I. Regional Context and Background

East Africa continues to bear a heavy burden of endemic disease and has a large migrant population. The East African region is becoming increasingly integrated with more people moving across borders, sometimes carrying health threats with them. Unemployment levels along national borders approach 70 percent and in some communities, 78 percent of females turn to sex work to survive. Transactional sex contributes to the current HIV epidemic in East Africa, particularly in hot spot communities along the major transport routes. Tuberculosis (TB) causes over 600,000 deaths a year. Ethiopia, Kenya, Tanzania, and Uganda remain among the 22 "high burden" countries for TB (cases per year are above 100 per 100,000). Maternal mortality ratios in East Africa are also high and vary greatly, ranging from 336 and 362 maternal deaths per 100,000 live births in Uganda (DHS, 2016) and Kenya (DHS, 2014), respectively, to 732 per 100,000 live births in Somalia (WHO, 2016). Additionally, an estimated 14.9 million people in East Africa face "stressed" to "crisis" levels of food insecurity. In the drylands, frequency of drought has increased significantly over the past decade. Stunting remains high in the region ranging from 26% in Kenya to 57.5% in Burundi and wasting continues to fluctuate ranging from 9.8% to 14.9% in the horn. Food insecurity is only likely to be exacerbated as a result of global climate change, political instability, lack of access to adequate health care, and unreliable access to quality inputs. Underserved populations in border areas are caught in a vicious cycle of chronic vulnerability, conflict, and instability. While migration and mobility are increasingly recognized as determinants of ill health, the volume, the rapidity, and ease of today's travel poses new challenges to cross-border disease control and suggests the need to adopt innovative, systemic, and multi-sectoral responses.

II. Regional Stakeholders Consultation November 19-21, 2019- Nairobi, Kenya

USAID/KEA brought together stakeholders in the East Africa region including private sector, Regional Intergovernmental Organizations (RIGOs) - the East African Community (EAC) and the Intergovernmental Authority on Development (IGAD), USAID bilateral missions, and non-governmental organizations (NGOs) to discuss and identify the critical issues and barriers faced by cross border populations in achieving positive health outcomes, identify critical regional and national actors, and to review lessons learned from current and former cross border health activities in order to better inform an activity that could build on and catalyze existing strengths and capacities. The findings from this consultation are combined with findings from an earlier consultation with bilateral missions and the cross-border integrated health study by Measure Evaluation, University of North Carolina, on health services gaps and cross cutting challenges facing border communities of East Africa to capture a comprehensive list of challenges. The reports are attached in the annex.

A. Highlighted issues:

- Health officials and health facility staff reported that high proportions of their clientele come from across borders. Estimates as high as 40 to 60 percent were reported. Communities that reside across borders shared the same culture and identity, with

relatives residing on both sides of a border.

- Referral of non-national clients was challenging as community and health facility staff did not know where to refer them. Health officials reported little or no contact with their counterparts across the border and similarly there was little or no communication between health facilities across borders.
- Important cross border health policies and activities were not standardized or harmonized across countries so mechanisms, treatment protocols, regulations differ depending on which side of the border a beneficiary seeks services. Hard to maintain and track quality of care and services received.
- Commodity management was difficult for border counties and districts because forecasting was done for the local citizens and generally did not take into account clients from across the border. Most facilities reported stock outs because of failing to plan for people who cross borders for services.
- A lack of coordination and collaboration makes it difficult for cross border facilities to appropriately plan for, treat, and refer/track beneficiaries.
- Loss-to-follow up related to HIV and TB treatment, prenatal care and delivery and childhood immunization was high. Health officials reported that people crossed borders for HIV, STI or TB testing and treatment, and if positive, were put on treatment. Once services were provided, these clients returned to their home countries, most disappeared from the system and there was little that health officials could do to follow up these clients.
- Disease surveillance across borders was challenging. For example, a Tanzanian child was treated in a Kenyan health facility, and then returned to Tanzania. A specimen taken from the child was sent to a lab in Nairobi and the child was found to have polio. Kenyan health officials were unable to locate the child for further investigations. Such situations pose a great health threat to the region.
- There is no current data on the status of medicines or levels of substandard and or falsified medical products for the region which puts the health of cross border and mobile populations at risk.

B. Lessons learned:

- Limited data around needs of cross border and mobile populations leads to a lack of the evidence needed to support advocacy and evidence-informed action.
- It is important to recognize and address political sensitivities around the sharing of data
- Silos between bilateral and regional programming leads to gaps as well as duplication of efforts
- Governments and regional partners already have systems and institutions in place either formally or informally, but they do not speak to each other.
- Private sector is already investing in health especially in areas that are hard to reach and in some cases up to 50% of healthcare facilities are private health care facilities, and yet private facilities and service providers are often not considered or engaged by other actors including national governments, RIGOs, and donors.
- There is a lack of capacity in cross border areas (technology, human and financial resources).
- Digital technologies offer potential solutions to issues in the collection, management,

monitoring and use of health data but will require investment in capacity building. Digital technology should also be considered for easier portability of health insurance.
- There is a strong link between public health and the environment that needs to be taken into consideration, especially for mobile and pastoralist communities that are most vulnerable to changes in climate and environment degradation.

C. <u>Gaps and potential areas of intervention:</u>

- Evidence based policies, guidelines, curriculums, regulations and protocols that are standardized and harmonized across local, national, regional, and international levels with appropriate implementation and enforcement.
- Interoperable health data that can be shared across health facilities in different countries. This could potentially be supported with a move toward digitization of health management information systems.
- Regional health financing policies that lead to comprehensive and portable health insurance for cross border and mobile populations.
- Implementation and or strengthening of real-time disease control and health data surveillance systems that feed into national and regional data systems for improved monitoring, quality assurance, advocacy, and accountability.
- A collaborative and appropriately integrated multi-sectoral approach that better incorporates the private sector, CSOs, communities, and other actors that are often left out of efforts to improve health systems.

III. Ongoing Efforts

For the last 10 years, USAID/KEA has been working in the East African region to improve the health of vulnerable and mobile populations that cross borders. It is important to build on and leverage the successes of those activities and to take into account the lessons learned. Below are some examples of those efforts, from the current USAID/KEA funded cross border health activity, most relevant to the priority gaps identified above.

The Cross-Border Health Integrated Partnership Project (CB-HIPP), was officially launched at the East African Community (EAC) Secretariat in Arusha by the EAC Secretary General and, USAID/Kenya and East Africa Mission Director in March 2015. Between 2014 and 2016, CB-HIPP has succeeded in helping local, regional, and international understanding of the unique needs, risks, vulnerabilities, and complexities of cross-border communities and mobile populations. The health team conducted ***detailed assessments and studies to understand the cross-border geographic migratory dynamics, health service programming gaps and differing standards of disease treatment and management protocols***.

To help address those gaps, CB-HIPP, in collaboration with key stakeholders, defined and piloted a model for cross-border health delivery and referral at Busia, Malaba, Sio Port/Port Victoria/Majanji, Kenya-Uganda land and wet cross-border sites through the use of cross-border health units (CBHUs). The CBHUs are composed of cross border peer educators (CBPEs), Ministry of Health-linked community health education workers (CHEWs)/village health teams (VHTs), facility-based health care workers designated as cross-border health focal persons,

health records officers, and health facility-in-charge. The CBHUs in all participating border ***public and private facilities are responsible for community mobilization, referral, service delivery, defaulter tracing and follow-up for sustainable cross-border health service delivery***. Through the CBHUs, CB-HIPP has initiated a cross-border ***manual data management system whose components include a set of tools to document and track cross-border facility referral, client profile and service delivery, as well as community demand creation.*** These CBHU tools enable community-facility and facility-facility referrals and support compiling data on target populations' mobility and HIV treatment cascade to facilitate follow-up for care, ***including data management and sharing for decision-making and planning***.

CB-HIPP, in consultation with Partner State counties and districts, identified and trained health care workers from border health facilities on provision of comprehensive integrated health services targeting cross-border mobile key and priority populations***. In addition to technical skills building, CB-HIPP included migration health sensitivity training during continuous medical education sessions to ensure that the total workforce at CBHUs has the capacity to meet distinctive health care needs of cross-border populations at any point of service within a border health facility***.

Below are relevant studies and reports from work on cross-border health:

- USAID/KEA Regional Partners and Stakeholders Forum, November, 2019
- Kenya-Uganda Cross Border Health Services Review and Joint Planning Meeting
- Defining a Regional Health Benefit Package for EAC Partner States and Considerations for Operationalization
- Multi-country comparison of ability and willingness to pay for health insurance and save for healthcare expenses at cross-border locations in East Africa
- An assessment of cross border health facility's financial and institutional capacity: Kenya, Rwanda, Tanzania and Uganda
- Burundi Research Summary
- Kenya Research Summary
- Uganda Research Summary
- Tanzania Research Summary
- TB Assessment Report

Measure Evaluation:

- CB-HIPP/baseline/Cross-border study

EAC

- Digital Reach Initiative Strategic Plan 2019-2028
- Harmonized compendium on safety of medicines and technologies

ECSA

- ECSA TB Supply Chain Portal

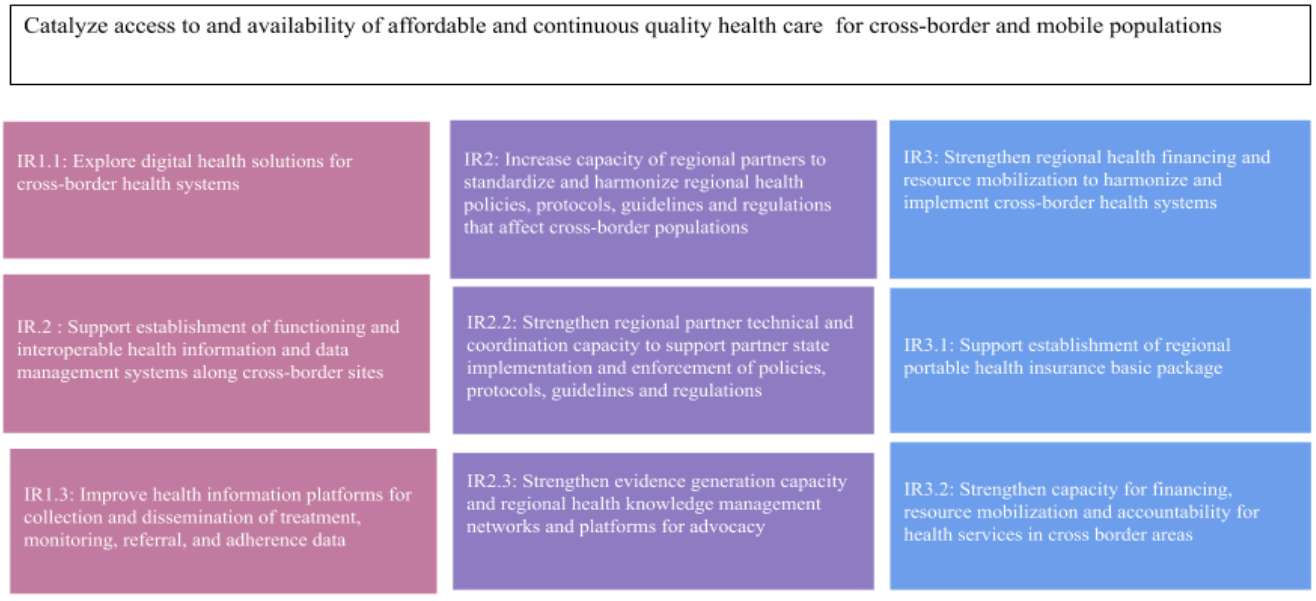
IGAD

- RAD: Digital Health Landscape Analysis

IV. Illustrative Results Framework

The meeting also resulted in the identification of three high level objectives which you will see listed in the illustrative results framework below. We recognize that the identified objectives are also long term goals for the region. However, we feel it is important that we begin and/or continue to work toward those goals. We seek your feedback, within this context, and within the parameters of five year $10-$24.9 million activity, on how best to catalyze change through a collaborative and multi-sectoral approach that leverages the strengths and capacities of existing regional institutions in both the private and public sectors.

Overarching Goal:	Improved management of risks that transcend borders (USAID, Regional Development Cooperation Strategy (2016 - 2021)
Through:	East African led health policies and coordination strengthened for populations vulnerable to risks that transcend borders (PAD level)
Resulting in:	Improved access to and availability of affordable and continuous quality health care for cross-border and mobile populations (Activity level)



***Geographic Focus:** Countries in the East Africa region as defined in the RDCS. These include: Burundi, Djibouti, Ethiopia, Kenya, Rwanda, South Sudan, Somalia, Tanzania, and Uganda.

V. Guiding Principles

The following principles will serve as pillars for programming and implementation plans. These include incorporating tenets of key United States Government (USG) strategies and international mandates including the USAID Kenya and East Africa Regional Development Cooperation Strategy (RDCS).

a. **Journey to Self-Reliance.** USAID focuses on building countries' self-reliance - defined as the ability of a country, including the government, civil society, and the private sector, to plan, finance, and implement solutions to solve its own development challenges. The approach fosters locally led development, mobilization of domestic and other financial resources, and building the capacity of local partners. It also focuses on increasing inclusion of community voices, especially those from youth, women and people with disabilities, to ensure greater collaboration, accountability, economic development, and well-being of all community members. USAID/KEA regional partners working at the national and regional levels will be expected to support the journey to self-reliance, aligned to USAID's approach. There will be a need for partners to redefine relationships with regional intergovernmental organizations (RIGOs) l to develop mobilize national level resources that lead to self-reliance; and working closely with national governments to develop self-reliance matrices, put in place strategies for transition of interventions and legacy programs, enhance financing of interventions through country contributions towards self-reliance, and promote private sector engagement both for service delivery, systems strengthening and financing of health interventions through partnerships and or corporate responsibility.

b. **Invest in Regional leadership, capacity, and systems for long-term ownership, and sustainability.** USAID/KEA places an important focus on developing, supporting, and sustaining the considerable professional talent and institutional capabilities that exist within the region. This requires an investment of time, effort, and resources in developing individual and local organization competencies, systems and processes. Activities will continue to support RIGOs, government and local implementing partners' ability to improve the quality of health and cross-border health systems. The effectiveness of leadership development will be reflected in program outcomes. This activity will build upon past work and successes; and ensure close collaboration with regional partner institutions to ensure that funding supports African agendas that further joint objectives, rather than driving those agendas. The East African Community (EAC) and the Intergovernmental Authority on Development (IGAD) are regarded as key partners in this effort. The EAC is the leading regional economic organization in the region, promoting broad based economic growth and integration. In the health sector, EAC is working to improve the quality of life of the most vulnerable and at-risk mobile and border populations of East Africa through harmonizing health policies and standards. IGAD's mission is to "assist and complement the efforts of the Member States to achieve, through increased cooperation, food security and environmental protection; promotion and maintenance of peace and security and humanitarian affairs; and economic cooperation and integration." Support to both of these RIGOs is strategically designed to leverage existing

capacities as well as other investments and maximize the reach and cost-effectiveness of interventions.

c. Evidence-based Interventions. The interventions must be aligned and direct respond to the needs of the people in cross-border areas, scaling up evidence-based models and that are scalable across countries in the region. The program will work with RIGOs, governments and non-government actors to strengthen management systems to build a body of evidence to improve current and future cross-border programming.

d. Increase involvement of the private sector. The activities must ensure they leverage strategic private sector partnerships and alliances to improve on cross border health systems. The private sector offers expertise in the use of digital technologies for health and in implementing cost-effective models that can complement access to comprehensive services, maximize efficiency and enable beneficiaries and countries to become self-sufficient through various opportunities.

e. Ensure strategic collaboration and coordination. Activities will be implemented in targeted geographic areas to ensure strong collaboration between the RIGOs, their partner states, multi-sectoral structures, civil society organizations, other USG-funded programs and other development partners. USG programs include HIV prevention, treatment and care, child survival programs, (e.g., malaria, maternal, neonatal, child health and reproductive health, nutrition, agriculture and food security as well as education and youth programs). Awards will integrate collaborating, learning and adapting (CLA) framework within, and among implementing partners, RIGOs and their partner states, civil society, community volunteers to strengthen the discipline of development and improve aid effectiveness. They will build synergies across sectors, and leverage resources, including with major donors and agencies such as the Global Fund, World Bank, UNICEF, World Food Program and Governments among others to increase access to, and complement health services and systems for the vulnerable and marginalized populations in cross border areas, minimize duplication of effort and reduce transaction costs.

f. Gender. USAID/KEA is committed to addressing inequities and harmful gender norms that place people at-risk of disease, poor health, and violence. The activities will improve access to and uptake of evidence based cross border health systems interventions by addressing gender and resource inequities, or other barriers to accessing and using the services. Since men and women, girls and boys, access and use services differently, proposed activities will continue to use a gender lens. All interventions must align to USAID's Gender Equality and Female Empowerment Policy.

VI. Technical Guidance Questions

Please provide your responses in written English to the information requested below. Note that the submitted information may not exceed 5 pages.

A. Introductory Information

Please provide, at a minimum, the following contact information:
Name point of contact:

_____

E-mail point of contact:

_____

Name of organization:

_____

Address of organization:

_____

Please provide a short (1 paragraph) narrative about your organization, including its areas of focus.

B. Technical Information

We are interested in receiving feedback on any or all of the following questions

1. Do the problem (s) noted capture the health challenges faced by cross-border and other mobile populations? If not, what is missing?
2. Given the background of past programs focused on cross-border work, what are the main opportunities and critical challenges to improve health in these areas and among mobile populations?
3. What are the critical lessons learned or approaches in addressing cross-border health systems to catalyze accelerated results?
4. Taking into account your organization's experience, how do you think that USAID should prioritize investments so that there is alignment and complementarity of regional cross-border activities with national programs?
5. Within the set parameters of a five- year project timeline and funding levels of $10 - $24.99 million, are the proposed objectives feasible? If not, what do you think could be achieved within those parameters?
6. What are the current trends, innovations, or new approaches being used to address the interoperability of health management information systems? How are digital technologies being used in this area?
7. What are the current trends, innovations, or new approaches being used to address the health financing and insurance issues faced by cross border populations?
8. Given your knowledge of and experience in the region, which border areas do you think USAID should prioritize?

9. Who are the critical stakeholders working on cross-border health issues and what other programs are currently being implemented?
10. How could USAID engage the private sector, host governments and regional intergovernmental organizations (RIGOs) to maximize private sector contribution to address these cross-border health issues?