisherfolk are more likely than other women to face barriers in accessing routine health care due to limited access to health providers, direct and indirect costs of health care such as transport costs, and limited time to utilize services (Measure 2017). Male fisherfolk also experience barriers to accessing routine health care services. Fisherfolk cite the barriers as high cost of services (44 percent), long distance to services (37 percent), takes time to get services (32 percent), and high cost of transport (31 percent) (Zinsstag et al 2015). Fisherfolk in the lake region of western Kenya have an estimated 23.4 percent HIV prevalence (KEMRI Asembo Fisherfolk IBBS, 2016). In Tanzania, the HIV prevalence rate among fisherfolk in the Lake Victoria area is estimated as three times higher than the national prevalence (PEPFAR/Tanzania 2020).

Women

Existence of deep traditional and cultural norms limit women from accessing and utilizing health care services when they want and for what they need. For example, decisions on reproductive health services are often made by men particularly for married women (Hyun, Okolo and Munene 2020). Women of varying age, social class, education, occupation, ethnicity, and nationality constitute of cross-border and migrant populations. Women work as sex workers, illicit brew traders, traders, hotel/motel/lodge staff, bar attendants, and hairdressers. Some of these occupations expose them to health risks such as include HIV, STIs, UTIs, and sexual violence. The COVID-19 crisis had devastating effects on women-led enterprises, based on experiences shared by women at UNCTAD border workshops for women entrepreneurs. Women along border areas of Tanzania, Malawi and Zambia, reported experiencing significant drop in revenue due to border movement restrictions.

Women are often at risk of gender-based violence, harassment, high fines, bribes, and loss of their merchandise when impounded by border officials. As a coping mechanism, women use unauthorized entry points to bypass border authorities which may heighten their vulnerabilities to violence. Other studies indicate that these women experience multiple forms of violence from different actors like male businessmen, border officials, smugglers, and transport workers (Jacobson and Joekes 2019). Most women's businesses are informal, and they are unaware of their rights, obligations and formal and informal rules that govern cross-border trade, thereby

exposing them to violations. Sex work in East African countries is criminalized and female sex workers fall victim to harassment and gender-based violence, both for the general populations and also with specific vulnerabilities for cross-border women. Despite how common GBV is among women, response to GBV cases and referral mechanisms are weak. This is attributed by limited budgetary allocation and lack of approved health policies which limit access to referral care, justice, and trauma counsellors to support survivors particularly for cross-border migrant populations.

Female Sex Workers

Poverty is a driving factor for women and girl's participation in sex work or transactional sex (Hyun, Okolo and Munene 2020). Female sex workers, especially cross-border FSWs, are vulnerable to HIV/AIDS, STIs, and many forms of GBV including sexual, emotional, and physical violence. Female sex workers have high HIV prevalence rates, estimated at 29.3 percent (PEPFAR/Kenya 2020). Stigma and prejudices against female sex workers hinder them from seeking timely care and adhering to treatment. Female sex workers at cross-border sites have less access to information and access to justice, making them even more vulnerable compared to female sex workers in other contexts. Female sex workers are also more likely to have adverse health outcomes; among pregnant women, a lower proportion of female sex workers (77.3 percent) reported a live birth outcome, compared to youth women (87.8 percent) and female fisherfolk (95.4 percent) (MEASURE Evaluation 2017).

Children and Adolescents

When children protection systems are not harmonized across cross borders, children may experience gaps in care and protection. Inconsistent case management, custodial changes, gaps in cross-border national protection policies, undesirable perceptions about children who are displaced, uncoordinated family tracing processes will occur especially for people on transit (Save the Children 2020). Early child marriages and forced marriages are drivers of gender inequality, ill health, and marginalization for women and girls and are associated with poor health outcomes for girls (Yaya, Odusina, & Bishwajit 2019). Girls are taken across borders for female genital mutilation and avoiding laws; Kenya, in particular, is identified as a destination for cross-border female genital mutilation practice (UNICEF 2022).

Language is an important determinant of access and utilization of health services. The common dialect at the cross-border in East Africa is Kiswahili. Border residents can communicate to health care workers in Kiswahili; however, there are some border residents who are only conversant with their local language leading to language barrier when seeking health care services. Studies conducted at Busia border reveal variations of language among the populations (Lugwiri 2020). The youth (age 20-35 years) from Kenya and Uganda at the cross-border speak uniquely coined Kiswahili referred to as 'Sheng'. The middle aged speak Kiswahili mixed with some English, while the elderly speak minimal Kiswahili mix with local languages.

Persons Living with Disability

Globally, over one million people experience with disability (WHO 2021). Chronic health conditions and ageing population are main drivers of disability. Limited studies exist on experiences of persons with disability and cross-border health care. However, generally, discrimination and stigmatization characterize persons with disability's access to health care (WHO 2021). Other barriers they face include non-adapted health care systems to address different disability needs; individual level barriers due to low self-perception and stigma; economic barriers linked to unemployment; social barriers linked stigma. They also face barriers in accessing reproductive and sexual health services (Ganle 2020). Health care providers have limited knowledge on rights of person with disability as well as limited knowledge about their

health needs (Ganle 2020). Health facilities are located in areas that are physically and geographically in accessible to these populations. At the health care institutions, there are often no special rooms available for examining people with disabilities (Ganle 2020). EAC has in place a Policy on Persons with Disabilities which was adopted in March 2012. The aim of the policy is for partner states to create enabling environments for meaningful participation of Persons Living Disabilities in their development (EAC 2021). However, cross-border, migrant, or key populations are not mentioned in the document.

Annex E: Policy Research Questions

Below details a list of high-level, policy-focused questions developed to inform the desk review and final landscape analysis comprehensive questionnaire.

Landscape Analysis Policy Research Questions

Section 1: Digitized Cross-Border Health Information Systems

RQ1.1. What are the health information management policies, digitization, and interoperability systems in the RIGOs, focus countries, and cross-border sites?

RQ1.2. What are the existing data governance structures and frameworks in the RIGOs, focus countries, and cross-border sites?

> *Note: Data governance structures consist of policies, processes, and an organizational structure to support enterprise data management. The structure of a data governance program provides understanding, security, and trust around an organization's data among its stakeholders.*

RQ1.3. To what extent are health information technologies and digitization systems introduced and practiced in the RIGOs and focus countries?

RQ1.4. What is the current system of patient registration in focus countries and cross-border sites?

> *How do health practitioners record patient interactions?*
>
> *How is patient record information shared between health facilities in cross-borders, if any?*
>
> *What is the clinical referral and follow-up information sharing processes?*
>
> *Do patient records also include paying entities and payment modalities for the health providers?*

RQ1.5. How is health information data disaggregated (including by gender, age, and socio-economic status), compiled, and analyzed/interpreted? What data visualization capacities and practices exist in the cross-border areas?

> *What are the significant challenges and limitations?*
>
> *How are data used? If not used, why not?*

Section 2: RIGOs Capacity

RQ2.1. What are RIGO-level cross-border health policies and regulations? How are those policies and regulations implemented and enforced by member countries and cross-border sites?

RQ2.2. How do RIGOs and national governments work with and collaborate in areas of cross-border health?

RQ2.3. What are the existing RIGO-level health governance structures, platforms, and coordination mechanisms?

> *How are health information, finance, and health services provisions coordinated and governed?*

How are stakeholders, including the private sector, represented and participate in governance structures and practices?

RQ2.4. Are there overall RIGO initiatives around gender, equality, and social inclusion (GESI)? What GESI specific cross-border health initiatives do RIGOs have? How are cross-border GESI issues addressed by RIGOs?

What are the successes?

What are the limitations?

RQ2.5. Are there any examples of cross-border agreements on the use of health facilities by cross-border populations?

RQ2.6. What is the current relationship between RIGOs and the private sector? How do RIGOs utilize the capabilities of the private sector to engage the health sector, more specifically in cross-border sites?

Are there other sectors where private sector expertise is leveraged? What are the successful experiences and practices?

What are the gaps in engaging the private sector?

Section 3: Financing, Resource Mobilization, and Accountability

RQ3.1. How are the health systems within each LHSS focus country dealing with cross-border health issues? Are services available and provided in a friendly environment for cross-border GBV victims?

RQ3.2. Who provides health care services for mobile and vulnerable cross-border populations in focus countries?

RQ3.3. What is the role of government health facilities and programs in provision of services for mobile and vulnerable cross-border populations?

RQ3.4. What is the role of the private sector in provision of health services to cross-border sites?

For what health care services do mobile and vulnerable cross-border populations visit private providers?

How are the different mobile and vulnerable cross-border population groups accessing such services?

What is the major success in provision of health services to mobile and vulnerable cross-border populations?

What are their challenges and gaps?

RQ3.5. Are there comprehensive and inclusive financial protection programs in RIGO member countries? How are countries' health financing systems dealing with cross-border health challenges?

What risk pooling schemes, if any, are being implemented in the countries around cross-border areas?

Are any key demographic groups less likely to be covered by schemes? How are mobile population groups covered?

How do countries first enroll people in such financial protection programs/schemes, and once enrolled, how do they address the issue of portability, especially across borders?

RQ3.6. Is portable health insurance being discussed among countries currently? If so, through what mechanisms?

RQ3.7. What is the role of private sector and other non-state actors in financing health care services from mobile and vulnerable cross-border populations?

RQ3.8. Are there any forms of financial protection programs that are catered to and/or include mobile and vulnerable cross-border populations?

RQ3.9. What services are covered under any form of financial protection programs and are they adequate for mobile and vulnerable cross-border populations?

Annex F: Comprehensive Questionnaire

Date: _____/_____/_____	**Interviewer Name: _____**
Respondent Name: _____	
Respondent Organizational Affiliation: _____	
Respondent Designation: _____	
Respondent Email: _____	
Respondent Phone No.: _____	
Interview Site Location: _____	

Overview

Briefly describe your current role and position within your organization.

	Response	G1[13]	G2	G3	G4	G5	G6
Respondent Role and Position	a) Role:	X	X	X	X	X	X
	b) Position:						

Section I: Cross-Border Health Information Systems

Briefly describe the current health information management policies and interoperability/digitization systems in cross-border sites and focus countries.

Section 1.1: Assessing Health Information Management System Practices			G1	G2	G3	G4	G5	G6
1. What is the current composition of staff at your organization?	**Staff Members**	**Number**	X		X			
	a) HIS Experts							
	b) Cross-Border Health Authority							

[13] Note: G1 = cross-border health officers/stakeholders; G2 = beneficiary associations/representatives; G3 = private health entities; G4 = national and regional stakeholders; G5 = HMIS affiliated entities; G6 = RIGO affiliated entities

	c) Facility Management								
	d) Other								
	e) If other, please specify:								
2. Do you have a functional technical team or committee responsible for reviewing overall data quality?	**Yes**	**No**	**Don't Know**						
a) If yes, what is the composition of the team (please list designations)?				**X**		**X**			
b) If no, who reviews the data quality?									
3. Does your data collection system validate data as it is collected?	**Yes**	**No**	**Don't Know**	**X**		**X**			
4. Do you utilize any digitized health management information system (HMIS)?	**Yes**	**No**	**Don't Know**						
a) If yes, specify the HMIS that is used.				**X**		**X**			
b) If no, specify any other health information systems used.									
5. What system is used for patient registration?				**X**		**X**	**X**	**X**	
6. Do you know if the system was updated in the last 3 months?	**Yes**	**No**	**Don't Know**	**X**		**X**	**X**	**X**	
7. Who is responsible for keeping the system updated?				**X**		**X**	**X**	**X**	
8. How is patient record information shared between health facilities in cross-borders, if any?				**X**		**X**	**X**	**X**	
9. How is confidentiality of patient data ensured?				**X**		**X**	**X**	**X**	
10. Are cross-border and mobile populations comfortable sharing their health records across borders?	**Yes**	**No**	**Don't Know**						
				X	**X**	**X**		**X**	
a) Please elaborate what the considerations are.									
11. What constraints or norms hinder patients from disclosing accurate				**X**	**X**	**X**		**X**	

information about their health when interacting with health practitioners?								
12. What constraints do health care providers face when collecting, documenting, and sharing disaggregated data?	**Constraints Collecting Data On:** a) Sex: b) Age: c) Social status: d) Economic status: e) Other:			X	X	X		X	
13. Do health care service users pay for the services offered?	**Yes**	**No**	**Don't Know**	X		X			
a) If yes, is there a billing system available?	**Yes**	**No**	**Don't Know**						
b) If yes, is the billing system interoperable with the patient registration system?	**Yes**	**No**	**Don't Know**						
Section 1.2: Assessing Availability of Technology Infrastructure and Digitization									
1. For each of the following categories, what is the total number of equipment, and functional equipment, in your organization?	**Number of Equipment**	**Number of Functional Equipment**		X		X			
	a) Laptops:	a) Laptops:							
	b) Desktop computers:	b) Desktop computers:							
	c) Printers:	c) Printers:							
	d) Tablets:	d) Tablets:							
2. What operating system(s) are in use by HMIS systems?	**Operating Systems**	**Tick**		X		X			
	a) Windows								
	b) Linux/Ubuntu								
	c) Other (specify):								
3. On average of 21 working days in a month, how many days is the electricity supply interrupted?	**Number of Days**	**Tick**		X		X			
	20 days or more								
	10 – 19 days								
	Less than 10 days								
4. What electricity backup system is in place?	**Backup Systems**	**Tick**		X		X			
	UPS								
	Generator								
	Solar								
5. Is access to the internet available?	**Yes**	**No**	**Don't Know**	X		X			

a) If yes, what type of internet connections are available?	**Internet Type**		**Tick**	X		X			-
	a) Broadband								
	b) Mobile Data								
	c) Dialup								
	d) Other (specify):								
b) If yes, what is the connectivity speed?									
c) If yes, who is responsible for the maintenance of network infrastructure and hardware?									
d) If yes, how often does maintenance occur for network infrastructure and hardware?									
e) If yes, on average of 21 days, how many working days a month do you have access to internet?	**Days**		**Tick**						
	20 days or more								
	10 – 19 days								
	Less than 10 days								
Section 1.3: Assessing Priority Health Problems through Data									
Data Collection									
1. What are the priority health problems monitored by your organization?				X		X			
2. What are the priority populations monitored by your organization?				X		X			
a) Why are they listed as priority populations?									
3. What are the priority health problems monitored by the health system (health facilities at the cross-border, MOH and RIGO levels)?							X	X	
4. Are all priority health problems reported in your organization's data collection tools?	**Yes**	**No**	**Don't Know**	X		X	X		
5. Are data collection tools used within your country standardized?	**Yes**	**No**	**Don't Know**	X		X	X	X	

6. Are data collection tools used across the two regional intergovernmental organizations (EAC and IGAD), focus countries, and cross-border sites standardized?	**Yes**	**No**	**Don't Know**	X		X	X	X	
7. Who uses the data?				X		X	X	X	
a) How is the data used?									
b) If not used, what are the reasons for not using the data?									
8. What policies and legal frameworks are in place, if any, to support data disaggregation?							X	X	
9. Is routine health data collected?	**Yes**	**No**	**Don't Know**	X		X	X	X	
10. If yes, how frequently is routine health data collected?	**Frequency**		**Tick**	X		X	X		
a) Daily									
b) Weekly									
c) Monthly									
d) Quarterly									
e) Other specify:									
11. List indicators used to monitor the priority health problems.				X		X	X		
Data Reporting									
12. Explain your data flow process (i.e., how data flows from different levels).				X			X		
13. Is there any additional data collected for own internal purposes above what is required for reporting?	**Yes**	**No**	**Don't Know**	X		X	X		
a) If yes, please specify what data and what it is used for?									
Data Analysis									
14. Do the RIGOs produce any report or bulletin based on an analysis of routine health data?	**Yes**	**No**	**Don't Know**				X	X	

a) If yes, list the reports produced.								
15. How is the data flow managed or administered using cross-border HMIS?						X	X	
16. What data analysis governance mechanisms are available at cross-border level structures?						X	X	
17. Which tools or digital solutions are used for data verification and analysis in the cross-border sites and focus countries?						X	X	
Section 1.4: Assessing Feedback Mechanisms								
1. Is there any written feedback on data quality provided in the past 3 months?	**Yes**	**No**	**Don't Know**	X		X	X		
a) If yes, which authority structure is tasked with giving feedback on data quality?								
b) If no, please elaborate or give reasons why.								
c) Are the feedback authority structures maintained by a joint steering committee?	**Yes**	**No**	**Don't Know**					
Section 1.5: Assessing Availability of Policies, Legislation, Guidelines and Regulations								
1. Are written health information system guidelines/standard operating procedures (SOPs)/regulations for data collection, verification, and analysis available in cross-border sites?	**Yes**	**No**	**Don't Know**	X		X			
a) If yes, which ones are they?								
b) If yes, are these guidelines current, signed, and dated?	**Yes**	**No**	**Don't Know**					
c) If no, are there any plans in place for these documents to be developed?	**Yes**	**No**	**Don't Know**					
2. Is there a bilateral data sharing agreement/arrangement between	**Yes**	**No**	**Don't Know**				X	X	

countries especially in cross-border sites?									
a) If yes, please elaborate.									
b) If no, are there plans in place for bilateral data sharing agreement/arrangement between countries in cross-border sites?	**Yes**	**No**	**Don't Know**						
3. Are written guidelines or SOPs for data review and quality control available in the cross-border sites?	**Yes**	**No**	**Don't Know**						
a) If yes, which ones are they?				**X**		**X**			
b) If yes, are these guidelines current, signed, and dated?	**Yes**	**No**	**Don't Know**						
c) If no, are there any plans in place for these documents to be developed?	**Yes**	**No**	**Don't Know**						
4. What interoperability guidelines/SOPs/policies are available in the cross-border sites and focus countries?							**X**	**X**	
5. Do the cross-border sites, focus countries, or even RIGOs have referral pathways or health information sharing policies and guidelines?	**Yes**	**No**	**Don't Know**						
a) If yes, please elaborate.							**X**	**X**	
b) If no, are there any plans in place to make such policies available in cross-border areas?	**Yes**	**No**	**Don't Know**						
Section 1.6: Assessing HMIS Skills for Future Capacity Building									
1. Is data verification and analysis conducted at cross-border sites?	**Yes**	**No**	**Don't Know**						
a) If yes, who is conducting data verification and analysis?							**X**	**X**	
b) If yes, how would you rate their proficiency in data verification?	**Scale**		**Tick**						
	5 = Excellent								

	4 = Very Good							
	3 = Good but Needs Further Training							
	2 = Poor, Needs Training							
	1 = No Knowledge							
c) If yes, how would you rate their proficiency in data analysis?	**Scale**	**Tick**						
	5 = Excellent							
	4 = Very Good							
	3 = Good but Needs Further Training							
	2 = Poor, Needs Training							
	1 = No Knowledge							
2. Do health management information experts conduct data capturing on the HMIS?	**Yes**	**No**	**Don't Know**					
a) If no, who is tasked with data capturing?								
b) What is their level of proficiency in data capturing?	**Scale**	**Tick**						
	5 = Excellent							
	4 = Very Good							
	3 = Good but Needs Further Training							
	2 = Poor, Needs Training						**X**	**X**
	1 = No Knowledge							
c) What is their level of proficiency of the tasked personnel in running monthly data quality checks, for reporting rate, timeliness, accuracy and generating feedback reports?	**Scale**	**Tick**						
	5 = Excellent							
	4 = Very Good							
	3 = Good but Needs Further Training							
	2 = Poor, Needs Training							
	1 = No Knowledge							
3. Are facility managers responsible for data capturing at health border sites?	**Yes**	**No**	**Don't Know**					
a) If yes, how proficient are they in data visualization using HIS?	**Scale**	**Tick**					**X**	**X**
	5 = Excellent							
	4 = Very Good							

	3 = Good but Needs Further Training							
	2 = Poor, Needs Training							
	1 = No Knowledge							
b) If no, are there plans in place for capacity building on the use of HMIS for the responsible personnel?								

Section II: Regional Intergovernmental Organization Capacity

Briefly describe the RIGOs-level cross-border health policies and regulations, and how they are implemented and enforced within cross-border sites and focus countries.

Section 2.1: Assessing RIGO Cross-Border Health Policies and Regulations				**G1**	**G2**	**G3**	**G4**	**G5**	**G6**
1. Do the RIGOs have policies and regulations governing cross-border health?	**Yes**	**No**	**Don't Know**						
a) If yes, what specifically do regulations cover?									
b) If yes, are they documented and disseminated? May we have a copy?	**Yes**	**No**	**Don't Know**						
c) If yes, how well are the policies and regulations understood and adhered to?	**Scale**	**Tick**							
	5 = Excellent								
	4 = Very Good								
	3 = Good but Needs Further Collaboration						**X**	**X**	**X**
	2 = Poor, Needs Collaboration								
	1 = No Knowledge								
d) If yes, who is responsible for implementing and enforcing the policies and regulations within cross-border sites and/or focus countries?									
e) If yes, are identified individuals clear about the roles and	**Yes**	**No**	**Don't Know**						

responsibilities, and empowered to carry out their role?									
f) If yes, what policies and regulations have been difficult to implement, and why?									
g) If no, are there any plans in place to make such policies and regulations on cross-border health?	**Yes**	**No**	**Don't Know**						
2. What factors have supported or inhibited implementation of cross-border health policies?							X	X	X
3. What mechanisms are in place, if any, to identify gaps in enforcement of these policies?									
a) How often are gaps identified?	**Frequency**	**Tick**					X		X
	Never								
	Daily								
	Weekly								
	Monthly								
	Quarterly								
b) What is the process of identifying and reinforcing policies?									
4. What external laws and policies limit cross-border and mobile population groups' access to health services?							X		X
5. What laws and policies encourage cross-border and mobile population groups' access to health services?							X		X
6. What policy actors are important in ensuring laws and policies for cross-border and mobile populations are gender and socially inclusive?							X		X
a) What are the policy actors' roles?									
Section 2.2: Assessing RIGOs Collaboration									
1. What role do RIGOs have in areas of cross-border health?							X		X
a) Are the roles clear and well understood?	**Yes**	**No**	**Don't Know**						

2. What role do the focus countries have in areas of cross-border health?							
a) Are the roles clear and well understood?	**Yes**	**No**	**Don't Know**				
3. Do RIGOs and focus countries collaborate on matters of cross-border health?	**Yes**	**No**	**Don't Know**				
a) If yes, what is the nature of that collaboration?							
b) If yes, how often do the RIGOs and focus countries interact or meet?	**Frequency**	**Tick**					
	Never						
	Daily						
	Weekly						
	Monthly						
	Quarterly						
c) If yes, what does a typical agenda include?							
d) If yes, how effective is the collaboration?	**Scale**	**Tick**					
	5 = Excellent						
	4 = Very Good						
	3 = Good but Needs Further Collaboration						
	2 = Poor, Needs Collaboration						
	1 = No Knowledge						
e) If no, what are the barriers to promoting this collaboration?							
Section 2.3: Assessing RIGOs Structures, Platforms, and/or Coordination Mechanisms							
1. What are the existing RIGOs-level structures, platforms, and/or coordination mechanisms in place for 1) health information systems, 2) health financing, and 3) health services?	**Mechanisms**						
	Health information systems:						
	Health financing:						
	Health services:						
2. What is the purpose or mandate of these existing structures, platforms, and/or coordination mechanisms?							

3. What is the role of focus countries in engaging with these mechanisms?							X	X
4. Do focus countries engage or participate in these mechanisms effectively?	**Yes**	**No**	**Don't Know**				X	X
5. Who are other key stakeholders in the area of cross-border health represented in these mechanisms?							X	X
Section 2.4: Assessing Regional Cross-Border Agreements on Service Provision and Care								
1. Are there written agreements governing the use of health facilities by cross-border populations?	**Yes**	**No**	**Don't Know**				X	X
a) If yes, what is an example, and is this readily accessible?								
2. What other cross-border agreements facilitate effective coordination of information, financing, and services?	**Agreements**						X	X
	Health information systems:							
	Health financing:							
	Health services:							
3. Are there overall RIGO initiatives around gender or ensuring accessibility and quality for different populations? (e.g., sex workers, LBGTQI individuals)	**Yes**	**No**	**Don't Know**				X	X
a) If yes, what are the successes?								
b) If yes, what are the limitations?								
4. Do RIGO initiatives consider gender, level of education, work opportunities?.	**Yes**	**No**	**Don't Know**				X	X
a) If yes, what is an example?								
Section 2.5: Assessing Private Sector Engagement with RIGOs on Cross-Border Health								
1. How are private sector providers involved with cross-border health?						X	X	
2. What types of private sector providers are involved?	**Provider Type**	**Tick**				X	X	
	a) Drug shops							
	b) Pharmacies							
	c) Clinical providers							
	d) Laboratories							
	e) Other (specify):							

3. Why might an individual seek services from a private facility at cross-border sites?						X	X		
4. Are there other potential providers of cross-border services?	**Yes**	**No**	**Don't Know**				X		
a) If yes, who are those providers?									
b) If yes, what is their current engagement with RIGOs?									
5. How do focus countries engage private sector providers at cross-border sites?						X	X		
6. What current agreements or understandings exist between RIGOs, focus countries, and private sector providers at cross-border sites?						X	X		
a) Are these agreements well understood?	**Yes**	**No**	**Don't Know**						
b) What are the challenges, and lessons learned, from such agreements?									
Section 2.6: Assessing RIGO Evidence Generation and Knowledge Sharing Capabilities									
1. How is knowledge shared and managed across the RIGOs and focus countries?							X		X
2. How is knowledge shared and managed across the RIGOs and cross-border sites?							X		X
3. Describe what unit is responsible for generating evidence and sharing knowledge within the RIGOs and focus countries.	**Unit Responsible**						X		X
	a) RIGOs:								
	b) Focus countries:								
4. What is the process for compiling and analyzing evidence on cross-border health?							X		X
5. Are best practices and learnings in cross-border health shared between RIGOs?	**Yes**	**No**	**Don't Know**				X		X
a) If yes, how are those best practices and learnings utilized within RIGOs?									

Section III: Regional and National Financing, Resource Mobilization, and Accountability for Cross-Border Health

Briefly describe the services for cross-border and mobile populations, and focus country health financing systems for cross-border health care.

Section 3.1: Assessing Cross-Border and Mobile Populations Seeking Services				G1	G2	G3	G4	G5	G6
1. Who do you consider the mobile and vulnerable population groups crossing borders?				X	X	X			
2. What jobs do mobile populations typically have, and what are the health-associated risks, for both men and women?	**Jobs:**		**Health Risks**	X	X	X			
	a) Male:		b) Male:						
	c) Female:		d) Female:						
3. What factors help cross-border and mobile populations access to health services?				X	X	X			
4. What factors hinder cross-border and mobile populations access to health services?				X	X	X			
5. Where do cross-border and mobile populations typically receive their information about health?				X	X	X			
Section 3.2: Assessing Service Provision in Cross-Border Sites									
1. Is there stigma associated with providing services to cross-border and mobile populations?	**Yes**	**No**	**Don't Know**	X	X	X			
a) If yes, please elaborate.									
2. Are safe and confidential services available and provided in a friendly environment for cross-border gender-based violence (GBV) victims?	**Yes**	**No**	**Don't Know**	X	X	X			
a. If yes, which GBV services do they offer?									
3. For what health care services do cross-border and mobile populations visit private providers?					X	X			

a) What populations access what services?							
4. For what health care services do cross-border and mobile populations visit government providers (can also include government programs, such as HIV service delivery projects, sexual and reproductive health, TB, MCH, immunization, etc.)?		X	X		X		
a) What populations access what services?							
b) How do these population groups learn about government providers/programs?							
5. What are the major successes in provision of health services to cross-border and mobile populations through private facilities?				X	X		
6. What are their challenges in provision of health services through private facilities?				X	X		
7. What are the major successes in provision of health services to cross-border and mobile populations through government facilities?		X			X		
8. What are their challenges in provision of health services through government facilities?		X			X		
9. Are men and women equally likely to access services?	**Yes** / **No** / **Don't Know**	X	X	X			
a) If yes, which services?							
b) If yes, are they private or government services?							

Section 3.3: Assessing Payment Options for Cross-Border Populations									
1. How do cross-border and mobile populations pay for health care services?				X	X	X			
2. If services are paid for by government, who pays for those programs?				X	X				
3. Of the different payment options you identified, what are the most common methods for cross-border and mobile populations?				X	X	X			
4. What are any financing options that work across borders (e.g., a savings plan, an insurance product, etc.)?				X	X	X			
5. Are there any forms of financial protection programs catered to cross-border and mobile populations?	**Yes**	**No**	**Don't Know**	X	X	X			
6. In your opinion, how should payment for health care services for cross-border and mobile populations be organized?				X		X			
Section 3.4: Assessing Health Financing Systems for Cross-Border Health									
1. What risk pooling schemes, if any, are being implemented in the focus countries?				X		X	X		
2. What risk pooling schemes, if any, are being implemented in the cross-border sites?				X		X	X		
3. How are cross-border and mobile population groups covered?				X		X	X		
4. What, if any, key demographic groups are less likely to be covered by schemes?				X		X	X		
5. What criteria were used to inform what health insurance packages cover?				X		X	X		
	Yes	**No**	**Don't Know**	X		X	X		

6. Are any key populations or key services left out?									
a) If so, through what mechanisms?									
7. How are people enrolled in such financial protection programs/schemes?				X		X	X		
8. Once enrolled, how is the issue of portability across borders addressed?				X		X	X		
9. Is portable health insurance being discussed among focus countries currently?	**Yes**	**No**	**Don't Know**	X		X	X		
a) If yes, through what mechanisms?									
10. What is the role of private sector and other non-state actors in financing health care services for cross-border and mobile population groups (e.g., mobile populations like truck drivers being provided insurance products from freight companies)?				X	X	X	X		
11. Are private providers contracted under these financing programs?	**Yes**	**No**	**Don't Know**	X		X	X		
12. What services are covered under any form of financial protection programs for cross-border and mobile population groups?				X		X	X		
a) Are these services adequate?	**Yes**	**No**	**Don't Know**						
13. What policy or regulatory factors need to be considered if cross-border and mobile population groups are to successfully access health services across cross-border sites?				X		X	X		
14. What are the remaining challenges with offering financial protection and health services to cross-border and mobile populations?				X		X	X		