East African Community

EAC REGIONAL HEALTH POLICY

NOVEMBER 2016

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LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Anti-Retro Viral Therapy
ARV	Anti- Retro-Viral
AU	African Union
BCG	Bacillus Calmette–Guérin
CBOs	Community Based Organization
CBR	Crude Birth Rates
CoEs	Centers of Excellence
CSOs	Civil-Society Organizations
DD	Demographic Dividend
DHIS2	District Health Information System 2
DHS	Demographic and Health Survey
DMIS	District Management Information System
DPML	Directorate of Pharmacies/Medications/ Laboratories
DTP3	Diphtheria Tetanus Pertussis
EAC	East African Community
EAC-RHP	East African Community Regional Health policy
ECSA	East, Central and Southern Africa Health Community
EMHS	Essential Medicines and Health Supplies
FBOs	Faith Based Organizations
GDP	Gross Domestic Products
HIV	Human Immunodeficiency Virus
HLIS	Health Logistics Information System
HMIS	Health Management Information System
HRH	Human Resources for Health
HSS	Health System Strengthening
HSSF	Health Sector Services Fund
HSSP	Health Sector Strategic Plan
ICT	Information & Communication Technology
IGAD	Inter Governmental Authority for Development
ILO	International Labour Organization

IMR	Infant Mortality Rate
IOM	International Organization for Migration
IRS	Indoor Residential Spraying
ITN	Insecticide Treated Mosquito Nets
M&E	Monitoring & Evaluation
MDG	Millennium Development Goal
MERS-COV	Middle East Respiratory Syndrome Corona Virus
MMR	Maternal Mortality Ratio
MoH	Ministry of Health
MSD	Medical Stores Department
NCD	Non-Communicable Disease
NHA	National Health Accounts
NMRA	National Medicines Regulatory Authority
NTD	Neglected Tropical Diseases
OOP	Out of Pocket
PBF	Performance Based Financing
PPP	Public Private Partnership
PRS	Poverty Reduction Strategy
PS	Partner State
R&D	Research and Development
RHP	Regional Health Policy
SHP	Social Health Protection
STI	Sexually Transmitted Infection
SWOT	Strength, Weaknesses, Opportunities & Threats
TB	Tuberculosis
TFR	Total Fertility Rate
THE	Total Health Expenditure
TRIPS	Trade-Related Aspects of Intellectual Property Rights
TWG	Technical Working Group
U5MR	Under-Five Mortality Rate
UHC	Universal Health Coverage
UN	United Nations
URTI	Upper Respiratory Tract Infection
WHO	World Health Organization
WTO	World Trade Organization

FOREWORD BY THE SECRETARY GENERAL OF THE EAST AFRICAN COMMUNITY

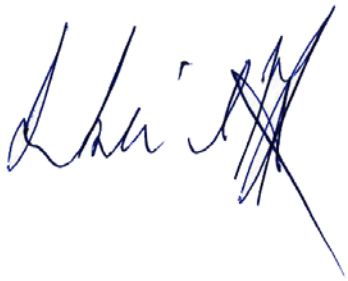
Article 118 (b) of the Treaty on the establishment of the East African Community (EAC), with respect to co-operation in health activities stipulates that the partner states undertake to promote the management of health delivery systems and better planning mechanisms to enhance efficiency of health care services within the partner states. This necessitated the development of a coherent guiding document to advance the objectives of the treaty and to cope with current and policy future health challenges.

With the vision of having healthy and productive population in the EAC, this Health Policy which is the first since the establishment of the EAC, articulates the 9 regional policy objectives and related strategies to improve the quality of life and overall wellbeing of the people of East Africa through the strengthening and integration of health systems to facilitate cross-border provision of affordable, accessible and quality health services in accordance with the vision and mission of the EAC. I hope that this RHP will help to achieve the SDGs targets and specifically the Universal Health Coverage in the East African Region.

In order to successfully operationalize the EAC Regional Health Sector Strategic Plan, development of national and regional strategic health sector plans, policies, guidelines and protocols will be developed under its framework. This requires concerted efforts of the Ministries responsible for health in EAC Partner States and their private sector, civil society and international development partners involved in health in the region

I therefore call upon all stakeholders stated above to support implementation of the EAC Regional Health Policy.

To this end, the office of the EAC Secretary General in collaboration with all EAC Organs and Institutions will continue to support the health agenda and mobilize global and regional leaders to ensure coordinated and coherent implementation of the Policy and the attainment of its objectives.



Ambassador Liberat Mfumukeko
Secretary General
East African Community

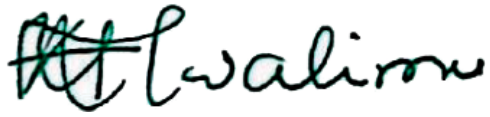
MESSAGE OF ENDORSEMENT BY THE EAC SECTORAL COUNCIL OF MINISTERS OF HEALTH

As the Policy Organ for Health Sector in the East African Community, We, the Ministers responsible for Health from the Republic of Burundi, Kenya, Rwanda, United Republic of Tanzania and Uganda, hereby referred to as the Sectoral Council on Health endorse the EAC Regional Health Policy as the main document to guide the development of other health related documents in the region .We approved the EAC Health Policy on 18th November 2016 during the 13th ordinary meeting of the sectoral council.

The development of this East African Community Regional Health Policy marks an important milestone in the continued strengthening and deepening of regional cooperation and integration in the health sector in accordance with the relevant provisions of the Treaty for the establishment of the East African Community.

This EAC Regional Health Policy will inform and guide the development of Health policies and strategic plans across EAC Partner States and its implementation will be coordinated and overseen by the EAC Sectoral Council on Regional Cooperation on Health as established by the 4th Ordinary Session of the EAC Council of Ministers on 2002.

We, the Ministers responsible for Health of the EAC partner state wish to express our full commitment and dedication to the implementation of this Health Policy.



Hon. Ummy A. Mwalimu , MP
Chairperson of the EAC Sectoral Council on Health
United Republic of Tanzania

1. INTRODUCTION

1.1 Background and Legal Basis

The Treaty for the Establishment of the East African Community[1], in Article 118, requires the development of a Regional Health Policy (RHP) to proceed in the systematic follow up on the main policy areas listed in this article and to further embark on the detailing into a coherent and guiding document to advance the objectives of the treaty and to cope with current and future challenges.

Together with the EAC Protocol on the Establishment of the EAC Common Market,[2] the Treaty provides the legal basis for the development and implementation of future EAC health sector strategies. The EAC Development Strategy[3] and other EAC adopted Action Plans and Policies that impact the health sector provide further background and direction for the development of a RHP, i.e.

- Sustainable Development Goal 3
- EAC Regional Pharmaceutical Action Plan (2012-2016)
- EAC Regional Intellectual Property Policy on the Utilization of Public Health-Related WTO-TRIPS Flexibilities and the Approximation of National Intellectual Property Legislation[4]
- Protocol of the Establishment of the Health Research Commission
- Protocol on Environment and Natural Resources Management[5]
- EAC Food Security Action Plan (2011-2015)[6]EAC Climate Change Policy[7] with regard to the impact of climate on the health of the population

[1] Treaty for the Establishment of the East African Community (as amended on 14th December, 2006 and 20th August 2007)
[2] 20 November 2009
[3] EAC Development Strategy (2011/12-2015/16): Deepening and accelerating Integration, one people, one destiny
[4] February 2013
[5] 3 April 2006

The EAC Partner States are signatories to a number of International Treaties and commitments/initiatives, relevant for the health sector and the industries that provide goods and services for the sector such as the World Trade Organization (WTO), the International Labor Organization (ILO), the United Nations and African Treaties and Agreements such as the African Union (AU) and the Inter-Governmental Authority for Development (IGAD). These will also provide the legal basis and reference points for the design and implementation of the EAC Regional Health Policy. The national visions, policies, strategy documents, situation analyses, studies and statistical information were used for the conception of this RHP. The national representatives and academic institutions have corrected and/or completed the originally drafted overviews and analyses. This EAC Health Policy is the first one since the inception of the EAC Treaty.

1.2 Policy Development Process

Extensive consultations of EAC Partner State officials and representatives of their stakeholders have taken place, supported by National, Regional and International Consultants, guided by the EAC Secretariat. A five day workshop of EAC Secretariat, Partner State Health Policy experts and consultants, resulting in a first draft outline of the RHP, preceded consultation in all Partner States during the months of November 2014 to February 2015. The Consultative meetings were attended by all major stakeholders from Ministries of Health, national health institutions, public and community based organizations, health care providers, international and national partners. These consultations and follow-up and interviews with stakeholders, who not able to participate in the consultations, enriched drafting the of RHP. The revised draft was discussed in an EAC Technical Working Group on Health Systems and Policy (23 March 2015) and subsequently

[6] February 2011
[7] East African Community: EAC Climate Change Policy. EAC Secretariat. Arusha May 2010

updated and presented to the Sectoral Committee on Health on 19-20 March, 2016. The final revisions were made in validation workshop of Partner States experts on 22-26 August, 2016 and final version was approved in November 2016 by the 13th sectoral council of minister of Health.

2.0 SITUATIONAL ANALYSIS

2.1 The EAC Partner States Health Profile

The EAC Partner States are all affected by a similar triple burden of communicable diseases, Non-Communicable Diseases (NCDs), and injuries including disabilities. Also the Partners States continue to have poor reproductive, maternal, newborn, child and adolescent health (RMNCAH) indicators.

2.1.1 Communicable diseases, non-communicable diseases (NCDs), Injuries including Disabilities

Communicable diseases still remain a major challenge in the region despite the fact that there are known methods of prevention and control. This is a reflection of weaknesses in research, surveillance, control and public health systems for disease prevention, treatment and care. This situation is worsened by inadequate human resource capacity and poor health service delivery to the affected communities. The frequent population movement across the borders of the five countries poses an increasing risk of spreading communicable diseases from one country to another.

The leading causes of morbidity and mortality in the EAC Partner States include malaria, HIV and AIDS / Sexually Transmitted Diseases, Tuberculosis and Respiratory Tract Infections such as pneumonia, Upper Respiratory Tract Infection, Diarrheal diseases, food borne diseases, parasite and worm infestations. The prevalence of HIV/AIDS across EAC Partner States is still high with 7% in Uganda, 6% in Kenya, 6% in Tanzania, 3% in Rwanda while it is 1% in Burundi. The incidence of TB is generally high in EAC Partner States and three of them namely Uganda, Kenya and Tanzania are among 22 TB high burden countries. TB Incidence including HIV+TB cases ranges from 63/100,000 in Rwanda, 126/100,000 people in Burundi, 161/100, 00 people in Uganda, 246/100,000 people in Kenya and 327/100,000 people in Tanzania

to. The incidence of TB among HIV positive people follows the same trends of HIV and TB with 16/100,000 people in Rwanda, 17/100,000 in Burundi, 73/100,000 in Uganda, 89/100,000 in Kenya and 120/100,000 in Tanzania. The EAC region also faces high incidence of Malaria. These conditions threaten not only to overwhelm public health systems among EAC member states, but also reverse health gains and millennium development goals (MDGs) which have been achieved in the last decade of implementing Poverty Reduction Strategies (PRSs).

Non-communicable lifestyle-related diseases and health conditions such as hypertension, diabetes, heart disease, cancer, mental health and tobacco-related disease cause high burden of disease, stretch the already weak public health systems and contribute to reduced life expectancy, increased morbidity, mortality, disability, and ultimately increased poverty.

Treatment especially for *non-communicable* diseases like cancers is expensive and not readily available in the EAC region. Social determinants and unregulated practices determine the access to treatment. Inadequate investment in public health infrastructure, technologies and skilled human resources therefore hampers prevention, detection and control of diseases. Lack of harmonized health related policies, laws, guidelines, standards, procedures, and regulatory frameworks have limited provision and control of diseases at the regional level. For instance, treatment guidelines across the borders have affected access to care (treatment, nutrition and psychosocial support) and control of the diseases between and among Partner States.

The EAC has over the years experienced challenges in areas of coordination and harmonization of health policies and strategies for the region and monitoring regional and global commitments for health. Furthermore, the health systems are challenges by fragmented medical research, insufficient training on

communicable diseases, and inappropriate mainstreaming of health related issues such as: social determinants of health, education, nutrition and poverty into regional and national strategic plans among others. However, because of a broad based population pyramid in the countries of the region and in sub-Saharan Africa in general, they are bound to enjoy the benefits of demographic dividends. This entails freeing up of resources for a country's economic development and the future prosperity of its populace as it switches from an agrarian to an industrial and service economy.

2.1.2 Injuries, Mental Health, Alcohol consumption Tobacco use and Disability

Conditions such as, trauma and road traffic injury as well as mental health conditions are now becoming among the leading cause of death and disability among productive population category. Tobacco and alcohol are two main preventable risk factors for non-communicable diseases, with tobacco being the single largest preventable cause of death among young and middle-aged people in the world.

Injuries resulting from traffic collisions, drowning, poisoning, falls or burns - and violence - from assault , self-inflicted violence or acts of war–kill more than five million people worldwide annually and cause harm to millions more. A large proportion of people surviving their injuries incur temporary or permanent disabilities. In the EAC partner States, road injuries are one of major causes of deaths, morbidity and disability. In Kenya, the incidence of injuries and violence is on the increase, with mortality levels increasing over the years to account for 7.9% of all deaths in 2013, and mainly affecting the productive and younger population. Injuries especially from road traffic accidents and violence because 3.5% of disability adjusted life years and 7th leading cause of Disability adjusted life years. In Uganda, road traffic injuries remain a major cause of death, morbidity and disability ranking number six in 2013

and they accounts for 11% of all deaths in Burundi. In Rwanda, physical trauma is the most common cause of NCDs, a significant proportion of those cases being road traffic accidents. Likewise, road traffic accidents account for a high proportions of injuries followed by falls and assaults in Tanzania. Passengers accounted for a greater proportional of road traffic crash victims (38.2%) followed by pedestrians (31.9%). Motorcycles accounted for 47.3% of all road traffic crashes.

Mental health: Mental disorders include common conditions such as depression and anxiety, those due to abuse of alcohol and other substances, and also severe and disabling disorders such as schizophrenia and bipolar disorder.

Globally, mental disorders are progressively increasing and they are expected to account for 15% of the global burden of disease by 2020 according to WHO. Current predictions also indicate that by 2030 depression will be the leading cause of disease burden globally. Mental disorders are responsible of disability as when only the disability component is taken into consideration in the calculation of the burden of disease, mental disorders account for 25.3% and 33.5% of all years lived with a disability in low- and middle-income countries, respectively. In East African Community Partner States, the contribution of neuropsychiatric disorders to the global burden of disease is 5.7% in Kenya, 5.3% in Uganda and Tanzania, 4.9% in Burundi and 4.8% in Rwanda.

Alcohol use: The pure alcohol consumption among persons (age 15+) in liters per capita per year is high among EAC Partner States as three of them are among top seven countries with high consumption rate in Africa. After south Africa, Gabon, Namibia and Nigeria where the pure alcohol consumption per capita per year among persons aged more 15 years is 11 liters, 10.9 liters, 10.8 liters and 10.1 liters respectively, three EAC partner States follow with Uganda and Rwanda having the consumption rate of 9.8 liters per year per capita each and Burundi with 9.3 liters. Tanzania is not far as ranks number 11 in Africa with 7.7 liters per

capita per year while Kenya has the least consumption rate among EAC Partner States with 4.3 liters per capita per year.

Tobacco use: Tobacco use among population aged 15-49 years varies across EAC Partner States and it is higher among men compared to women of the same age group. Tobacco use among men is 21.2% in Burundi, 20.7% in Tanzania, 19% in Kenya, 16% in Uganda and 9.7% in Rwanda. Among women of the same age group, it is 10, 2% in Burundi, 2.8% in Uganda, 1.7% in Rwanda, 1.4% in Tanzania and 1% in Kenya.

Disability: The World Health Assembly (Resolution WHA 58.23 of 25th May 2005 on Disability, including prevention, management and rehabilitation) recognizes disability as a global, regional and national issue of public health importance as well a human rights issue and a development priority because people with disability, throughout the life course, face widespread barriers in accessing health and related services, such as rehabilitation, and have worse health outcomes than people without disability. The World Health Organization (WHO) points out that disability affects 15% of world population aged 15 years and above and is mainly associated with ageing population, disease, malnutrition, injuries due to war, violence, road traffic accidents among others. In EAC Partner States, lack of evidence-based data on the nature and extent of disabilities as well as other factors that affect persons with disabilities (PWDs) has posed challenges in terms of planning for this segment of the population.

2.1.3 Reproductive, Maternal, Newborn, Child, Adolescent Health (RMNCAH) in East Africa

Under-5 mortality rates in the EAC region range from 50 to 96 per 1000 live births with a regional average of 68. Kenya and Rwanda reported the lowest U5 mortality rates at 52 and 50 respectively, followed by Tanzania at 54 per 1,000 LBs, Uganda with 80 per 1,000 LBs and Burundi with 96 per 1,000 LBs. Likewise, Infant mortality

rates in the EAC region have dropped in the period 1990-2015 to reach a regional average of 56 per 1,000 live births (LBs).

The first 28 days of life (the neonatal period) is the most vulnerable time for a child's survival. Neonatal mortality declined steadily worldwide by 40 per cent between 1990 and 2013. However, in the EAC region this decline was weaker than for other RMNCAH indicators and it accounts for more than 50% of infant deaths in most of EAC partner States. More effort is required to address this slow progress.

All EAC Partner States have made important gains by reducing Maternal Mortality Ratios between 1990 and 2015. However, the Maternal Mortality Ratios (MMR) in the region is still unacceptably high: 500/100,000 LBs in Burundi; 438/100,000 LBs in Uganda, 432/100,000LBs in the United Republic of Tanzania; 360/100,000 LBs in Kenya which shows a downward trend compared with the 488/100,00, and 210/100,000 LBs in Rwanda. Most of the maternal deaths are largely due to preventable causes.

The EAC Partner States made significant progress to attain the health MDGs, however only Rwanda and Tanzania achieved MDG4, while Rwanda achieved MDG 5 as well.

Adolescent birth rate in the region is also generally high – it ranges from 45 births per 1,000 women aged 15-19 years in Rwanda, 134 births in Uganda per 1,000 women aged 15-19 years.

The average annual population growth rate in the region is still high. With the exception of Kenya and Rwanda whose total fertility rates are 3.9 and 4.2 children per woman respectively, the rates in Burundi, Uganda and the United Republic of Tanzania are in excess of 5 children per woman[8]. These figures above show that the region l requires accelerated efforts and stronger political backing for women and children to achieve SDGs.

[8] Latest Demographic and Health Surveys of the Respective Partner States

2.1.4 "One Health"

Nearly 75 percent of recent newly emerging or re-emerging diseases affecting humans have originated in animals. Notable reminders of how vulnerable the increasingly interconnected world is to emerging diseases include HIV/AIDS, influenza, hemorrhagic fevers like the Ebola virus, Rift Valley fever, and most recently the novel Middle East Respiratory Syndrome Corona virus (MERS-CoV). Newly emerging diseases, endemic zoonotic diseases, such as rabies and brucellosis, as well as other urgent issues such as increasing global trends in antimicrobial drug resistance have raised awareness of the global interdependence of human health, animal health, environmental health, and economic security.

Climate change and its impact on health has become a social, economic and environmental challenge facing humankind both at local and global level. Impacts include floods, frequent prolonged droughts, reduced water supply, decline in crop yields worsening food insecurity, increase in pests and diseases for livestock, wildlife and crops, increase in invasive species, increase of vector-borne diseases.
Free movement of people, animals, and animal products across borders of the Partner States has led to increased transmission of communicable diseases. This trend is worsened by inadequately developed and ill equipped cross border surveillance mechanisms. This situation contributes to low detection of infected persons and animals, contaminated foods and substandard medicines crossing the borders of the EAC Partner States.

2.1.5 Other Health Problems

Perennial conflicts within the horn of Africa and the Great Lakes region, terrorism and piracy threats, the proliferation of small arms and *influx of refugees and migrants* into the EAC region pose a

humanitarian problem which impacts the health sector's capacity and its financing.

Health services delivery, especially in rural and hard to reach areas is hampered by the following issues: inadequate health infrastructure and services, shortage of computer literate healthcare personnel, lack of training facilities with regard to the ICT in healthcare, absence of ICT based healthcare in medical curriculum, unstable communication services to facilitate e-Health services, inadequate social amenities and skewed distribution of high-level services and infrastructure.

Access to quality and essential medicines and vaccines: Generally the availability of and access to essential medicines in the health sector is low in all developing countries including the EAC Region. For example a study conducted by WHO[9] in 2008 shows that availability and access to essential medicines in sub-Saharan Africa was 34.9%. Average availability of selected essential medicines was 51.8% in public sector health facilities and 68.5% in the private sector over the period 2007-2011, up by a few percentage points on both counts from the previous measurement. Availability of essential (generic) medicines in the subsample for low- and lower-middle income countries was only 50.1 per cent in public sector health facilities and 67% in private facilities[10].

The major causes for low availability and access to essential medicines in the EAC region include inadequate legal and policy environment, inadequate public sector financing, weak supply chain systems and poor domestic manufacturing capacity. In addition to this, rational drug use is critical.

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[9] Ref: (Access to affordable essential medicines; www.who.int/**medicines**/*mdg/MDG08ChapterE***Meds***En.pdf)*

10 http://www.un.org/millenniumgoals/2012_Gap_Report/MDG_2012Gap_Task_Force_report.pdf

Health research and development: The EAC Partner States recognize the critical role of research and development in the promotion of quality health care. In this regard, the EAC set up a Regional Health Research Commission, which supports national research institutions. Nevertheless, the major challenges facing research and development in the region include inadequate funding, poor infrastructure, inadequate capacity and poor uptake and use of research findings and innovations.

Most of the research activities are donor-funded and therefore do not necessarily address regional health priorities. Hence, most research funding targets basic and operational research, which does not necessarily lead to product development. The linkages between academia, research institutes and Industries are still weak that they rarely collaborate in research and development.

Leadership and governance: Leadership and good governance ensure that health services are open, transparent, accountable, equitable, and responsive to the needs of the people. The WHO[11], underscores that the health system can only work efficiently and effectively in the presence of effective leadership and governance. For example, the 2014 Ebola outbreak in West Africa demonstrated how events could quickly spin out of control, with disastrous global consequences, in absence of effective health sector leadership and governance[12].

Promoting eHealth and Information and Communication Technologies (ICTs): The practice of medicine by using modern telecommunication technologies to provide health care services is one of the major innovations of the information age and the development of telemedicine practice in East Africa can greatly improve regional cooperation in health service provision in the three EAC Partner States.

[11] http://www.who.int/healthsystems/strategy/everybodys_business.pdf
[12] The Lancet, October 22014: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)61791-8/fulltext?rss%3Dyes

The implementation of the telemedicine in East Africa will improve access to specialty care, reduce the cost associated with long distance travel for medical examination and treatment, increase access to continuing medical education and training, and reduce professional isolation among doctors and other health staff located in rural and remote areas.

In this regard, the East African Community has embarked on an e-Government regional programme under which e-Health and telemedicine practice are among the identified key areas. In addition, the overall EAC Regional e-Government Policy and Framework for East African Community underscores the need for the installation of supporting Information Communication Technology (ICT) infrastructure at various levels, including the use of satellite–based communications.

The EAC regional e-Government Programme was started in 2004 when the East African Community (EAC) recognized the need for exploring the use of Information Communication Technologies (ICTs) to achieve the overall vision of regional integration and also to create wealth as well as to raise the living standards of all people of East Africa. The EAC Regional e-Government Programme aims at the efficient use of ICTs in public administrations combined with organisational change and development of new skills. The Programme further aims at enhancing and extending public services delivery, democratic processes that would support regional integration for political, economic, social and cultural development of the region as per the relevant provisions of the Treaty for the establishment of the East African Community.

The First Regional Stakeholders Workshop on e-Government which was held in Dar es Salaam on 17th to 19th November 2004, agreed on the need for the development of a Regional e-Government Framework for EAC. It also agreed on the initial priority areas for the implementation of e-government flagship

applications. In addition, the Regional e-Government Framework for EAC which was recently approved by the 13th regular meeting of the EAC Council of Ministers and the 8th Summit of the EAC Heads of States held in November 2006 identified e-Health as one of the seven focus areas in the implementation of the e-Government Programme.

As a follow up to this, the meeting of Ministers responsible for Communications held on 15th February 2007 agreed that projects in e-Health should be included in the priority list of initiatives that would be implemented under the third EAC Development Strategy: 2006-2010 and subsequent strategies, policies and legislation.

The Regional e-Government Framework recognizes that health services and facilities in the Partner States demand a lot of improvement and the challenges facing this sector are many. The highlighted challenges include the following, among others: lack of health infrastructure and services, shortage of computer savvy healthcare personnel, lack of training facilities with regard to Information Communication Technologies (ICTs) in healthcare, absence of ICT based healthcare in medical curriculum, unstable communication services to facilitate e-Health services.

In the context of the East African e-Government regional framework, e-Health refers to the use of modern information and communication technologies to meet needs of citizens, patients, healthcare professionals, healthcare providers, as well as policy makers and other stakeholders at local, national, regional and international levels. Thus, e-health practices provides an efficient mechanism for public health management (governance) and health care delivery systems in general, especially on the delivery of care to patients by health care professionals (hospitals, primary and home care, telemedicine, etc), health-related information (health care workers, general public) and enhance the trading in

health-related products and services (pharmaceuticals, medical devices and health technology).

On the other hand, Telemedicine or "Long distance medicine" typically refers to the use of modern telecommunication and information technologies for the provision of clinical care to individuals located at a distance and to the transmission of feed-back information to provide that care, especially in hard - to - reach areas or where specialist (s) opinion or joint consultation is required. Thus, telemedicine provides rapid access to shared and remote medical expertise by means of telecommunications and information technologies, no matter where the patient or relevant information is located.

The EAC Regional e-Government Policy and Framework considers an action roadmap in Strategic Areas supported by enabling legal environment, Secure Information Infrastructure and adequate human resources. On the policy front, it outlines the agreements and protocols that should be in place to sustain e-government services, applications and contents in a harmonized manner across the region. The policy issues also calls for a review and suitable adaptation of legislation at national and EAC level to ensure interoperability and competitive environment as well as to reduce legal obstacles to the services offered online.

Leadership and governance: Leadership and good governance ensure that health services are open, transparent, accountable, equitable, and responsive to the needs of the people.

The WHO[13], underscores that the health system can only work efficiently and effectively in the presence of effective leadership and governance. For example, the 2014 Ebola outbreak in West Africa demonstrated how events could quickly spin out of control,

[13] http://www.who.int/healthsystems/strategy/everybodys_business.pdf

with disastrous global consequences, in absence of effective health sector leadership and governance[14].
In the EAC Partner States, the major weaknesses include weak oversight, inadequate accountability mechanisms and enforcement of regulations and standards, poor prioritisation of programmes, inadequate and often inflexible funding, weak governance capacities and inadequate stakeholder engagement.

Global Health Security: The East African Community (EAC) is committed to the implementation of the "Global Health Security Agenda (GHSA)" which looks at infectious diseases as a common security issue for the whole world. The "Global Health Security Agenda (GHSA)" is a collaborative effort between various nations, international organizations and public and private stakeholders, to accelerate progress toward a world safe and secure from infectious disease threats and to promote global health security as an international security priority.

The **"Global Health Security Agenda (GHSA)"** acknowledges the essential need for a multilateral and multi-sectoral approach to strengthen both the global capacity and nations' capacity to prevent, detect, and respond to infectious diseases threats whether naturally occurring, deliberate, or accidental – capacity that once established would mitigate the devastating effects of highly pathogenic infectious diseases, and bioterrorism events, among others.

Through a partnership of various nations, international organizations and non-governmental stakeholders, the Global Health Security Agenda (GHSA) is facilitating collaborative, capacity-building efforts to achieve specific and measurable targets around biological threats, while accelerating achievement of the core capacities required by the World Health

[14] The Lancet, October 22014: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)61791-8/fulltext?rss%3Dyes

Organization's (WHO) International Health Regulations (IHR), the World Organization of Animal Health's (OIE) Performance of Veterinary Services Pathway, and other relevant global health security frameworks.

The Treaty for the establishment of the East African Community sets the basis for the countries in the region to jointly implement disease prevention and control actions that are of benefit to the populations of EAC. Article 117 defines the scope of cooperation that includes health; articles 108,114 and 116 focuses on Animal Health and Zoonotic Diseases and prescribe common outlook at management of natural resources and wildlife and article 118 provides for "joint action towards the prevention and control of communicable and non-communicable diseases and to control pandemics and epidemics..."

Furthermore, the East African Community (EAC) has adopted a multi-pronged "one-Health" and the "Whole of Society" approach in the control of these conditions as approved by the 9th Ordinary Meeting of the EAC Sectoral Council of Ministers of Health in 2014 and also the 29th Ordinary Meeting of the EAC Council of Ministers 2014. All countries in the region have adopted the WHO-advocated strategies of Integrated Disease Surveillance and Response (IDSR) and International Health Regulations (IHR (205) aimed at early detection, confirmation, reporting and response to the epidemics.

The East African Community (EAC) through the "East African Community Integrated Disease Surveillance and Response Network (EAIDSNet)" and in coordination and collaboration with the EAC Partner States and various national, sub-national and regional and international stakeholders and actors has implemented a number of EAC regional cross-border emergency preparedness and response actions to control the spread of the diseases. The 10th Ordinary Meeting of the EAC Sectoral Council of Ministers in 2014 and the 30th Ordinary Meeting of the EAC Council

of Ministers directed that the "East African Community Integrated Disease Surveillance Network (EAIDSNet)" be designated as the regional Focal point (Hub) for the "African Union Network of Infectious Diseases (the AUNIDS)" and it also urged the EAC Partner States to identify and designate a consortium of national institutions and constitute the National Centers on Infectious Disease Surveillance (NatCIDS) in each Country.

Sustainable Financing: Growth in EAC Partner States mirrors the economic growth of the African continent, averaging 4.5% per annum over the decade 2000–2010. Regional GDP growth is expected to exceed an annual average GDP growth rate of 5% in the period up to 2020. This growth is anticipated to continue apace, doubling per capita income across the EAC Partner States between 2010 and 2020. Currently, in EAC, level of unemployment and poverty levels are still high; these lead to poor access to social services including health and education, safe water supply and sanitation. There is very limited institutional mechanism in training and application of health economics tools in the region.

In the EAC region, only 64% of health care financing comes from domestic sources, with 20% coming from governments, and 16% from the private sector (e.g. voluntary health insurance) 28% is from Out Of Pocket (OOP) spending. External funding contributes for 36%; this poses a challenge of the sustainability of health financing in the region. Further, individual EAC Partner States have developed different funding mechanisms including HIV Trust Funds and The National Hospital Insurance Fund (NHIF) for the Republic of Kenya, Tanzania and Burundi; Community Based Health Insurance (CBHI) in Rwanda and Tanzania to enable the countries to have reliable and sustainable financing for health. Uganda is in the process of setting up a National Health Insurance Scheme.

The average real Total Health Expenditure (THE) for 2012/2013 for the EAC region is 45 USD per capita as compared to the 86 USD recommended for UHC with varying spending; Rwanda, 70 USD,

Kenya 66 USD, Tanzania 50USD, Uganda 49USD, and Burundi 21 USD per capita below the minimum recommended amount USD86 by WHO. For the region as a whole, the average expenditure to health out of the total public budget has grown from 4% in 2009/2010 to 5.5% in 2012/13.

Health Systems: In accordance with the relevant provisions of the Treaty on the establishment of the East African Community with regard to regional integration in the health sector, the EAC Partner States aim to take joint action and cooperate through the development and strengthening of a well-functioning integrated regional health system working in harmony and built on having trained and motivated health workers, a well-maintained physical infrastructure, equipment and facilities as well as strong organizational and institutional structures and a reliable supply of medicines and technologies backed by adequate funding, strong health plans and evidence based policies. At the same time, because of the interconnectedness of our globalized world, health systems need to have the capacity to control and address global public health threats such as epidemic diseases and other severe events.

2.2 Main Opportunities and Challenges

2.2.1 Opportunities:

i. Clear EAC Treaty mandate on regional cooperation on health (Article 118);
ii. Overall EAC Development Strategy (2012-2016).
iii. Establishment of EAC Sectoral Council of Ministers of Health and the five Technical Working Groups (TWGs) on Health;
iv. Vertical and horizontal linkages with organs and institutions of the EAC Partner States;
v. Development of EAC Web portal that is linked to National data warehouses;

vi. Strengthened Laboratory networking through the East African Public Health Laboratory Network project;
vii. Strong oversight for the health sector provided by the EAC Sectoral Council of Ministers of Health;
viii. Political goodwill from the leadership of EAC Partner States;
ix. Investment opportunities in the health sectors of member countries;
x. Support from development partners and through South-South cooperation;
xi. A rich agricultural base providing food to the population;
xii. Employment opportunities for skilled human resource in the health sector;
xiii. Provisions of the Common Market Protocol;
xiv. Existing medical and health research institutions;
xv. Reciprocal Recognition of Medical and Dental Schools across the Region, based on regionally adopted guidelines and inspection tools;
xvi. Reciprocal recognition of graduated professional practitioners across the region;
xvii. Information exchange across the region between regulatory bodies on regulatory affairs, including on disciplinary actions against professionals, e.g. in case of professional mistakes; and
xviii. A fast growing ICT sector.

2.2.2 Challenges:

i. Insufficient management of human resources: inadequate number and distribution of health workers, lack of tools to manage human resources and administrative services in health facilities, migration of health workers from the EAC Region leading to skewed distribution of health workers;
ii. Increasing triple burden of disease from both communicable and non-communicable diseases and injuries including disabilities;

iii. Weak supply chain management for medicines, diagnostics, supplies and medical devices and inadequate capacity for local production;
iv. Outdated and insufficient health infrastructure including health facilities and equipment;
v. Limited application of health economics tools in the health sector;
vi. Poor health care financing characterized by high out of pocket payments at the point of service inhibiting universal access to essential health services ; inadequate domestic financing of the health sector aggravated by dependency on external financing, planning of health service capacities and the implementation of effective provider payment mechanisms and fees/budgets to enhance appropriate use of resources;
vii. Limited coordination and oversight framework and governance of the health sector, prevalence of corruption, lack of transparency and accountability;
viii. Poor Health Management Information System and Inadequate use of ICT;
ix. Fragmented and non-harmonized national level health policies and strategies;
x. Inadequate research and surveillance;
xi. Lack of standardized and evidence-based treatment guidelines across borders;
xii. High cost of prevention, detection and treatment of non-communicable diseases;
xiii. Lack of integration of various disease programs, no effective coordination of programs and data related to diseases programs are not sufficiently integrated into the collection of information and information systems;
xiv. Increased cross- border movements coupled with weak disease surveillance systems;
xv. Globalization leading to change of lifestyle and food production patterns, increased movements;

xvi. Weak regulation and enforcement to prevent proliferation of sub-standard medical products including drugs, supplies and equipment;

xvii. Vulnerability of region to drought, floods and other disasters enhanced by Climate Change;

xviii. High population growth rates;

xix. Insufficient capacity and tools for rational decision making on new and existing health technologies;

xx. Crowding out of existing good and cheap medicines by actively marketed more expensive, but therapeutically equivalent medicines and thereby possibly reducing access to effective drugs, especially for the poor residents of the EAC;

xxi. Insufficient focus on consumer and patient protection in combination with limited awareness among the population about the health threats they face and what they can do to prevent exposure to these threats;

xxii. Low awareness among patients what they can expect from health care services and how to use these appropriately and timely;

xxiii. Unregulated cross-border use of health services without financial compensation;

xxiv. In effective and inefficient use of scarce resources resulting in the need for synergies in policy development and health services implementation, for the establishment of supra-national institutions and for mutual support in disaster management preparation and response; and

xxv. New possible health threats emerging from limited regulation and norm setting for industries that process and provide food, alcohol and tobacco and the industries' marketing efforts, including those for pharmaceuticals.

3.0 RATIONALE AND JUSTIFICATION

The RHP is prepared and ultimately endorsed to advance a number of objectives stated in the Treaty and subsequently in this policy. It ought to respond to major regional challenges, such as the lack of portability of health services entitlements to other countries of workers and in general of residents of partner state. This relates to one of the important goals of the Treaty and its Common Market Protocol: the free movement of citizens and workers.

The RHP also focuses on using and expanding regionally available capacities to support, coordinate and provide guidance to solve national or EAC common problems related to the health of the Community's population, the challenges faced by their health systems and the existing and emerging health threats, many of which cross borders and demand a regional solution. Hence the RHP provides also for guidance to Partner States for their strategies and policy formulations and subsequent regulatory and implementation activities.

Although the EAC has developed and implemented, together with the Partner States, many important activities, an overarching broad and far reaching health policy was missing. This RHP is providing such broad framework and is comprehensive in nature to cope with current and future challenges for the health sector, its governance and the cross border character of health threats. It facilitates the growing common market with its free movement of citizens, capital, services and goods, thus supporting a growing economy and a healthy and active Community population. It is further providing inputs for the application of the "One Health" principle related to environment, animal and plant health as well as food security and safety, in close collaboration with directly concerned EAC sectors and with all other sectors that have an impact on the health and wellbeing of the population.

4.0 POLICY ORIENTATION

4.1 Framework

The policy orientation is based on the legal framework mentioned in the introduction, the commonly perceived challenges as regards the health of the EAC, the common values of the EAC, the need of using effective and efficient health related interventions more equitably across the EAC. It is also guided by a number of principles, first of all related to the Treaty itself, secondly the added value of doing things regionally, thirdly as regards what could be better done or preferred to be done by countries themselves, also in light of decentralization and devolution in Partner States (subsidiarity principle) and, fourthly the criteria for prioritization and implementation of actions by the EAC Secretariat and Partner States.

4.1.1 Principles

The Treaty (Art. 6, d, e & f) lists fundamental principles or values some of which have specific relevance for the RHP, such as "good governance, including adherence to the principles of democracy, the rule of law, accountability, transparency, social justice. Equal opportunities, gender equality, human and people's rights... "And "equitable distribution of benefits and cooperation for mutual benefit", followed by operational principles "people centered and market-driven co-operation" (Art 7.1.a) and "the principles of complementarity"(Art 7.1.g) and "social justice" (Art 7.2). These principles and values can be specified for the health sector respect for life, environment and human dignity with regards to:

a) Diversity as regards culture, religious orientation, vulnerable categories of the population and people in vulnerable stages of their life and for equity by accepting the need for solidarity in financing of health services reduce financial barriers to universal access to health services; and

b) The principle of democracy which guarantees equal participation of society, through co-determination and inclusiveness

The principles reflected in the EAC Treaty and those in the Common Market Protocol, to which the Partner States should adhere to, are also relevant for the health sector, i.e. non-discrimination, most-favorable treatment, transparency and information sharing.

Specific principles for designing and implementing a health policy are the "one health" principle, related to all the living, the environment and food safety and food security, and hence the need for a multi-sector approach to health risks and risk mitigation. Further a sustainable health financing system; an open attitude to partnerships in the community and with partners outside it; common ethical standards in health, such as the World Medical Association's international code of medical ethics[15]; people, community and patient centeredness; responsiveness vis a vis the needs of the community, peoples, gender (specificity) vulnerable categories of the population, families and individual patient needs, confidentiality and respect for privacy of persons and patients.

4.1.2 Criteria for inclusion of issues, objectives and possible follow up strategies

The mentioned principle of subsidiarity and the Treaty's principle of complementarity are also main criteria for decision making on what should be done at which level in the development and implementation of the Regional Health Policy, i.e. on the EAC level or on country level.

Further criteria are:

i. Risk and problem orientation;
ii. Scale of problems:

[15] http://www.wma.net/en/30publications/10policies/c8/

a) Common regional problems
b) National problems with possible impact on neighbors
c) Possible synergy via a common approach;

iii. Decentralization and devolution in Partner States, shifting some important mandates to lower level governments;
iv. Effectiveness of proposed policies, follow-up strategies, instruments and actions;
v. Efficiency in the choice and application of the previous principle;
vi. Quality of care, patient safety and consumer protection against health risks;
vii. Contribution to economic growth but not at the cost of health;
viii. Contribution to universal health coverage (UHC) especially expanding social health protection;
ix. Participation of society and stakeholders in its development; and
x. Implementation capacity of EAC Secretariat and Partner States.

4.2 Policy

Vision

A healthy and productive population in the East African Community.

Overall Objective

To build a harmonized, equitable, sustainable and integrated health approach, supporting systems and services, adequately funded, for the general well-being of the EAC population and its environment.

Policy Objectives

Based on the requirements reflected in the Treaty, to be applied in the RHP, on the situation analysis and stated challenges, taking

into account the stated values, principles and criteria, the 9 objectives of the RHP are stated in the text tables hereafter. The non-exhaustive policy statements in these tables are included to show the policy directions of this policy.

Table 1: Policy Objective 1

Policy Objective 1: Capacity established and kept up to date for effective and efficient prevention, promotion, control measures for communicable and non- communicable diseases, injuries, disabilities, health effects of climate change and population control.
The EAC region is in need of an adequate response to control population growth to its triple burden of both communicable and Non- communicable diseases and injuries. Infectious diseases such as HIV/Aids, Malaria and TB are prevalent including neglected tropical diseases (NTDs) while at the same time there is also an increase in the cases of cancers, cardiovascular disease and diabetes mellitus while maternal, neonatal and child mortality and injuries are still high and important social determinants are at play, especially along transport corridors crossing borders. Road injuries are one of major causes of deaths, morbidity and disability. All these factors pose a major strain on the existing resources. The threats from effects of climate change will lead to flooding, droughts and the spread of communicable diseases to new geographic areas The already noticed effects of climate change, i.e. resulting in flooding, droughts and insect borne infectious diseases to new geographic areas will also need a health sector response. **Policy Statements:** I. Sustain and extend the gains achieved in the control of HIV, Malaria and TB in the region II. Strengthen the prevention and control measures to eliminate communicable including neglected tropical diseases in the region

III. Strengthen the prevention and treatment of substance abuse as well as rehabilitation of abusers

IV. Strengthen RMNACH services including population control

V. Strengthen an integrated, well-coordinated, comprehensive, effective and efficient surveillance system for infectious and non-infectious diseases,

a) for epidemics preparedness and immediate and sustained response capacity to emerging and re-emerging diseases and events of public health concern and

b) for overall disease control and NCD management,

c) Supported by a regional well-coordinated mechanism through regional centers for disease prevention and control, management of NCDs, which should be adequately resourced and include appropriate lab capacity and supported by secured communication technology and internet based information exchange for rapid response in the community for emerging threats.

VI. Put in place inter-sectoral and intra-sectoral health promotion programs including on consumer awareness of health risks, population growth and appropriate use of health services to address communicable and non-communicable diseases

VII. Establish a Health EAC Regional Centers of Excellence

VIII. Promote universal access to safe drinking water and sanitation

IX. Ensure in all health sector related activities and their support systems the protection of the environment and sustainable use of natural resources

X. Ensure food safety, food security and balanced nutrition as well as access to dietetics programs.

XI. Promote health of animals used in the food chain

XII. Put in place health norms and standards for industries as regards food, food products and potentially harmful consumables such as alcohol, tobacco and medicines,

including for their marketing to protect consumer rights and protect them from possible industry generated health risks

XIII. On climate change, support
   a) Development of effective early warning systems and emergency health measures for Climate Change related diseases in all EAC Partner states
   b) Community sensitization of health effects of climate change and rapid population growth
   c) Environmental impact assessment of investments and processes in the health sector
   d) Facilitate availability of health facilities, equipment and medicine to assist in early diagnosis and treatment of climate change related diseases
   e) Enhance capacity of medical personnel on climate change , including traditional/indigenous knowledge
   f) Emphasize strong community level health actions

XIV. To strengthen and implement effective injury prevention strategies in order to reduce their occurrence and the consequences in East African Region

XV. Reinforce the current strategies to promote mental health including actions to create living conditions and environment that allow people to adopt and maintain health.

XVI. To strengthen and implement effective injury prevention strategies in order to reduce their occurrence and the consequences in East African Region.

XVII. Maximize on the Demographic Dividend (DD) for accelerated positive socio-economic transformation trough advocacy and mobilization of domestic and external resources towards health, education, job creation, family planning and good governance in the EAC region.

Table 2: Policy Objective 2

Policy Objective 2: Mechanisms for providing coordinated, effective and appropriate preparedness and responses to disasters and complex emergencies instituted within the EAC
The region is prone to natural and manmade disasters such as landslides, floods and population displacement and influx of refugees due to conflict. **Policy Statements** I. Mainstream Disaster Risk Management within Development Planning in the health sector in all Partner States II. Strengthen Disaster Management planning, information sharing mechanisms, preparedness and institutionalized coordination on the EAC level and facilitate mutual support and coordination between Partner States to cope with emergencies and disasters III. Prepare for complex health emergencies such as for epidemics like the Ebola and pandemic influenza IV. Reinforce Vulnerability Risk Assessment, Mapping for disaster and Mass Care capacities commensurate with estimated risks.

Table 3: Policy Objective 3

Policy Objective 3: Strengthen and harmonize training of adequate and well skilled, productive and well-regulated human resources for health in the EAC region for delivery of quality health care.
Access and quality of health services significantly depends on the availability of up to standard health personnel with regards to knowledge, skills and attitude. Thus, investing in HRH, in regulatory bodies and mechanisms is essential and of great value for the health sector and society and in need of continuous support from the Region and the Partner States. Universal access to quality services delivery for the EAC population through sufficient and

qualified human resources for health, among others, ensured adequate and up to date professionals related education and regulatory mechanisms and standards as regards knowledge, skills, attitude and performance to advance professionalism, hence constantly assuring and improving quality of care and patient protection and the free movement of health professionals and equitable distribution across the Region.

Policy Statements:

I. Support the production and quality of human resources for health by expanding and strengthening education and training (including in-service training, pre-service training and continuing professional development) in accordance with public demand and develop a sustainable mechanism for its funding
II. Expansion of the faculty and infrastructure capacity of teaching institutions to augment HRH production and identify and cater for specialized training needs in the EAC region
III. Strengthen pre-service and in-service training on leadership, governance and management and quality of care.
IV. Improve HR management through provision of appropriate incentives and other reward packages that will ensure adequate and equitable distribution of well-resourced human resources for health across and within the EAC Partner States.
V. Facilitate free movement of qualified health professionals in EAC Partner States via, e.g. uniformization of curricula, standardisation of training, internships and registration/licensing procedures and credentialing requirements for mutual recognition and patient protection, includes for graduates from outside the EAC region, possibly also via Regional regulatory bodies.
VI. Ensure professional and institutional harmonization of regulatory bodies and cross-border exchange of information on licensed and de-licensed health professionals to protect

patients VII. Secure adequate regulation of professionals' training and their continuous professional development of health professionals according to international standards to allow for reciprocal recognition of health practitioners VIII. Secure effective and coordinating professional regulation bodies across the region, adequate regulations and licensing standards to assure state of the art practicing of health practitioners and to prevent patients from being exposed to substandard or even mal-practicing professionals and from possible harm being done by them IX. Focus on health-needs based training to be responsive to population needs and establish a regional mechanism to fund HRH education and training

Table 4: Policy Objective 4

Policy Objective 4: Mechanisms to improve access and quality of health services
Access to appropriate and timely use of quality health services, especially for the poor and vulnerable, is hampered by financial and geographical barriers, sub-standard quality of health services and ignorance among the population about their entitlements as well as lack of awareness about available and necessary services to stay in good health or regain it. **Policy Statements:** I. Explicitly commit the Partner States to embrace universal health coverage (UHC) II. Strengthen evidence for advocacy at country, regional and global levels to generate increased investments in health services, through communication, partnerships and networking with state and non-state actors III. Prioritization of an essential health services package, including palliative, with specific focus on the delivery of

such services package to marginalized and vulnerable populations at all levels

IV. Establish needs based planning and invest accordingly in health infrastructure to improve the supply side of access to care

V. Ensure availability, affordability of quality essential medicines, diagnostics, supplies, technologies and medical devices

VI. Strengthen a mechanism to ensure involvement of the community, civil society and private sector in developing policies, strategies, health services and their distribution

VII. Establish a comprehensive approach to continuous improvement of quality of care and providing support for targeted solutions for identified weaknesses, to be implemented by Partner States and their health related actors

VIII. Develop service delivery standards16 (including accreditation) to improve the quality of health services , covering private and public sectors, to ensure effective quality assurance and external evaluation mechanisms

IX. Foster mechanisms to increase public demand for and appropriate use of quality health services via health marketing and consumer education

X. Strengthen, harmonize and ensure effective management mechanisms (for HR as well as other health systems building blocks, referral systems, emergency response) of health services delivery systems

XI. Explore the options for more cost-effective procurement and market entry (registration) of quality essential medicines, diagnostics, supplies, technologies and medical devices and their efficient distribution and subsequently decide on such methods and on which level these should be implemented

[16] Standards can be used for different activities, related to quality of care. See Glossary of terms at the end of this draft

XII.	Create a mechanism to enable the poor to access highly specialized regional diagnostic and clinical services
XIII.	Effective regulation of private health service providers with regard to needs based, licensing and pricing
XIV.	Harmonize, strengthen and integrate package(s) of essential RMNCAH services and related standards and guidelines for the attainment of universal coverage of reproductive maternal new born child and adolescent health services.
XV.	Promote high impact reproductive maternal new born child and adolescent health partnership models and reduce preventable maternal newborn and child deaths and enhance wellbeing among women, children, adolescents and families.

Table 5: Policy Objective 5

Policy Objective 5: Effective and sustainable health financing mechanisms towards universal health coverage through social health protection
Guaranteeing timely access to necessary quality care without the risk of impoverishment or catastrophic expenditures requires sufficient and sustainable funding and monitored incentive based payment of providers and health staff. **Policy Statements:** I. Advocate and ensure increased public financing in line with Abuja declaration and also private domestic financial resources to the health sector, governed via effective and transparent functioning funding systems II. Develop and implement a long term, comprehensive and equitable health financing and social health protection strategy (SHP) to achieve UHC, improve access and quality of services to all EAC population and ensure portability across Partner States III. Improve mechanisms for monitoring and tracking

transparent allocation and utilization of resources to ensure effective and efficient service delivery

IV. Strengthen coordination and programming of domestic and external funding for health through improved harmonization and alignment to sector priorities, mutual accountability and improved reporting

V. Strengthen collaboration with private health actors and other sectors that have an impact on health in the EAC

VI. Systematically search for efficiency gains in current resource, allocation and use and subsequently implement the more efficient ways of services delivery.

VII. Strengthen mechanisms to facilitate portability of entitlement to health services across the EAC in support of free movement of persons and workers.

VIII. Strengthen strategic purchasing so as to improve health system outcomes and responsiveness.

Table 6: Policy Objective 6

Policy Objective 6: Enhanced Good Governance in the Health Sector
To make a health system work as intended, its governance mechanisms and the qualities, responsibilities, transparency operating and accountability of its actors are of utmost importance to get value for money and to keep the trust of society and external financiers. **Policy Statement:** I. Develop a Regional Centre of Excellence for health governance and leadership, complemented by training and leadership formation opportunities on national level, and ensure adequate regulatory mechanisms, auditing capacity, consumer and press/media access to governance related information on Regional and Partner State levels

II. Establish mechanisms for harmonization of health service level provision across Partner States at all levels of health care including harmonizing health service quality improvement frameworks and policies.
III. Put in place rules, regulations and structures to promote a social health protection framework in EAC partner states
IV. Prevention, active uncovering and redress of inappropriate use of resources and corruption
V. Put in place transparency mechanisms which involve stakeholders in planning, budgeting, supervision, M&E and complaints-handling to ensure social accountability
VI. Strengthening the technical and financial partnership and collaboration with the international and regional initiatives and partners
VII. Adopt a PPP policy and mechanisms for implementation of this and other policies and strategies, including for the education of specialized health professionals, and specify the levels at which private and public entities should partner
VIII. Strengthen accountability through enhanced public financial management mechanisms

Table 7: Policy Objective 7

Policy Objective 7: Capacities instituted for health systems and health services research to support evidence based policy and intervention formulation
Targeted and cost-effective use of resources in the health sector can be greatly enhanced by a society driven harmonized and coordinated process for health services development and resulting health system, supported by target and prioritized services research. **Policy Statements:** I. Prioritize the health research agenda and support the use of research findings for decision making towards effective and

efficient health systems and services, including the use of health economic studies and analyses, as a routine in EAC Partner States to make the case for increased allocation to the health sector and of health technology assessment for planning of facilities, adoption of health technologies, benefits package decisions and fee-level setting

II. Establish a regional center of excellence for health services research and health technology assessment to coordinate and collaborate with strengthened national centers

III. Promote international cooperation and exchange of best practices in research

IV. Establish a dynamic M&E framework linked to the use of pre-agreed and well defined data

V. Promote research capacity and advocate for increased research financing

VI. Advocate for the utilization of data on demographic dividend to advocate for increased focus on empowerment of adolescents and youth, with special attention on young women and marginalized populations

VII. Establish a regional research repository to promote data storage and information sharing

VIII. Regulate use of alternative and traditional medicine

IX. Strengthen reproductive maternal new born child and adolescent health research, evidence informed interventions, innovations, and knowledge management.

Table 8: Policy Objective 8

Policy Objective 8: Enhanced access to essential medicines and health technologies
The Partner States have to import many of the health commodities at high costs while potential for domestic research and production is either under-utilized or absent and their natural resources are not researched for their therapeutic properties. For locally produced commodities a large potential regional market exists. **Policy statements:** I. Build research to facilitate product development, manufacturing capacities and promote health service innovations II. Adequately plan investment in research and innovation to overcome the health priority challenges in the region and include adequate allocation of resources for research and innovation including for studies and analyses of traditional health practices so as to identify which good practices can be promoted III. Expand research and development (R&D) into health related products and technologies such as essential medicines and diagnostics; including research into herbal, alternative and traditional medicine with focus on consumer protection IV. Promote and support the development of local manufacturing of health products and technologies, including vaccines V. Ensure scaling up of the AU and WHO policies on the incorporation of intellectual property rights on new discoveries in the region and protection of indigenous/traditional knowledge in as far as local production of health products and practices are concerned VI. Advocate for the establishment a system for promotion and protection of biodiversity in order to promote one-health

approach VII. Strengthen coordination and promote uniformity in registration and quality control of pharmaceutical products VIII. Develop regional procurement chain and strategic purchasing IX. Develop and harness the potential contribution of Traditional and Complementary Medicine (T&CM) to health, wellness and people-centered health care by promoting the safe and effective use of Traditional and Complementary Medicine (T&CM) through regulating, researching and integrating Traditional and Complementary Medicine (T&CM) products, practitioners and practice into health systems, where appropriate in the EAC region.

Table 9: Policy Objective 9

Policy Objective 9: Sustainable, dynamic and appropriate information system developed and maintained for timely and evidence based decisions
To support good governance and facilitate effective management, communication and information exchange within and between Partner States and to use possibilities of telemedicine, information and communication and other business support systems and good connectivity will be needed, capable to technically communicate with each other. **Policy Statements:** I. Establish an EAC data repository which is linked to the Partner States' Health Information systems II. Establish an integrated and effective disease surveillance system for information sharing and rapid response in the community III. Strengthen e-health, e-finance and e-governance systems and infrastructure to support service delivery and disease surveillance, financial management and governance and

portability of health insurance through ICT.

IV. Ensure sustainable and secured communication for disease surveillance and disaster management including early warning systems

V. Guarantee and regulate compatibility of health management information systems, human resource information systems and health logistics information systems

VI. Develop and implement a harmonized secure EAC Regional e-Health System and promote the use of various Information Community Technologies (ICTs) in the region that targets specific high priority health care programmes and selected hard-to-reach populations, including displaced persons and migrant populations in cross-border areas.

5. IMPLEMENTATION FRAMEWORK

5.1. Leadership, Governance and Coordination

For effective implementation of the RHP and subsequently adopted strategies, the EAC Council of Ministers will provide leadership, coordination and define distinct responsibilities of EAC Secretariat in line with the Treaty and strengthen its capacity to facilitate the implementation of the policy hence assuring a comprehensive, coordinated and effective approach. It will further ensure the participation of Partner States and Partner State institutions, the private sector, CSO's and CBO's and commit to support the necessary regulatory bodies, and regulatory and institutional adjustments, to provide sufficient resources to facilitate implementation of agreed protocols, adopted action plans and relevant EAC guidelines. Development partners are invited and coordinated to allow for effective, efficient and appropriate use of the resources provided.

All Partner States through their respective sectors will provide leadership in the implementation of the RHP and subsequent health sector strategic plans.

All partners and institutions will comply with principles of good governance (clear responsibilities, transparency and accountability), supported by tools for e-health, e-governance and e-finance to ensure appropriate use of resources for the sector and of the funds provided for the implementation of the agreed actions.

In general the EAC Partner states' policies and their subsequent strategies, based on the RHP, will take into account the various modes of governance in the region, including decentralization and devolution in terms of governance, service delivery and implementation.

Besides continuing their collaboration with development partners and international organizations to which the Partner States are

signatories, such as UN and its technical agencies, the EAC and Partner States will also seek partnerships with other regional bodies.

EAC and Partner States, when preparing the implementation of the RHP, will take into account the policies and strategies of other international and regional bodies and the formal commitments to which the EAC has committed itself to avoid contradictions or overlap and to look for possible synergies in the implementation.

5.2 Roles and Responsibilities

The EAC Secretariat shall advocate for resource mobilization to contribute to improvement of the health financing systems and to the sustainability of health systems; shall initiate the establishment of supra-National Institutions such as Centers of Excellence; Laboratory Networking and Commissions; a regional Institute of Public Health; a Regional centre of excellence for disease control and an institutionalized mechanism for disaster management; develop guidelines, an M&E framework and suitable indicators.

The EAC Secretariat shall establish an institutional framework and sufficient capacity to coordinate the sector programs which have clear linkages to Partner States; coordinate social health protection measures and implementation; coordinate and facilitate harmonization of Policy, Professional Boards Regulations and registration of professionals and allied professionals; Support the creation of an enabling environment for research and innovation; conduct comparative research in the region to stimulate and support Partner States in strengthening and speeding up agreed actions; advocate resource mobilization to support the implementation of their mandate; sensitize policy makers of EAC Partner States on the importance of the policy; implement and/or facilitate assessment of health technologies in support of rational and evidence based policy implementation by Partners States.

The EAC Partner States will ensure the implementation of the EAC Policy, adopted guidelines and agreed action plans; accelerate the reform processes in implementation of this policy and subsequent strategies; increase domestic resources for health financing including for the professionals regulatory bodies and their adopted regulations; coordinate the stakeholder mandated interventions; and ensure cross border collaboration and information exchange. Partner States will build capacities of CSOs and CBOs.

Development Partners will contribute and provide technical and financial support for the implementation of this policy; for population sensitization and mobilization; and to build the capacity of CSOs and CBOs.

Civil Society Organizations shall be fully involved in the policy formulation and policy dialogue to ensure accountability and shall participate/contribute in and to the implementation of the policy; provide advocacy and mobilize the community including as regards the appropriate use of health services; and foster development in the provision of knowledge at the grassroots level.

The Private Sector will provide for provision of medicines, diagnostics, supplies, technologies, medical devices and health services; invest in health service delivery including specialized health care; support and perform innovation, research, training and development; and contribute to health insurance and health finance in general.

Professionals Boards, Councils and Associations shall provide for oversight and regulation of health sector staff; support the harmonization effort for mutual recognition and collaboration between the partners states and accreditation and registration for expatriate staff; certification, regulations and standards.

Research and training institutions shall provide for training, research and innovation.

Community Based Organizations (CBOs) shall be fully involved in the policy formulation and policy dialogue to ensure accountability. CBOs themselves shall support mobilization and sensitization for policy implementation; development of and change in the Community and engage in advocacy.

5.3 Monitoring and evaluation framework

The monitoring and evaluation (M&E) framework will focus on the overall performance in accordance with the RHP objectives, the implementation processes, outcomes, impact, capacities developed as well as activities carried out by the EAC Secretariat itself, the supra-national institutions, the Partner States and their efforts to implement the policy.

The EAC level set list of regional level indicators will be used to set baselines for the M&E of implementation of the policy and of its successive strategies. The indicator set can be adjusted as deemed necessary. Subsequent strategies, based on the RHP, will have additional indicators. Partner States will timely submit their data in accordance with the indicator set.

The M&E framework and its data collection and indicator set needs to be harmonized with the national data collection systems like domestic and household surveys.

5.4 Requirements for Indicator Setting

To adequately perform the M&E tasks, clear targets, timelines and supporting efforts will be preceded by the formulation of uniform indicators that are measurable, useful, are relatively easy to collect without posing the need for new procedures and responsibilities, i.e. using existing channels and already available data as much as possible while avoiding duplication and restriction to those indicators that can and will be used for further

decision making. Indicators for morbidity and mortality will be based on the current International Classification of Diseases (ICD). Indicators for comparing performance of Partner States of specific activities will be agreed with Partner States.

Baseline indicators shall be developed using the sources of data. The indicators will act as flags, offering Partner States direction to search for causes that may contribute to relative underperformance in implementation of policies and in achieving improved outcomes of healthcare17. Besides morbidity and mortality data, already available, the strategies based on the RHP will contain the more specific targets and indicators related to the specific actions pursued. They will be linked with the main health indicators that track health issues in EAC Partner States. Next to outcome indicators, also process indicators or milestones will be defined, reflecting main achievements of the implementation of the RHP via its subsequent to be adopted strategic plans.

5.5 Processes and institutional framework

Indicator sets will be agreed with Partner States and the providers will be consulted in the interpretation of data and the information and conclusions that can be drawn from them.

Responsible authorities and institutions will be designated to collect, audit and submit data and their interpretation. The EAC Secretariat will guide the uniform application of agreed processes, data definitions and production of statistics and overviews. To this end, it will also support the effective and efficient use of support mechanisms such as electronically supported HMIS, HLIS and connectivity via internet and mobile devices. Data will be disseminated and utilized for decision making.

[17] See also the OECD indicator attention to quality of care for comparative research: http://www.oecd.org/els/health-systems/health-care-quality-indicators.htm

5.6 Reporting

The Partner States will provide annual reports on RHP and subsequent health sector strategy implementation. EAC Secretariat will provide consolidated yearly reports on the implementation status, the possibly encountered problems and propose how to overcome these.

6. CONCLUSION

The EAC Regional Health Policy has been developed in conformity of the EAC Treaty, Art 118 and provides a framework for the development of national and regional strategic health sector plans, policies, guidelines and protocols. It also acts as a reference for other health subsector policies and policies of other sectors impacting on health. This policy will build a harmonized sustainable and integrated health approach for the general wellbeing of the EAC population and environment.

GLOSSARY OF TERMS

Demographic Dividend: The economic growth potential that can result from shifts in a population's age structure, mainly when the share of the working-age population (15 to 64) is larger than the non-working age share of the population (14 and younger and 65 years and older)**.**

Disaster: A serious disruption of the functioning of a community or a society involving widespread human, material, economic or environmental losses and impacts, which exceeds the ability of the affected community or society to cope using its own resources.

Disease outbreak: The occurrence of cases of disease in excess of what would normally be expected in a defined community, geographical area or season. An outbreak may occur in a restricted geographical area, or may extend over several countries. It may last for a few days or weeks, or for several years[18].

Harmonization: Ensuring that different processes in Partner States are well tuned to each other and work in harmony to avoid contradictions, negative overall results and inefficiencies.

Health technologies: Medical equipment and other devices, pharmaceuticals, medical interventions and medical procedures etc.

Health technology assessment: Review of health technologies as regards medical effectiveness, comparative cost-effectiveness (in comparison with other technologies), health gains, costs on national level (related to epidemiology and hence expected use), uptake in benefits package, ethical, legal and consumer perspectives and support decisions on capacity planning and

[18] World Health Organization: http://www.who.int/topics/disease_outbreaks/en/

distribution (geographic and over level of care), on fee/price-setting of health technologies.

Quality of care

The following definitions are used for quality of care improvement purposes and derived from ISQUA's[19]

Accreditation: Act of granting credit or recognition by an external evaluation organisation of the achievement of accreditation standards, demonstrated through an independent external peer assessment of that organisation's level of performance in relation to the standards

Assessment /Reassessment: Process by which the characteristics and needs of patients/service users, groups or situations are evaluated or determined so that they can be addressed. The assessment forms the basis of a plan for services or action

Audit: A systematic independent examination and review to determine whether actual activities and results comply with planned arrangements

Certification: Formal recognition of compliance with set standards validated by external evaluation

Credentialing: Checking and offering proof of an individual's knowledge, skills, and competence and their compliance with specific requirements

Guidelines: Principles guiding or directing action

[19] International Society for Quality of Health Services: Guidelines and Principles for the Development of Health and Social Care Standards 4th Edition Version 1.1, July 2014; Guidelines and Standards for External Evaluation Organisations, 4th Edition. Version 1.1, July 2014

Indicator: Performance measurement tool that is used as a guide to monitor, evaluate and improve the quality of services. Indicators relate to structure, process, and outcomes and are rate based, i.e. have a numerator and denominator so that they can be compared and benchmarked

Licensing: Grant a license to permit the use of something or to allow an activity to take place

Quality: The degree of excellence, extent to which an organisation meets clients' needs and exceeds their expectations

Quality improvement: On-going response to quality assessment data about a service in ways that improve the processes by which services are provided to clients

Standard: A desired and achievable level of performance against which actual performance is measured. (Standards can be used for different aspects and activities in the health sector)

Standard Operating Procedure: Written sets of instructions conveying the approved and recommended steps for a particular act or series of acts

South-South cooperation (SSC): developing countries working together to find solutions to common development challenges[20].

Uniformization: ensuring that processes and standards are similar/uniform across Partner States

Disability: the consequence of an impairment that may be physical, cognitive, mental, sensory, developmental, or some combination of these that result in restrictions on an individual's

[20]http://www.undp.org/content/undp/en/home/ourwork/povertyreduction/focus_areas/focus_development_finance/south-south_cooperation.html

ability to participate in what is considered **"normal"** in their everyday society.

Traditional medicine: means the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness.

Traditional Health Practitioners: means people who use the total combination of knowledge and practices, whether explicable or not, in diagnosing, preventing or eliminating a physical, mental or social disease and in this respect may rely exclusively on past experience and observation handed down from generation to generation, verbally or in writing, while bearing in mind the original concept of nature which included the material world, the sociological environment whether living or dead and the metaphysical forces of the universe.