STRATEGY FOR THEIMPLEMEMENTATION OF THE OPEN HEALTH INITIATIVE TO IMPROVE THE HEALTH OF WOMEN AND CHILDREN IN THE EAST AFRICAN COMMUNITY PARTNER STATES

March 2012

The objectives of 'The Open Health Initiative' are to promote innovative interventions and enhance access to data and information for better results, better tracking of resources and stronger oversight of results and resources for women's and children's health nationally and regionally within the East African Community Partner States towards achievement of Millennium Development Goals 4 and 5.

I. Regional Context

The world is making important progress in reducing the number of women and children dying from preventable diseases and ill health. Of the eight (8) Millennium Development Goals (MDGs), the two specifically concerned with improving the health of women and children are the furthest from being achieved by the target date of 2015. With very few exceptions, efforts to reach these Goals in the East African Community are not on track. Improving the health of women and children contributes extensively to economic development, which in turn contributes to better conditions for women and children.

The East African Community countries share similar characteristics with respect to the disease burden (challenges of new diseases such as HIV/AIDS and old endemic diseases like malaria), delivery systems (decentralized health care delivery through Districts, Governmental and Non-State providers), constraints imposed by limited budgets, and challenges to meet the health-related Millennium Development Goals (MDGs), 4, 5 and 6. The improvement in the health and overall quality of life and social well being of the women and children of East Africa depends very much on the provision, affordability and access to good health services to the general population at large.

Maternal mortality and morbidity remain a serious concern in the East African Community region. The Maternal Mortality Ratio (MMR) for 2010 was estimated at 410/100,000 live births for Kenya, 454/100,000 for Tanzania, 435 /100,000 in Uganda, 750/100 000 for Rwanda, and 866/100,000 for Burundi, giving a weighted Maternal Mortality Ratio (MMR) average of 583/100,000 live births for the region. These rates are high by any standards. It is estimated that for every woman who dies, 15 suffer long-term illness and disability, including obstetric fistulae, whose true magnitude is still unknown. The high mortality and morbidity can be explained in part by the fact that the vast majority of births still take place at home and are not attended by skilled attendants. Skilled attendance coverage remains relatively low in all the countries of the region (58% in Kenya, 42% in Uganda, 46% in Tanzania, 61.6% in Rwanda and60.0% in Burundi).

Although some gains have been made in reducing infant and under-five mortality and morbidity in many of the countries in the sub-region, this progress is largely attributed to the significant improvement in the general immunization status of children. The Infant Mortality Rate (IMR) for 2010 was estimated at 116/1,000 infants for Burundi, 51/1,000 infants for Tanzania, 76/1,000 infants in Uganda, 52/1,000 infants for Kenya and 72/1,000 infants for Rwanda, giving a weighted IMR average of 71/1,000 infants for the region. The weighted Under-Five Child Mortality Rates (U5-CMR) average rate for 2010 was

71/1,000 children for the region. With some exceptions, there appears to have been little improvement in neonatal mortality rates and to some extent gains made in child health have in recent years been adversely affected by the HIV/AIDS pandemic. Maternal health and child survival problems are worsened by poor performance of health systems; inappropriate reproductive behavior and the low status of women among others.

Amongst other initiatives, in July 2010, the Heads of State and Governments from various African Countries gathered in Kampala, Uganda to discuss the major issues and challenges facing their continent with special focus on maternal, newborn and child health and the attainment of MDGs 4 & 5. During this Summit, the African Heads of State pledged to meet the 15% Abuja target for allocation of national resources for health and also the creation of the "Campaign for the Accelerated Reduction of Maternal Mortality in Africa (CARMMA)".

II. Global Context and the "Open Health Initiative"

In September 2010, in an effort to accelerate progress, the Secretary General of the United Nations launched the initiative "Every Woman, Every Child" which is a global strategy to improve the health of women and children and to accelerate progress towards the achievement of Millennium Development Goals 4 and 5. The "Every Woman, Every Child" is a multi-stakeholder strategy in which the public sector, private sector, nongovernmental organizations, academia, professional groups, and the UN are all included, engaged, and making and implementing explicit commitments. In support of this, a special Commission on Information & Accountability for Women's and Children's Health was created, which aimed to propose ways to encourage countries and their partners to be more accountable for women's and children's health.

In a related development, and in recognition that none of these and other development gains can be achieved without good governance, the 'Open Governance Initiative' was launched in 2011. It aims to secure concrete commitments from governments to promote transparency, empower citizens, fight corruption, and harness new technologies to strengthen governance. Nearly 50 countries including some from the East African Community have already joined this Initiative.

A third critical development globally has been the on-going global financial crisis. While the economies of East African Community Partner States have weathered this storm relatively well, it has had impact on the available international investments and development aid resources. Calls for greater efficiency and effectiveness have increased to ensure the limited resources available to improve the health of our populations can be maximized. The recent cancellation of the Global Fund's Round 11 is one very real expression of the current global financial constraints we are all facing.

In is in this context that the 'Open Health Initiative' was conceived. In light of the above, three themes emerged as the most relevant for this particular Initiative:

1. Accountability for Results and Resources;
2. Performance-Based Financing; and
3. Innovation.

Given the EAC's increasing cohesion and integration; given how relevant MDGs 4 & 5 are for our region; and given how relevant these themes are to our countries currently, it was felt most appropriate to launch the 'Open Health Initiative' in the East African Community initially.

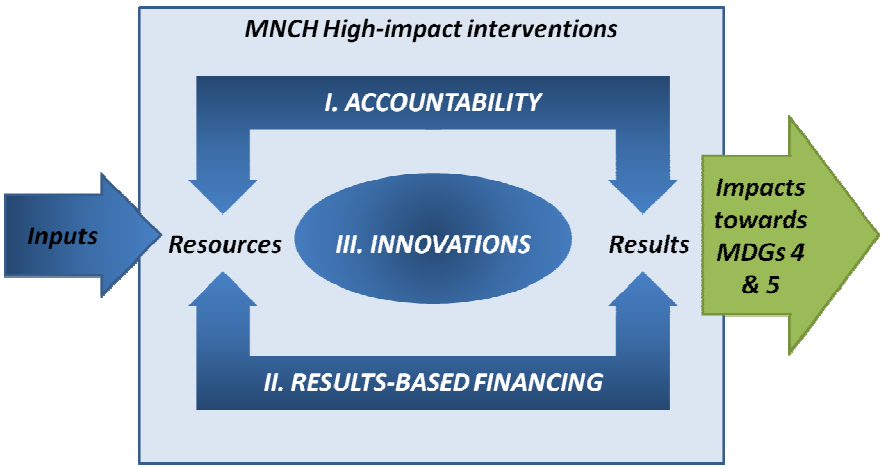
III. Goals and Objectives of the "Open Health Initiative"

Supported by a number of global partners, including the Government of Norway, the East Africa Community's 'Open Health Initiative' is a concrete and clear response to the regional needs and the global context.

The overall **goal** of this Initiative is to contribute to the improvement of maternal and child health and ultimately the achievement of the Millennium Development Goals (MDGs 4 and 5) within the East African Community Partner States.

More specifically, the **objectives** of this Initiative are to promote innovative interventions and enhance access to data and information for better results, better tracking of resources and stronger oversight of results and resources for women's and children's health nationally and regionally within the East African Community Partner States as illustrated in Figure 1:

Figure 1. The Open Health Initiative Framework



Having a regional approach could greatly serve to leverage the tremendous efforts already on-going across all countries in the region. For example, this regional Initiative will:

1. **Increase Value for Money:** Across all EAC countries, numerous and often similar initiatives and pilots are being implemented to tackle MDGs 4 and 5. The high up-front investment costs (i.e. time spent designing an intervention, testing it, evaluating it) could be reduced if these were shared across the region: a successful intervention in one country could lead it to being more rapidly adapted and/or adopted in another country if shared appropriately. Though each country has indeed its own specificities, many of the challenges are nonetheless similar and we do need to 're-invent' the wheel every time. Similarly, investments in new systems, tools, technologies could benefit from greater economies of scale, in particular in the areas of e-health.

2. **Leverage Political Momentum:** The 'Open Health Initiative' is also a way to increase political commitments, generate greater political momentum towards reaching MDGs 4 and 5, and raising the profile of some of the thematic areas beyond the health

sector. Furthermore, in order to more quickly address some critical issues – such as greater transparency and accountability - the five member states would stand to gain by speaking as One Voice, both internally as well as when engaging with external partners.

3. **Learn and Scale-up:** All five EAC Partner States are making progress towards MDGs 4and5. At current rates, however, most will not reach these goals by 2015. This approach seeks to harness what has already been achieved in each country and leverage that across the region in order to accelerate scale-up. Networking, sharing of lessons learnt, and facilitating scale-up could make a dramatic difference as the countdown to 2015 begins. Experience has taught us that such sharing and learning does not happen automatically: it must be facilitated and supported, something the EAC is well positioned to do.

In this initial phase of the 'Open Health Initiative', between now and the Heads of State Summit in November 2012, the EAC Secretariat will work with all Partner States to develop a robust 'Open Health Initiative' Strategy, supported by concrete and costed implementation plans across all three thematic areas. A particular focus will be placed on developing a regional e-health strategy in order to accelerate advances made by several countries already, such as Rwanda and Kenya. In consultation with all Partner States, the EAC Secretariat will also design a platform and mechanisms that will enable all Partner States to more actively and constructively share best practices and lessons learnt in order to accelerate the achievement of MDGs 4 & 5.

IV. Thematic Overviews

Theme 1: Accountability for Results and Resources

This theme is growing in importance across all countries and sectors. It speaks to both programmatic accountability as well as financial accountability. Together with the notions of transparency and greater openness, this is at the heart of current global and regional efforts to accelerate progress towards the MDGs and improve the efficiency and effectiveness of major global and national public health efforts.

In the context of the EAC, particular attention should be paid to maternal and child health and the implementation plan of the Commission on Information & Accountability for Women's and Children's Health. A number of countries in the region have already undertaken positive steps in this direction. We see this theme very much linked as well to issues of 'efficiency and effectiveness', whereby we must strive to get 'better health for the resources,' as highlighted by the recent work of the Taskforce on Innovative International Financing for Health Systems.

Given the focus on women and children, one of the important parts of this work will be to strengthen vital registration systems and introduce mandatory maternal, neonatal and child death audits at health facility and community levels. Community empowerment along with local political support through parliamentary and civic leadership will be critical for successful outcomes. As well stated in the final report of the Commission on Information and Accountability for Women's and Children's Health, key words in this respect include the need to *Monitor* – providing timely and relevant information on what is happening – to *Review* – analyzing data to see where progress is being made and where more efforts are required – and to *Act* – using the information and evidence that emerge from the review

process and doing what has been identified as necessary to accelerate progress towards improving health outcomes and meeting commitments.

The same applies to financial resources. Better and more accurate resource tracking is equally important as the large donors are becoming tighter with available funds and in some cases due to financial constraints cancel large expected donations *(Global Fund Rd. 11)*. In this regard, one of the best way to expand health care and reach MDG 4 & 5 is to ensure funds are being budgeted and spent most 'efficiently and effectively.'

A number of countries in the region have already made great strides towards great accountability for results and resources. To illustrate this, below are three examples from Rwanda and Uganda.

- *Rwanda:* Since 2009, Rwanda has implemented a yearly resource tracking exercise. It looks at all health sector spending and budgets and drills down the information to the activity-level, which is then categorized by cost category, health sector strategic objectives, district, etc. This allows all stakeholders to see where the resource are going, for which priority areas, to do what, from whom they are coming from and who is implementing. This gives Rwanda the ability to identify gaps or redundancies as close to real-time as possible.
- *Uganda:* The MoH recently has begun an HIV assessment to track the absorption rates of partner funds publically committed to the fight of HIV. This assessment will allow the government to address donors with low absorption rates and increase the amounts available to address the current gap between patients in need of treatment and patients accessing treatment.
- *Rwanda:* Rwanda is now scaling-up its mHealth system for Community Health Workers to track pregnant women, as well as better collect and report on Millennium Development Goal indicators at the community level

Selected actions to move this theme forward across the region include:

a. Develop EAC Regional and National level strategies to implement identified priority recommendations of the WHO Commission on Information and Accountability;
b. Develop and implement an EAC regional and national level framework agreement and mechanism for monitoring and evaluation of data and information and ensure accountability for results and resources to improve the health of women and children in the EAC Partner States, including a web-enabled GIS and HealthMapper integrated information management system;
c. Implement detailed and yearly country resource tracking exercises with a particular focus on areas relevant to maternal and child health, as a complement to National Health Accounts
d. Agree on common approach (speaking as 'one voice') to strategically and operationally engage with development partners on resource allocation and alignment with country priorities and greater predictability and sustainability of external funding across the EAC

Theme 2: Results-Based Financing

Over the last decade, multiple countries in the EAC have begun piloting and implementing RBF to accelerate the improvement of maternal and child health. These include performance-based financing schemes based on services provided or health outcomes, various health insurance schemes, co-payment modalities, public-private partnerships, targeted taxes or levies to increase the fiscal space, etc. Some of these initiatives have been very successful, and many could have an even greater impact if brought to a larger scale across the EAC. By accessing the market size of the EAC it will allow some of these financing mechanisms to move towards greater sustainably.

Due to the success of some of these programs there is considerable interest and commitment to scaling up these financing mechanisms for health in all the five countries of the EAC. That said there are some limitations leading to duplication in effort and hindering projects ability to scale nationally or regionally: multiple pilots are on-going without a clear sense of their results or impact, knowledge sharing across countries (and even sometimes within countries) is sub-optimal, and there are also local specificities that need to be considered and which require certain successful approaches to be adapted appropriately.

A more concerted and deliberate effort to look at these interventions across the region has therefore huge potential impact, in particular for those countries not yet implementing such approaches. An important part of the work over the next few months will be to gather evidence and information on successful interventions and best practices in the region with regards to Results-Based Financing. While there is not a 'one-size-fits-all' model there are certain principles and key requirements necessary to enable a functioning RBF system that is needed, including a functioning HMIS and clear roles and responsibilities between 'purchasers' of care, 'providers' of care, and independent verifiers of results. Below are examples from Rwanda, Tanzania and Burundi:

- *Rwanda:* Rwanda has a nation-wide PBF mechanisms, which rewards facilities against a series of indicators across all areas. This is largely a fee-for-service model, whereby facilities are rewarded based on the number of interventions/acts undertaken, with also some quality measures. This is probably the most comprehensive PBF model to date in the region and has recently been expanded to Community Health Workers as well.
- *Tanzania*: Tanzania is currently implementing a large-scale pilot of another model of an RBF specifically targeting maternal and child health, with the support of Norway and the Clinton Health Access Initiative. In this model facilities are being rewarded against a set of 7 outcome indicators along the continuum of maternal, newborn and child care, all of which can be captured in the country's HMIS. There are also a few indicators addressing quality of care (i.e. use of partograms). While the pilot is still on-going, the region in which it is being piloted has shown a drastic increase in HMIS submissions rates of about 50%.
- *Burundi:* Burundi has been implementing PBF schemes in various parts of the country for several years with success. It has also experimented the approach with private purchasers of results.

Selected actions to move this theme forward across the region include:

a. Country level advocacy and sensitization showing the value of sharing information about country level RBFs across the region;
b. Develop an overview document and information portal for knowledge sharing of successful RBFs programs across the region;
c. Develop an EAC regional and national level RBF operational manual and implementation framework through involvement of National Ministries responsible for Health, Economic Planning and Finance;
d. Mainstream RBF activities into key health sector systems and services to improve health of women's and children's health (Promotive, Preventive, Curative, Rehabilitation and Implementation Research)
e. Identify and implement changes required to re-focus the health platform to be results-oriented rather than input- or process-oriented, including increased focus on creating demand, applying quality improvement methods, and making governments and providers more accountable for results

f. Establish and operationalise relevant technical committees (Joint Technical Steering etc) of the various EAC regional policy organs (EAC Council of Ministers & EAC Health Ministers) and EAC Partner States' National Ministries responsible for Health, Economic Planning and Finance and ICTs and Research
g. Increase country capacity to manage, oversee, and operate national health systems through the use of information and evidence for decision-making;
h. Conduct joint assessments of EAC regional and national health programs, shared reviews of financing gaps and absorptive capacity, and refined auditing and reporting tools through multilateral and special global partnerships.

Theme 3: Innovation

Innovation can mean many different things. In this context, we refer to the use of innovative technologies or approaches that can help accelerate the achievement of a result, make more efficient use of limited staff time and resources, or help us d things we were not able to without new tools and technologies. Currently technological innovations are seldom widespread but often small scale and not coordinated or integrated within the broader health system. They are rarely scaled nationally let alone regionally. This leads to inefficiencies and duplications of successful – and unsuccessful – pilots. By addressing this regionally we can leverage successes beyond countries and accelerate scale up, with a focus on three particular aspects of innovation:

1. **Technological Innovations** in support of healthcare delivery through e-health or m-health are particularly important, but need to be better integrated into broader health strategies.
2. **Innovations in Implementation and Scale-up** need to be better harnessed, leveraging national and regional networks of institutions. Methods and experiences on how to successfully move from pilot to scale-up need to be shared, as these have proved to be particularly challenging. Indeed, too often pilots are implemented but never scaled-up despite successful results.
3. **Innovations for 'hard to reach populations'** are equally important if EAC countries are to reach the MDGs equitably across all geographies and populations. This is particularly relevant in some of the border areas between Partner States.

Examples of innovations are included below:

- *Kenya:* SMS technology is being used in Kenya to reduce the time lag between when HIV exposed infants are tested and receive results. This has greatly reduced the risk of HIV exposed babies not receiving their results due to the result being unavailable at the time when caregivers returned to the facility. In addition, Kenya has set up a web based information system, including a dashboard, where over 2,000 facilities can now access, via the web, the number of infants tested and positivity rates.
- *Rwanda:* Rwanda has been a leader amongst developing countries in terms of rolling out eHealth. Particular efforts have been made to ensure a national, integrated approach is adopted through the development of a national eHealth Strategy and the development of a common Enterprise Architecture Framework to ensure that all IT systems and databases can interact with each other.
- *Tanzania/Zanzibar:* Zanzibar is scaling up a mobile phone-based decision support application that helps health workers identify and treat children with severe acute malnutrition

Selected actions to move this theme forward across the region include:

a. Begin country level advocacy and sensitization showing the value of sharing information regarding innovation programs currently being implemented in EAC countries;
b. Develop an overview document and information portal for knowledge sharing of successful innovative programs across the region;
c. Develop through consultation with Partner States, an "EAC Regional e-Health Strategy 2012-2016";
d. Identify innovative priority strategies to address health system bottlenecks that constrain improved health for women and children and their communities and develop potential regional scale-up plans to benefit from economies of scale;
e. Work with relevant national health and research institutions to establish robust support network and best practice guidelines across the region, with a particular focus on moving from pilot to sustainable scale-up;
f. Identify and integrate parallel vertical programs to effectively and efficiently utilize all available resources;
g. Map hard-to-reach populations and systemic bottlenecks that create barriers to care for them, and adopt a regional approach to addressing this particular challenge, in particular in border areas.

V. Way forward

Following discussions and inputs by the 'Reproductive, Child, Adolescent Health and Nutrition' and 'Health and Health Systems, Research, and Policy' Technical Working Groups at the at 15th Ordinary Committee Meeting the timeline below was agreed upon to ensure that the 'Open Health Initiative' can be adopted by the Heads of States in November 2012:

Date	Milestone	Key action point
March	Council of the Ministers of Health	Open Health Initiative discussed and agreement that the Initiative be included in the Heads of State Summit agenda
April - May	In-country consultations	Develop draft v1 of the 'Open Health Initiative' through in country consultations and conferences
Mid May	Initiative Review by an Expert Committee compiled of individuals from each Partner State	Draft v2 of the 'Open Health Initiative' strategy is prepared with Partner State input and consultation and disseminated
Mid June	Proposed workshop for Ministers of Health	Draft strategy v3 is discussed and edited as needed
Mid July	Joint EAC Technical Working Group review and feedback	Draft strategy v4 is discussed and edited as needed by TWG on Health Systems and Policy and TWG on Maternal, Reproductive and Child Health
Mid August	16th Ordinary Meeting of the Health Sector Committee	Final draft of the 'Open Health Initiative' strategy is presented and discussed
End August	Final draft of the Open Health Initiative is completed	Final 'Open Health Initiative' strategy is disseminated to Partner States ahead of Council of Ministers
End September	Council of the Ministers of Health	'Open Health Initiative' is presented and discussed
End November	Council of Ministers	'Open Health Initiative' approved by Council of Ministers for adoption by Heads of States
End of November	Heads of States Summit	'Open Health Initiative' strategy adopted