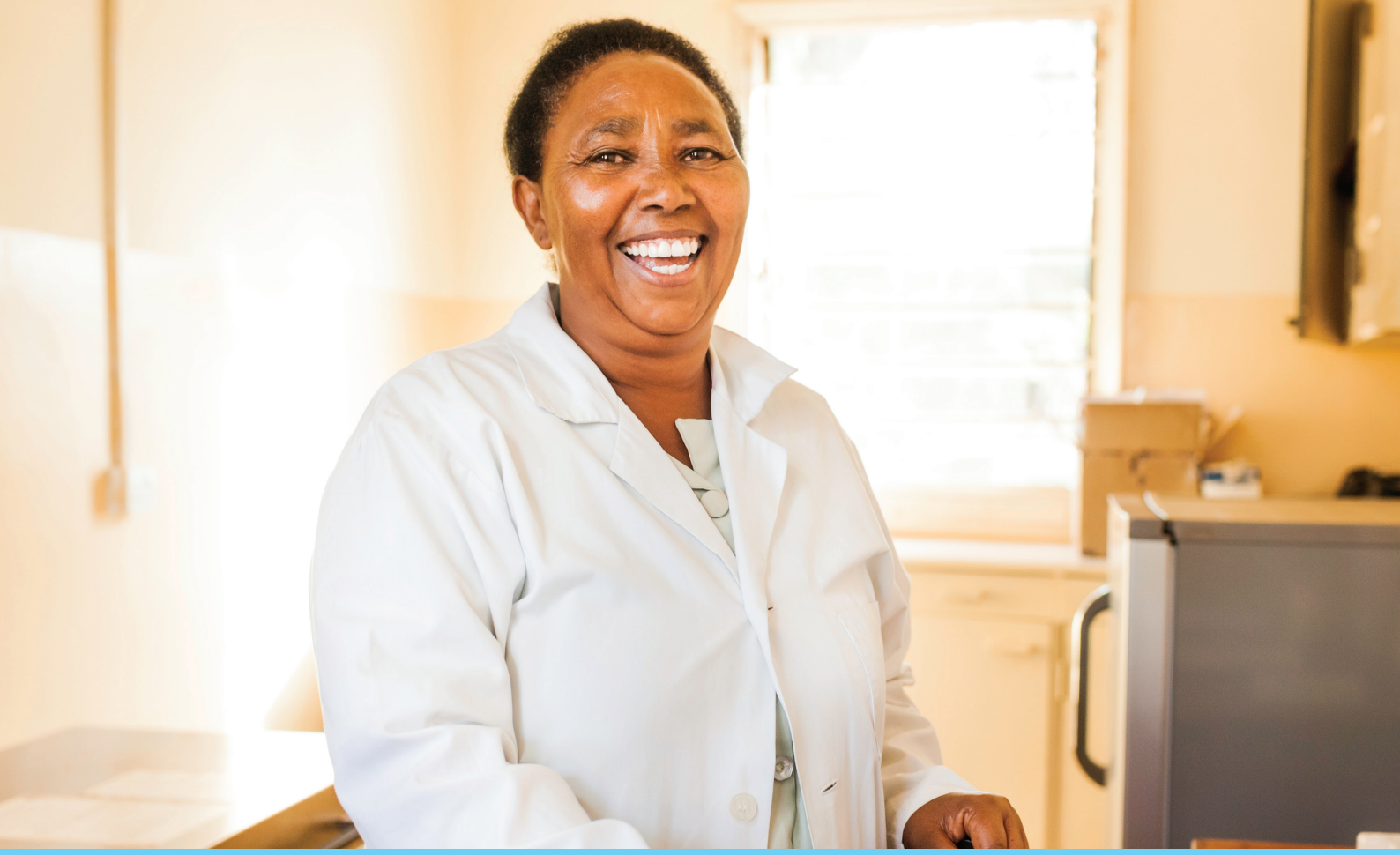


Defining a Regional Health Benefit Package for EAC Partner States and Considerations for Operationalization

2017

USAID FROM THE AMERICAN PEOPLE

Abt ASSOCIATES

fhi360 THE SCIENCE OF IMPROVING LIVES

This document was made possible by the generous support of the United States Agency for International Development (USAID). It was prepared by the Cross-Border Health Integrated Partnership Project, Award Number: AID-623-L-14-00001. The author's views expressed in this publication do not necessarily reflect the views of USAID or the United States Government.

Cross-Border Health Integrated Partnership Project (CB-HIPP). 2018. Defining a Regional Health Benefit Package for EAC Partner States and Considerations for Operationalization. Nairobi, Kenya.

Cover photo: IStock.com

ACKNOWLEDGEMENTS

This report was written by Benson Chuma, Mbogo Bunyi and Katherine Brouhard.

The authors acknowledge the leadership and facilitation of Dorothy Muroki and Boniface Kitungulu from FHI 360. The documented benefited from review by Jeanna Holtz.

The authors are grateful to the USAID Kenya/East Africa Mission for providing the resources for this study.

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

ART	Antiretroviral therapy
CBHI	Community based health insurance
CB-HIPP	Cross-Border Health Integrated Partnership Project
COC	Combined Oral Contraceptive Pill
EAC	East African Community
EACPBP	East African Community Portable Benefit Package
EAC Minimum BP	East African Community Minimum Benefit Package
EAHRC	East African Health Research Council
EPHS	Essential package of health services
GIZ	The Deutsche Gesellschaft für Internationale Zusammenarbeit
HCT	HIV counselling and testing
IEC	Information, education and communication
PITC	Provider initiated testing and counselling
BCC	Behaviour change communication
MOH	Ministry of Health
PLHIV	HIV
UHC	Universal health coverage
WTP	Willingness to pay
WTS	Willingness to save

1 INTRODUCTION

The East African Community (EAC) Vision 2050 aims to accelerate economic growth and transformation in the region. The Vision recognizes the need for the EAC to have a healthy workforce that can contribute to economic development of the region. Complementing this, the EAC Common Market Protocol aims to support the economic and social transformation of the EAC through harmonization of social services across partner states health services. During a recent EAC joint heads of state retreat, expansion of health insurance coverage and social health protection was noted by officials as a key deliverable for the EAC. The lack of an enabling environment, including health financing mechanisms, allowing access to care across borders within the EAC is one of the key challenges that must be addressed to improve access to care across the region. An EAC portable benefit package (EACPBP) would help address this challenge, aligns well with overall EAC policy direction, and complements efforts to accelerate progress towards universal health coverage (UHC) for the EAC.

The EAC has already developed the *EAC Minimum Package of Health and HIV and AIDS/STI Services* (EAC minimum BP) through a participatory, interactive process, involving several stakeholders from the Partner States and led by the EAC Regional Task Force on Integrated Health and HIV and AIDS Programming along Transport Corridors in East Africa. This report uses the EAC minimum package as the reference benefit package. It builds on the work done by the Task Force and uses reports and studies done by the CB-HIPP project to inform ways to enable access to the services by EAC partner state citizens as they move from state to state – i.e. portability of the benefit package.

In this report, **benefit package** refers to an explicit list of included and/or excluded health care services, and any applicable limits.

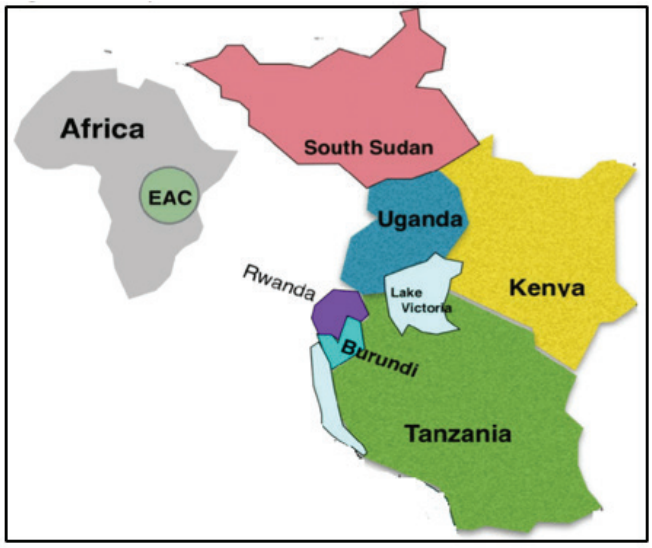
The Cross-Border Health Integrated Partnership Project (CB-HIPP) funded by the U.S. Agency for International Development (USAID) and implemented by FHI360, aims in part to support these effort and extend integrated health services across EAC cross-border areas. Through Abt Associates, the CB-HIPP project has undertaken a number of studies and reviews, to add to the existing literature, which provide insights on how this extension of services can take place and factors that need to be taken into consideration.

1.1 Overview of the EAC

The EAC is a regional intergovernmental organization comprised of six partner states: Burundi, Kenya, Rwanda, South Sudan, Tanzania and Uganda (see map, Figure 1). It has its headquarters in Arusha, Tanzania. The region has an estimated total population of 173 million people and an estimated nominal GDP of USD 163 billion in 2016 (IMF 2016).

The health systems and disease burden are relatively similar across the EAC. For example, the top ten leading causes of mortality by EAC state comprise similar diseases, including HIV/AIDS, Diarrheal diseases and cardiovascular diseases (Annex 1). Characteristics of EAC state health systems including health financing approaches are also similar across states (Annex 2) and primarily characterized by centralized state-run systems. The most significant difference comes with insurance coverage – Rwanda has over 90% coverage where no other state has more than 20%.

Figure 1. Map of the EAC



1.2 Contribution to universal health coverage and improved health outcomes

There is global interest in making progress towards UHC. Accordingly, the EAC states have explicit health financing strategies and roadmaps to reach UHC. Core to the discussion on UHC is a key policy question: *what services should be made available and under what conditions?*

In response, UHC advocates have focused on designing a minimum set of services that citizens should have access to, otherwise known as an *Essential Package of Health Services (EPHS*). An EPHS can be defined as the set of health services that a government is providing or is aspiring to provide to its citizens in an equitable manner. Governments have traditionally used an EPHS to support coverage of priority health services as one tool to achieve UHC (Wright & Holtz 2017*)*.

WHO defines UHC to mean "*all people can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not cause financial hardship".*

Each partner state has an EPHS and is at various stages of implementing it. There are similarities in the EPHSs across EAC states (Annex 3). It is important to note that differences in how the EPHSs are delivered to the people may exist across the states. For example:

Components of the EPHS may be provided at different levels of care by country

Treatment and care management guidelines for the same or similar conditions may differ by country

These differences will need to be assessed prior to implementation of an EACPBP to ensure similar standards of care across countries as the EACPBP is introduced. As outlined in table 2 below, some of this work has already been done as a part of the CB-HIPP and other projects in the region.

A number of studies have been undertaken which can be used to inform the next steps to establish an EACPBP. Table 1 below indicates critical data sources and their importance to defining an EACPBP while Table 2 lists reports and studies already completed.

Table 1 Potential sources of data for use in developing an EACPBP

	Source of data	Potential use
a	Health utilization data for EAC citizens	Enable policy makers to estimate the costs of including different services in the EACPBP
b	MOH budgets/ data	Would aid in understanding health seeking behaviors of EAC citizens. Aid in understanding costs of implementing various health interventions that would be included in the EACPBP. Aid in understanding priority health needs for different partner states
c	Costing studies	Aid in understanding unit costs of various health interventions and across various levels and types (public and private) of providers.
d	Cost effectiveness studies	Can be used to compare two or more interventions and show which interventions offers the most health outcomes for a given amount of money
e	Financial modelling	As data may not always be complete for all the regions, there is a role for creating financial models to help policy makers understand estimated costs of including different services in the EACPBP
f	Regulatory and policy frameworks	This would allow policy makers to understand existing health and health financing regulatory and policy frameworks in the EAC and the necessary laws that may need to be implemented to support implementation of the EACPBP.
g	Clinical treatment guidelines for priority services across the EAC	For all the services included in the EACPBP, an analysis of treatment guidelines and various norms and practices of delivering care would support efforts to ensure continuity in care across the EAC for the beneficiaries. In addition, this would lay the ground for harmonization of guidelines of select priority health interventions.

Table 2 Reports and Studies completed that can provide insights in the process of finalizing and implementing the EACPBP

Document Name	Author/ Source	Use	Date
Situational Analysis and Feasibility Study of Options for Harmonization of Social Health Protection (SHP) Systems Towards Universal Health Coverage in the East African Community Partner States	Gesellschaft für Internationale Zusammenarbeit (GIZ)	Focused on EAC with a wider UHC health financing/systems approach	2013
Mapping of Health Services Along Major Transport Corridors in East Africa	The study was commissioned by the East African Community (EAC) Regional Task Force on Integrated Health and HIV and AIDS Programming along Transport Corridors and implemented by research teams from FHI 360 Kenya, the International Organization for Migration (IOM) and North Star Alliance, in conjunction with Makerere University.	Mapping of private and public facilities along transport corridors	March 2015
Guidance Document for Minimum Package for HIV and other Health Services on East African Community (EAC) Transport Corridors	Developed at the request of EAC secretariat, HIV and AIDS unit and is a product of a collaborative effort, commitment and support from partners, Civil Society Organizations and experts from the five Partner States (Burundi, Kenya, Rwanda, Tanzania, Uganda, and Zanzibar) under the leadership of the EAC secretariat. Supported by the CB-HIPP project	Lays out an EAC Minimum Benefit Package	March 2015
A regulatory analysis of access and financing of HIV and AIDS services in the East African Community: Towards establishing a regional financing mechanism	CB HIPP – Abt Associates	Analysis of Health Finance and regulatory mechanisms in EAC countries specific to HIV & AIDS	February 2016
CB HIPP standard package for Cross Border Health Programming in the EAC	CB HIPP – FHI360	Working document for the CB-HIPP project – based on from EAC minimum package of services doc	2017

CB-HIPP Health Facility Financial and Institutional Capacity Assessment: Kenya, Uganda, Tanzania and Rwanda	CB HIPP - Abt Associates	Initial assessment on financial capacity of cross-border facilities.	January 2017
Multi-country comparison of the costs of healthcare services at cross-border locations in Kenya, Rwanda, Uganda and Tanzania	CB HIPP - Abt Associates	Costing data on Health services at cross-border sites – shows differences in cost of similar services in different countries	February 2017
CB-HIPP Baseline Evaluation Report and Lessons Learned Validation Meeting Report	CB HIPP - FHI360	Baseline report describing the health outcomes, risk factors, behaviors and access to services among target populations in the land and wet/lake cross-border sites.	June 2017
East Africa Cross Border Integrated Health Study	Measure Evaluation	Describes the health status and behaviors of mobile and vulnerable populations living in 12 cross-border sites	June 2017
Background Study for the EAC Strategy and Roadmap for SHP Portability within the context of the EAC Common Market Protocol and the EAC Vision 2050	Gesellschaft für Internationale Zusammenarbeit (GIZ)	Gives an overview of background of health financing systems and how to move ahead with social health protection from a health financing/ UHC perspective	July 2017
The EAC Strategy and Roadmap for SHP Portability within the context of the EAC Common Market Protocol and the EAC Vision 2050	Gesellschaft für Internationale Zusammenarbeit (GIZ)	Provides recommendations following validation meetings.	July 2017
Multi-country comparison of ability and willingness to pay for health insurance and save for health care expenses at cross-border locations in East Africa	CB HIPP - Abt Associates	Indicates target population's willingness and ability to pay and save for health related costs	August 2017
Pricing of a portable benefit package for cross-border and mobile vulnerable populations, as a rider to the Kenya National Hospital Insurance Fund benefit package	CB-HIPP - Abt Associates	Projection of health insurance premiums based on costing report, ATP/WTP and modelling on utilization. Kenya only	October 2017

3 THE EAC MINIMUM BP AND TARGET POPULATIONS

CB-HIPP suggests that services already prioritized by the EAC Minimum BP form the basis of an EACPBP. These priority services were derived through a consultative process with multiple stakeholders from across the EAC that considered the needs of populations living along the EAC transport corridors and focused on HIV prevention and treatment (Table 3). As a result, the current list of EAC priority services is a good place to start but may not fully represent priorities across all services and for all populations.

Table 3 - Summary of priority services as per the EAC Minimum BP

- HIV testing and counselling
- Linkage of those testing HIV positive to care and early ART initiation
- Provider initiated testing and counselling (PITC) offered to all patients attending health facilities
- Distribution of targeted information education and communication (IEC) materials with clear, accurate and tailored behaviour change communication (BCC) messages to generate demand and uptake of services
- Demonstration and distribution of condoms (male and female), provision of messages on dual protection and support for correct and consistent use counselling on condom negotiation skills
- Risk-reduction counselling and skill building
- Education on prevention of sexually transmitted diseases, including HIV, and diagnosis and treatment
- Verbal screening for TB and referral
- Counselling and provision of short- acting FP methods with referral for LAPM of FP
- Counselling on improved water, sanitation and hygiene (WASH) practices— keeping water supplies safe, washing hands, domestic hygiene, keeping household environment free of excreta and solid waste
- First aid services
- Basic treatment, care and support for common illnesses
- Basic laboratory services

The CB-HIPP project has develop a prototype benefit package that used the EAC minimum BP to prioritize key health services that could be provided at cross border sites. This benefit package considered populations living at EAC cross-border sites whose health needs should be prioritized as part of an overall HIV prevention and care strategy – one of the aims of the EAC minimum package. The target populations included:

- female sex workers
- men who have sex with men
- people who use drugs
- PLHIV and discordant couples
- vulnerable women and girls
- transport and other migrant workers and fisher folk.

In contrast, the EAC Minimum BP is broader then the CB-HIPP benefit package, in that is also targets the general population and prison populations and includes emergencies and road traffic accidents.

4 FINDINGS FROM CB-HIPP THAT CONTRIBUTE TO DEVELOPING AN EACPBP

As noted above the EAC has already taken the important first steps of defining a potential benefit package and target beneficiaries. In order to make the benefit package truly portable across international borders and accessible to those populations, a number of key considerations need to be addressed. This section looks at those and summarizes insights from CB-HIPP's body of work that can contribute to these important next steps in the creation of an EAPBP. These considerations include – cost of services across borders, the option of using a health insurance model to pay for services, and the capacity of facilities to manage on the ground implementation of the EACPBP (i.e. appropriate payment processing).

4.1 Cost of priority services in the EAC

The CB-HIPP project carried out a study of costs of providing care in public and private facilities at selected cross-border sites in Kenya, Uganda, Tanzania and Rwanda. There were significant variations in costs across the countries as well as the different types and levels of facilities. For example, the results showed that average costs of outpatient care varied from USD 0.75 to 3.13 across levels of care at public and private facilities in Kenya, Rwanda, Uganda and Tanzania. The average cost of an HIV counselling and testing (HCT) visit varied from USD 2.80 to USD 12. In addition, annual costs of providing HIV adult and pediatric antiretroviral therapy (ART) ranged widely between countries: Kenya (Adult USD 91.73; Pediatric USD 100.69); Rwanda (Adult USD 70.46, Pediatric USD84.46); and Uganda (Adult USD 27.99; Pediatric USD 19.51).

These differences in cost would need to be factored into the design of an EACPBP. The countries involved should find an equitable arrangement to ensure that the payer (government, private, etc.) is paying an equivalent amount in each country for the same services provided.

Note that while these costing results begin to inform the cost of care in cross-border areas, they are not generalizable to inland facilities in the EAC due limitations of the study such as lack of data from hospitals.

4.2 Willingness and Ability to Pay and Save for Health Services

To complement findings from the costing study, the CB-HIPP project conducted a study of households and mobile and vulnerable populations (MVP) at cross-border sites looking at health seeking and healthcare financing behaviors. In addition, the study tested willingness to pay (WTP) and ability to pay (ATP) and willingness to save (WTS) for two product prototypes, one for health insurance and one for health savings used exclusively for health expenditures.

Select findings from the WTP/ATP study

- **Most health expenses are paid for out of pocket; few people have health insurance.** The study revealed that 30 percent of MVP respondents reported incurring a health-related expense on their most recent work trip of which 81 percent paid for out of pocket and 3 percent had covered by their health insurance. Health insurance enrollment was 23 percent across all mobile and vulnerable populations and was lowest among fisherfolk-5 percent. This discrepancy between health insurance coverage and health insurance use could be due to the services covered vs. services needed or due to being out of the country when the service was accessed – i.e. lack of portable insurance product means patients are paying out of pocket.
- **About one quarter of MVP respondents save specifically for health care needs**. Although 52.9 percent of respondents reported saving, only 25.6 percent saved specifically for health care.
- **Willingness to pay for health insurance falls short of the estimated premium.** When presented with a basic health insurance product based on the CB-HIPP benefit package and priced at USD 6.7, only 28. 1 percent of household respondents were willing to pay for it. On average, they were willing to pay less than half this among (USD 0.6 to USD 3.0 per month).

Overall, findings from the study indicate low insurance coverage as well as low ability to pay or save among cross-border MVP and household populations. This indicates that if the EACPBP is a product that beneficiaries must pay for, the price will have to be very low in order to bring in beneficiaries. Even then the study indicates that uptake may be quite low. In this case the pool of beneficiaries would have to be very large in order to make the product financially feasible. The actuarial analysis discussed below give a further indication of this and provides information on the potential pool of beneficiaries.

4.3 Actuarial analysis using costing data, ability to pay and willingness to pay to price insurance products.

The project undertook an actuarial analysis (using data from the costing study and WTP/ABT studies) which explored the option of developing a portable product offered as a rider to Kenya's National Health Insurance Fund (NHIF). This approach, considering a product attached to an existing insurance fund, was considered to increase the financial sustainability of portable benefit package when compared to a standalone insurance product for the target population. The portable benefits included seven service components comprising HIV testing, antiretroviral treatment, tuberculosis treatment, family planning services and screening services. In this scenario, benefits could be accessed by NHIF members enrolled in the rider at NHIF empaneled facilities in the EAC. The pricing for the rider was estimated for two population groups:

- Households living in the cross-border areas and
- Mobile and vulnerable populations living or transiting cross-border areas including truck drivers, fisher folk, and clearing and forwarding agents.

The analysis included pricing three enrolment options for a portable benefit package added as a rider to the current NHIF benefit package for populations in three cross-border counties in Kenya. The enrolment options considered were:

a) Opting in: voluntary for NHIF beneficiaries who were willing to pay the additional premium in addition to normal NHIF premiums
b) Opting out: automatic inclusion in the extra benefits offered by the rider, with the additional premium for the rider incorporated into NHIF rates; those not willing or unable to pay for this rider would need to actively opt out
c) Compulsory: additional premium is incorporated into NHIF rates for all beneficiaries, with no option to opt out.

The estimated premium per member for the rider was largely similar for each enrolment option at approximately KES 1,370 (USD 13.7) per member per annum. For a household with four members, this would translate to KES 5,480 (USD 54.8) per annum and approximately KES 457 (USD4.57) per month. This additional premium represents a 90 percent increase to the current monthly NHIF premium of KES 500 (USD 5) for voluntary informal sector members. Given the findings from the WTP/ATP study we know that this is unlikely to be feasible for the target populations to pay such amounts even if it were possible to increase premiums by such a magnitude.

However, NHIF has an estimated 20 million members, of whom approximately 6.5 million are principal members who contribute monthly premiums. If the cost of the rider for the three border counties/ target populations was spread across the all 6.5 million principal members the estimated premium would be markedly lower at KES 11.4 (USD 0.11) per principal member per annum, representing a much more modest increase of 0.19% to the existing premium for informal sector members. The NHIF could also consider absorbing this much lower expected cost per principal member per year in lieu of attempting to implement a minor premium increase, given the historical challenges for the NHIF to effect increases.

While the actuarial analysis did just look at the NHIF in Kenya the overall lesson is broader. The target populations are generally low-income with low willingness and ability to pay for health insurance products – thus making the EACPBP a product only available to cross-border populations for a fee is likely to result in high-premiums and low uptake. However, making the EACPBP available to a much wider population can make it financial feasible. In order to ensure that the target populations are well served by the portable benefit package the EAC can focus on those communities for enrolment campaigns and ensure that facilities in those areas are accessible through the EACPBP, if they choose to make the PBP an insurance-like product.

4.4 Facility Capacity

Finally, ensuring that target populations can enrol in a low cost EACPBP is only one piece in ensuring that they have access to health services – facilities must be available to offer services and must have the capacity to work with the EACPBP. The CB-HIPP project conducted an assessment of the financial and institutional capacity of selected cross-border health facilities to provide the services outlined in the EAC minimum package. The study found that the majority of both public and private health facilities in the cross-border regions of Uganda, Kenya, Tanzania and Rwanda have room for considerable improvement in financial management and institutional capacity for increasing sustainability of the facilities.

These results show that there are a number of interventions which may be beneficial to improving the sustainability of these facilities. The most relevant to being able to become accredited to participate in the EACPBP are related to financial management capacity. Areas for strengthening financial management capacity include:

a) Regular financial statements, including cash flow, income statement, balance sheet and budget. Train facility-in-charges/owners on how to use the data for decision-making and improving performance;
b) Financial and inventory control systems, including procedure manuals, automated systems, and inventory tracking systems as appropriate;
c) Finance manual development and updating for private facilities, and documenting procedures for public facilities; and
d) Internal and external audit functions.

If the EACPBP is set up as an insurance-type product these facilities will need to strengthen all of these functions in order to be able to appropriately process clients and bill the insurer. Even if the portable benefit package does not end up as an insurance product these facilities could expect an uptick in patients which would also necessitate stronger financial management systems.

5. CONCLUSION

The EAC Minimum BP and target populations is well aligned with ongoing policies aimed at promoting social services and economic growth collectively in the EAC. UHC for EAC citizens across the EAC is an aspiration for EAC member states and a common portable benefit package is a mechanism to achieve this. The unique health needs and characteristics of mobile and vulnerable communities living at EAC cross-border sites and transport corridors should be taken into particular consideration as the EAC works to create and operationalize a portable benefit package based on the minimum BP as these populations are most likely to benefit from an EACPBP.

The process of finalizing and operationalizing the PBP is likely to require extensive stakeholder consultation amongst EAC policy makers and in country within national and regional policy makers as they work to answer questions such as who should be covered, who should pay, where should services be offered and how to align costs and service standards across countries.

Findings generated by the CB-HIPP project provide insights that can advise this design and implementation process. These findings indicate that:

- Costs vary widely across countries, facility levels and services. In designing PBP the EAC will likely need to establish a common cost re-imbursement structure or other mechanism to ensure that the payment burden does not fall inequitably on some countries vs. others.
- Offering an EACPBP as stand-alone voluntary health financing product is unlikely to be economically feasible due to inability to pay, adverse selection and other challenges common to voluntary insurance programs, particularly where public subsidy is insufficient. The actuarial analysis using data from Kenya suggests that even when coupled as a rider to a national health insurance program such as Kenya's NHIF, an EACPBP offered only to cross-border populations would still need be unaffordable for most. CB-HIPP suggests that the EAC states either consider making the portable benefit package mandatory and available to the entire population or that subsidies will be needed to cover key populations with limited ability to pay.
- Cross-border facilities do not currently have the financial management capacity to participate in an EACPBP scheme. Facilities will need strengthening in financial management capacity to manage the payment process for patients accessing services under the PBP. This could include an accreditation process with clear guidelines and standards (both in management and clinical capacity) that have to be met along with a training program for facilities in need of additional support.

In addition to the insights above, this review and the documents available do not address the following considerations:

- EAC partner states will need to determine which entity or entities can purchase health services for an EACPBP. Uganda and South Sudan have some form of public health purchaser which can serve as the lead agent for revenue collection, pooling and purchasing health services from providers. The ministries for health in the other partner states may be suitable to be a lead purchasing agents.
- Particularly with regards to HIV care and treatment, the EAC states legal policies and processes do not always align and this may hamper delivery of specific services through the EACPBP. These misalignments, as well as any differences in service delivery standards for covered services will need to be proactively addressed in the process of developing the PBP.

Despite such challenges, it is conceivable that a well-designed and implemented EACPBP with sufficient subsidy could over time enable EAC citizens to access essential health care outside their home country but within the EAC. To advance efforts to implement an EACPBP, there is a need to expand actuarial and other analyses across the states to inform decision making. Policy makers will need to consider when and how to introduce an EACPBP and how to reach those who are most in need of coverage. They will need to establish, then adapt an EACPBP based on public health and citizen priorities that also reflect the political, fiscal and health system realities across the EAC.

6. REFERENCES

Agnes Gatome-Munyua and Matthew Kukla, 2017. Multi-country comparison of ability and willingness to pay for health insurance and save for healthcare expenses at cross-border locations in East Africa. Bethesda, MD.

Ama Pokuaa Fenny, Robert Yates, Rachel Thompson, 2016. Social health insurance schemes in Africa leave out the poor, *International Health*, Volume 10, Issue 1, 1 January 2018, Pages 1–3

Amanda Glassman, Ursula Giedion, Yuna Sakuma & Peter C. Smith, 2016. Defining a Health Benefits Package: What Are the Necessary Processes? Health Systems & Reform, 2:1, 39-50, DOI: 10.1080/23288604.2016.1124171

EAC Secretariat 2015. Health and HIV and AIDS along the East African Community (EAC) transport corridors: A situation analysis report

Eamon Kelley and Agnes Gatome-Munyua. October 2017. Pricing of a portable benefit package for cross-border and mobile vulnerable populations, as a rider to the Kenya National Hospital Insurance Fund benefit package. Bethesda, MD.

Global Burden of Disease (GBD) Collaborative Network 2017. Global Burden of Disease Study 2016. Results. Seattle, United States: Institute for Health Metrics and Evaluation (IHME), 2017.Available from http://ghdx.healthdata.org/gbd-results-tool.

Jenna Wright and Jeanna Holtz, 2016.

International Monetary Fund -IMF (2016) Report for specific countries: East Africa Community member states. World Economic Outlook Database

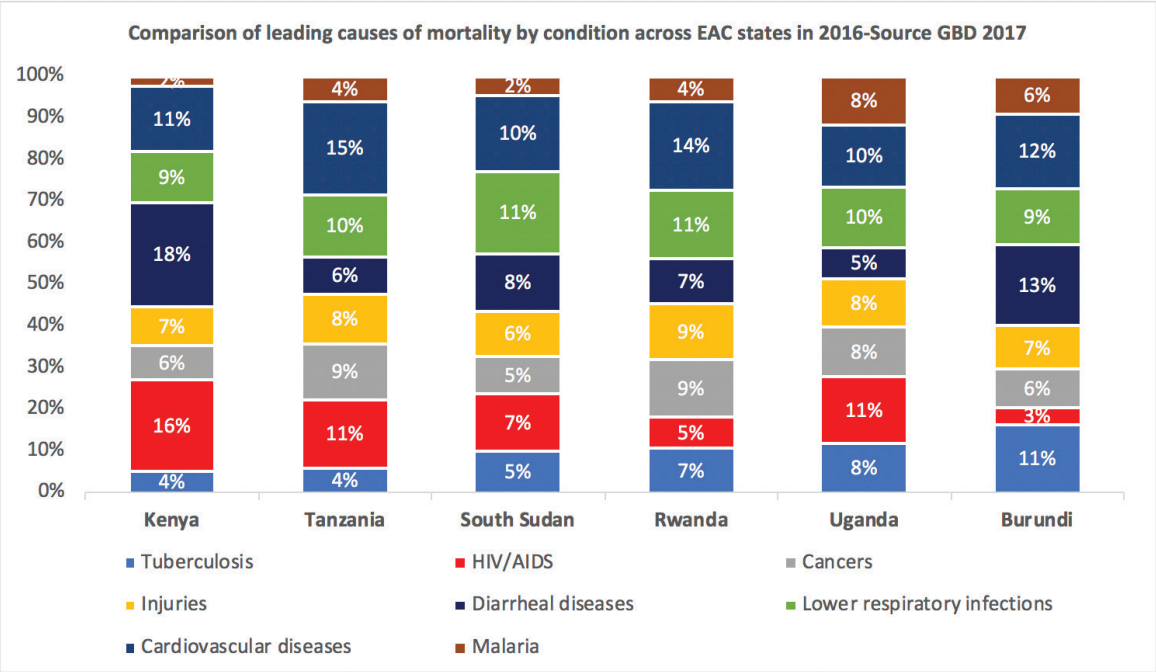
Ministry of Health MOH-Rwanda 2010 Rwanda community based health insurance policy

Robert Holzmann and Johannes Koettl, 2011. Portability of Pension, Health, and Other Social Benefits: Facts, Concepts, Issues.

Mwaura, Racheal Njeri; Barasa, Edwin; Ramana, G.N.V.; Coarasa, Jorge; Rogo, Khama.2015. The Path to Universal Health Coverage in Kenya: Repositioning the Role of the National Hospital Insurance Fund. IFC Smart Lessons. World Bank, Washington, DC. © International Finance Corporation. https://openknowledge.worldbank.org/handle/10986/23485 License: CC BY-NC-ND 3.0 IGO."

WHO Africa Health Observatory, 2018. Burundi Analytical summary - Universal coverage- http://aho.afro.who.int/profiles_information/index.php/Burundi:Analytical_summary_-_Universal_coverage/fr

ANNEX 1: MORTALITY ACROSS EAC PARTNER STATES



ANNEX 2: EAC PARTNER STATES HEALTH SYSTEMS ARE COMPARABLE

Comparison of select health system characteristics in the EAC						
	Rwanda	**Burundi**	**Kenya**	**South Sudan**	**Uganda**	**United Republic of Tanzania**
Lead authority	Ministry of Health	Ministry of Public Health and the Fight Against AIDS	Ministry of Health	Ministry of Health	Ministry of Health	Ministry of Health, Community Development, Gender, Elderly and Children
Decision making and provision of care	Centralized	Centralized	Devolved and centralized	Centralized	Centralized	Centralized
Health providers	Largely Public	Mixed	Mixed	Mixed	Mixed	Mixed
Social Insurance	CBHI	Carte d'Assurance Maladie	NHIF	None	None	NHIF CHF
Population with some form of public/social coverage	91%	13%	20%	-	-	NHIF 17% CHF 4%
EPHS present	Yes	Yes	Yes	Yes	Yes	Yes

ANNEX 3: OVERVIEW OF PRIORITY SERVICES IN THE EPHS ACROSS THE EAC STATES

Service	Description	Burundi	Kenya	Rwanda	Uganda	Tanzania	South Sudan
Child health	Systematic examination of children under five, identification and referral for malnutrition.	✓	✓	✓	✓	✓	✓
	Immunization for Under five	✓	✓	✓	✓	✓	✓
	Deworming	✓	✓	✓	✓	✓	✓
	Distribution of essential foods	✓	✓	✓	✓	✓	✓
	Integrated Management of Childhood (IMCI)	✓	✓	✓	✓	✓	✓
	Management of Respiratory, Diarrhoea infections	✓	✓	✓	✓	✓	✓
	Distribution of Mosquito nets	✓	✓	✓	✓	✓	✓
Screening for communicable conditions	Prevention and treatment of common diseases-HIV/AIDS, TB, STI	✓	✓	✓	✓	✓	✓
	Diagnosis and Treatment for Malaria	✓	✓	✓	✓	✓	✓
Antenatal and Post Natal Health	Physical examination of pregnant mother; tetanus vaccination; supplementation (*Folic acid, multivitamins, calcium, ferrous sulphate);* intermittent presumptive treatment for malaria in endemic areas; antenatal profiling; delivery planning; syphilis detection and management; provision of family planning services	✓	✓	✓	✓	✓	✓
PMTCT	Counselling on early initiation of breastfeeding and exclusive breastfeeding	✓	✓	✓	✓	✓	✓
Integrated vector management	Residual spraying with insecticide	✓	✓	✓	✓	✓	✓
	Distribution of LLITN	Distribution of bed nets	✓	✓	✓	Use of insecticide treated mosquito nets (ITNs)	✓
	Vector Control		Destruction of malaria breeding sites			control of malaria in pregnancy, and	✓
	Vector Control		Household vector control (cockroaches, fleas, rodents)			malaria epidemics prevention and control	✓
Good Hygiene practices	Appropriate hand washing with soap, appropriate latrine use, food outlet inspections, household water treatment	✓	✓	✓	✓	✓	✓
HIV and STI prevention	Management of sexually transmitted infections, post exposure prophylaxis, condom distribution/ provision, HIV testing and counselling (HTC/ PITC)	Included but with emphasis on syndromic management	✓	✓	✓	✓	✓
HIV/STI/TB Treatment	ARV therapy, TB treatment, treatment for STI	✓	✓	✓	✓	✓	✓